

**IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION**

TEXAS MEDICAL ASSOCIATION, <i>et al.</i> ,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	No. 6:22-cv-372-JDK
	)	
U.S. DEPARTMENT OF HEALTH AND	)	LEAD CONSOLIDATED CASE
HUMAN SERVICES, <i>et al.</i> ,	)	
	)	
Defendants.	)	
	)	

NOTICE OF FILING OF JOINT APPENDIX

Pursuant to this Court's November 4, 2022 Order (ECF No. 61), the Defendants respectfully submit the attached joint appendix, containing copies of those portions of the administrative record that are cited or otherwise relied upon in any memorandum in support of or in opposition to the cross-motions for summary judgment in this action.

Dated: December 13, 2022

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JOINT APPENDIX

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Federal Register / Vol. 87, No. 165 / Friday, August 26, 2022 / Rules and Regulations

DEPARTMENT OF THE TREASURY**Internal Revenue Service****26 CFR Part 54**

[TD 9965]

RIN 1545-BQ01 and 1545-BQ02

DEPARTMENT OF LABOR**Employee Benefits Security Administration****29 CFR Part 2590**

RIN 1210-AB99 and 1210-AC00

DEPARTMENT OF HEALTH AND HUMAN SERVICES**45 CFR Part 149**

[CMS-9909-F and CMS-9908-F]

RIN 0938-AU62 and RIN 0938-AU63

Requirements Related to Surprise Billing

AGENCY: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Final rules.

SUMMARY: This document includes final rules under the No Surprises Act, which was enacted as part of the Consolidated Appropriations Act, 2021 (CAA). The document finalizes certain disclosure requirements relating to information that group health plans, and health insurance issuers offering group or individual health insurance coverage, must share about the qualifying payment amount (QPA) under the interim final rules issued in July 2021, titled *Requirements Related to Surprise Billing; Part I* (July 2021 interim final rules). Additionally, this document finalizes select provisions under the October 2021 interim final rules, titled *Requirements Related to Surprise Billing; Part II* (October 2021 interim final rules), to address certain requirements related to consideration of information when a certified independent dispute resolution (IDR) entity makes a payment determination under the Federal IDR process.

DATES: *Effective date:* These final rules are effective on October 25, 2022.

Applicability date: See Section III of the **SUPPLEMENTARY INFORMATION** section for information on the applicability dates.

FOR FURTHER INFORMATION CONTACT:

Shira McKinlay, Internal Revenue Service, Department of the Treasury, at 202-317-5500; Elizabeth Schumacher or David Sydlík, Employee Benefits Security Administration, Department of Labor, at 202-693-8335; Deborah Bryant, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at 301-492-4293; Lindsey Murtagh, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at 301-492-4106.

Customer Service Information

Individuals interested in obtaining information from the Department of Labor (DOL) concerning employment-based health coverage laws may call the Employee Benefits Security Administration (EBSA) Toll-Free Hotline at 1-866-444-EBSA (3272) or visit the DOL's website (www.dol.gov/agencies/ebsa).

In addition, information from the Department of Health and Human Services (HHS) on private health insurance coverage, coverage provided by non-Federal governmental group health plans, and requirements that apply to health care providers, health care facilities, and providers of air ambulance services can be found on the Centers for Medicare & Medicaid Services (CMS) website (www.cms.gov/ccio), and information on surprise medical bills can be found at www.cms.gov/nosurprises.

SUPPLEMENTARY INFORMATION:**I. Background****A. Preventing Surprise Medical Bills Under the CAA**

On December 27, 2020, the CAA, which includes the No Surprises Act, was enacted.¹ The No Surprises Act provides Federal protections against surprise billing by limiting out-of-network cost sharing and prohibiting "balance billing," in many of the circumstances in which surprise bills arise most frequently. Balance billing refers to the practice of out-of-network providers billing patients for the difference between: (1) the provider's billed charges, and (2) the amount collected from the plan or issuer plus the amount collected from the patient in the form of cost sharing (such as a copayment, coinsurance, or amounts paid toward a deductible). In particular, the No Surprises Act added new provisions applicable to group health plans and health insurance issuers offering group or individual health

insurance coverage to Subchapter B of chapter 100 of the Internal Revenue Code (Code), Part 7 of the Employee Retirement Income Security Act (ERISA), and Part D of title XXVII of the Public Health Service Act (PHS Act). Section 102 of the No Surprises Act added section 9816 of the Code, section 716 of ERISA, and section 2799A-1 of the PHS Act,² which contain limitations on cost sharing and requirements regarding the timing of initial payments and notices of denial of payment for emergency services furnished by nonparticipating providers and emergency facilities, and for non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, defined as hospitals, hospital outpatient departments, critical access hospitals, and ambulatory surgical centers. Section 103 of the No Surprises Act amended section 9816 of the Code, section 716 of ERISA, and section 2799A-1 of the PHS Act to establish a Federal IDR process that allows plans and issuers and nonparticipating providers and facilities to resolve disputes regarding out-of-network rates. Section 105 of the No Surprises Act added section 9817 of the Code, section 717 of ERISA, and section 2799A-2 of the PHS Act. These sections contain limitations on cost sharing and requirements for the timing of initial payments and notices of denial of payment for air ambulance services furnished by nonparticipating providers of air ambulance services, and allow plans and issuers and nonparticipating providers of air ambulance services to access the Federal IDR process described in section 9816 of the Code, section 716 of ERISA, and section 2799A-1 of the PHS Act.

The No Surprises Act provisions that apply to health care providers, facilities, and providers of air ambulance services, such as prohibitions on balance billing for certain items and services and requirements related to disclosures about balance billing protections, were added to title XXVII of the PHS Act in a new part E.

The Departments of the Treasury, Labor, and Health and Human Services

² Section 102(d)(1) of the No Surprises Act amended the Federal Employees Health Benefits Act, 5 U.S.C. 8901 *et seq.*, by adding a new subsection (p) to 5 U.S.C. 8902. Under this new provision, each Federal Employees Health Benefits (FEHB) Program contract must require a carrier to comply with requirements described in sections 9816 and 9817 of the Code, sections 716 and 717 of ERISA, and sections 2799A-1 and 2799A-2 of the PHS Act (as applicable) in the same manner as these provisions apply with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage.

¹ Public Law 116-260 (December 27, 2020).

(the Departments) previously issued interim final rules implementing provisions of sections 9816 and 9817 of the Code, sections 716 and 717 of ERISA, and sections 2799A–1 and 2799A–2 of the PHS Act to protect consumers from surprise medical bills for emergency services, non-emergency services furnished by nonparticipating providers with respect to patient visits to participating facilities in certain circumstances, and air ambulance services furnished by nonparticipating providers of air ambulance services.³ The interim final rules also implement provisions requiring the Departments to create a Federal IDR process to determine payment amounts when there is a dispute between payers and providers or facilities over the out-of-network rate due for emergency services, non-emergency services furnished by nonparticipating providers with respect to patient visits to participating facilities in certain circumstances, and air ambulance services furnished by nonparticipating providers of air ambulance services.⁴ To implement these provisions, the Departments published in the **Federal Register** the July 2021 interim final rules on July 13, 2021 (86 FR 36872), and the October 2021 interim final rules on October 7, 2021 (86 FR 55980).⁵ The July 2021 interim final rules and October 2021 interim final rules generally apply to group health plans and health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans) with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022; and to health care providers and facilities, and providers of air ambulance services with respect to items and services provided during plan years (in the individual market, policy years) beginning on or after January 1, 2022.⁶

³ 86 FR 36872 (July 13, 2021) and 86 FR 55980 (October 7, 2021).

⁴ The Federal IDR process does not apply if an All-Payer Model Agreement under section 1115A of the Social Security Act or a specified State law applies.

⁵ The interim final rules also include interim final regulations under 5 U.S.C. 8902(p) issued by the Office of Personnel Management that specify how certain provisions of the No Surprises Act apply to health benefit plans offered by carriers under the Federal Employees Health Benefits Act.

⁶ 86 FR 36872 (July 13, 2021) and 86 FR 55980 (October 7, 2021). These provisions apply to carriers in the Federal Employees Health Benefits Program with respect to contract years beginning on or after January 1, 2022. The disclosure requirements at 45 CFR 149.430 regarding patient protections against balance billing are applicable as of January 1, 2022.

B. July 2021 Interim Final Rules

The July 2021 interim final rules implement sections 9816(a)–(b) and 9817(a) of the Code, sections 716(a)–(b) and 717(a) of ERISA, and sections 2799A–1(a)–(b), 2799A–2(a), 2799A–7, 2799B–1, 2799B–2, 2799B–3, and 2799B–5 of the PHS Act.

Among other requirements, the July 2021 interim final rules generally prohibit balance billing for items and services subject to the requirements in those interim final rules.⁷ The July 2021 interim final rules also specify that consumer cost-sharing amounts for emergency services furnished by nonparticipating providers or facilities, and for non-emergency services furnished by nonparticipating providers with respect to patient visits to certain participating facilities, must be calculated based on the “recognized amount,” which is defined as one of the following amounts: (1) an amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act; (2) if there is no such applicable All-Payer Model Agreement, an amount determined by a specified State law; or (3) if there is no such applicable All-Payer Model Agreement or specified State law, the lesser of the billed charge or the QPA. The July 2021 interim final rules establish the methodology for calculating the QPA, which in most circumstances will be the plan’s or issuer’s median contracted rate that was in effect for the particular item or service on January 31, 2019, increased for inflation. Cost-sharing amounts for air ambulance services provided by nonparticipating providers of air ambulance services must be the same as the cost-sharing amounts that would apply if the services were provided by a participating provider of air ambulance services, and these cost-sharing amounts must be calculated using the lesser of the billed charge or the QPA.

The No Surprises Act directs the Departments to specify the information that a plan or issuer must share with a nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services, as applicable, after determining the QPA. Therefore, 26 CFR 54.9816–6T(d), 29 CFR 2590.716–6(d), and 45 CFR 149.140(d) require that plans and issuers make certain disclosures about the QPA with each initial payment or notice of denial of payment, and that plans and issuers provide certain additional information

⁷ 45 CFR 149.410(a), 149.420(a), and 149.440(a).

upon request of the provider, facility, or provider of air ambulance services. This information must be provided in writing, either on paper or electronically, to a nonparticipating provider, facility, or provider of air ambulance services, as applicable, when the QPA serves as the recognized amount.

With an initial payment or notice of denial of payment, a plan or issuer must provide the QPA for each item or service involved as well as a statement certifying that, based on the determination of the plan or issuer: (1) the QPA applies for purposes of the recognized amount (or, in the case of air ambulance services, for calculating the participant’s, beneficiary’s, or enrollee’s cost sharing), and (2) each QPA shared with the provider, facility, or provider of air ambulance services was determined in compliance with the methodology outlined in the July 2021 interim final rules.

A plan or issuer is also required to provide a statement that, if the provider, facility, or provider of air ambulance services wishes to initiate a 30-day open negotiation period for purposes of determining the amount of total payment, the provider, facility, or provider of air ambulance services may contact the appropriate person or office to initiate open negotiation, and that if the 30-day open negotiation period does not result in an agreement on the payment amount, the provider, facility, or provider of air ambulance services typically may initiate the Federal IDR process within 4 days after the end of the open negotiation period. The Departments note that these time frames are measured in business days, and plans and issuers should reflect this in the statement. The plan or issuer must provide contact information, including a telephone number and email address, for the appropriate office or person for the provider, facility, or provider of air ambulance services to contact to initiate open negotiation for purposes of determining an amount of payment (with the amount including cost sharing) for the item or service.

It has come to the Departments’ attention that some plans and issuers are requiring nonparticipating providers, nonparticipating emergency facilities, and nonparticipating providers of air ambulance services to utilize plan- or issuer-owned web systems to initiate an open negotiation period. As discussed earlier, the July 2021 interim final rules require plans and issuers to provide a telephone number and email address for providers, facilities, and providers of air ambulance services to initiate the open

negotiation period. When a party to a payment dispute chooses to initiate the open negotiation period, the October 2021 interim final rules specify that the party must use the standard notice of initiation of open negotiation issued by the Departments and may satisfy the requirement to provide notice to the opposing party by sending the notice electronically if the party sending the notice has a good faith belief that the electronic method is readily accessible to the other party and the notice is also provided free of charge in paper form upon request.⁸ For example, it is reasonable for a provider, facility, or provider of air ambulance services to have a good faith belief that an email address provided by a plan or issuer with the initial payment or notice of denial of payment is readily accessible to the plan or issuer. Thus, if a provider, facility, or provider of air ambulance services sends the standard notice of initiation of open negotiation to the email address identified by the plan or issuer in the notice of denial of payment or initial payment, that transmission would satisfy the regulatory requirement to provide notice to the opposing party (so long as the provider, facility, or provider of air ambulance services also sends the notice free of charge in paper form upon request).⁹ Although plans and issuers may encourage the use of an online portal for nonparticipating providers, facilities, and providers of air ambulance services to submit the information necessary to initiate the open negotiation period, or may seek additional information to inform good faith open negotiations, such as through use of a supplemental open negotiation form, the July 2021 interim final rules require plans and issuers to provide a telephone number and email address for providers, facilities, and providers of air ambulance services to initiate the open negotiation period, and the October 2021 interim final rules permit a party to initiate the open negotiation period by sending the standard notice of initiation electronically to the email address identified in the notice of denial of payment or initial payment. Accordingly, a plan or issuer cannot refuse to accept the standard notice of initiation of open negotiation from a provider, facility, or provider of air ambulance services because the provider or facility did not utilize the plan's or issuer's online portal when the standard notice of initiation of open

negotiation is provided in a manner consistent with the requirements of the July 2021 and October 2021 interim final rules.

In addition, upon request by the provider, facility, or provider of air ambulance services, a plan or issuer must provide, in a timely manner, information about whether the QPA includes contracted rates that were not set on a fee-for-service basis for the specific items and services and whether the QPA for those items and services was determined using underlying fee schedule rates or a derived amount.¹⁰ If an eligible database was used to determine the QPA, the plan or issuer must provide information to identify which database was used. Similarly, if a related service code was used to determine the QPA for an item or service billed under a new service code, the plan or issuer must provide information to identify which related service code was used.

Finally, upon request by the provider, facility, or provider of air ambulance services, the plan or issuer must provide a statement, if applicable, that the plan's or issuer's contracted rates include risk-sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments that were excluded for purposes of calculating the QPA for the items and services involved.

C. October 2021 Interim Final Rules

The October 2021 interim final rules build on the July 2021 interim final rules and implement the Federal IDR process under sections 9816(c) and 9817(b) of the Code, sections 716(c) and 717(b) of ERISA, and sections 2799A–1(c) and 2799A–2(b) of the PHS Act.

The October 2021 interim final rules provide for a Federal IDR process that group health plans and health insurance issuers offering group or individual health insurance coverage and nonparticipating providers, facilities, and providers of air ambulance services may use to determine the out-of-network rate for items and services that are emergency services, non-emergency services furnished by nonparticipating

providers with respect to patient visits to participating facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services, where an All-Payer Model Agreement or specified State law does not apply. The October 2021 interim final rules generally specify rules to implement the Federal IDR process, including the requirements governing the open negotiation period; the initiation of the Federal IDR process; the Federal IDR process following initiation, including the selection of a certified IDR entity, submission of offers, payment determinations, and written decisions; costs of the Federal IDR process; certification of IDR entities, including the denial or revocation of certification of an IDR entity; and the collection of information related to the Federal IDR process from certified IDR entities to satisfy reporting requirements under the statute.

The October 2021 interim final rules provide that, not later than 30 business days after selection of a certified IDR entity, the certified IDR entity must select one of the offers submitted by the plan or issuer and the provider, facility, or provider of air ambulance services to be the out-of-network rate for the qualified IDR item or service.¹¹ For each qualified IDR item or service, the amount by which this out-of-network rate exceeds the cost-sharing amount for the qualified IDR item or service is the total plan or coverage payment (with any initial payment made by the plan or issuer counted towards the total plan or coverage payment).

The October 2021 interim final rules state that, in selecting the offer, the certified IDR entity must consider the QPA for the applicable year for the same or similar item or service, or, in the case of batched or bundled items or services, the QPA or QPAs for the applicable year. The preamble to the July 2021 interim final rules provides that if multiple items and services are reimbursed under non-fee-for-service contractual arrangements, such as a bundled or capitated arrangement, and are billed for under a single billing code, plans and issuers must calculate a QPA for each item or service using the underlying fee schedule rates for the relevant items and services if the underlying fee schedule rates are available.¹² If there is no underlying fee schedule rate for an item or service, the plan or issuer must calculate the QPA

⁸ 26 CFR 54.9816–8T(b)(2)(iii)(B), 29 CFR 2590.716–8(b)(2)(iii)(B), and 45 CFR 149.510(b)(2)(iii)(B).

⁹ 86 FR 55980, 55990 (Oct. 7, 2021).

¹⁰ 26 CFR 54.9816–6T(d)(2)(i), 29 CFR 2590.716–6(d)(2)(i), and 45 CFR 149.140(d)(2)(i). Under the July 2021 interim final rules, plans and issuers are required to calculate the QPA using underlying fee schedule rates or derived amounts when the plan or issuer has sufficient information to calculate the median of its contracted rates, but the payments under the contractual agreements are not on a fee-for-service basis (such as bundled or capitation payments). 26 CFR 54.9816–6T(b)(2)(iii), 29 CFR 2590.716–6(b)(2)(iii), 45 CFR 149.140(b)(2)(iii). Plans and issuers are not otherwise permitted to use underlying fee schedule rates or derived amounts to calculate the QPA.

¹¹ Qualified IDR item or service has the same meaning as set forth in 26 CFR 54.9816–8T(a)(2)(xii), 29 CFR 2590.716–8(a)(2)(xii), and 45 CFR 149.510(a)(2)(xii).

¹² 86 FR 36893 (July 13, 2021).

using a derived amount.¹³ In addition, the October 2021 interim final rules state that the certified IDR entity must also consider information requested by, or submitted by the parties to, the certified IDR entity relating to the offer, to the extent a party provides credible information that is not otherwise prohibited under 26 CFR 54.9816–8T(c)(4)(v), 29 CFR 2590.716–8(c)(4)(v), and 45 CFR 149.510(c)(4)(v).

The October 2021 interim final rules also require the parties to provide certain information to the certified IDR entity, including practice size and practice specialty or type; geographic region used to calculate the QPA; the QPA for the applicable year for the same or similar item or service as the qualified IDR item or service; and, if applicable, information showing that the Federal IDR process is inapplicable to the dispute. In addition, prior to vacatur in the United States District Court for the Eastern District of Texas, in the cases of *Texas Medical Association, et al. v. United States Department of Health and Human Services, et al.*, Case No. 6:21–cv–425 (E.D. Tex.) (*Texas Medical Association*) (February 23, 2022) and *LifeNet, Inc. v. United States Department of Health and Human Services, et al.*, Case No. 6:22–cv–162 (E.D. Tex.) (*LifeNet*) (July 26, 2022), these interim final rules specified that the certified IDR entity may request additional information relating to the parties' offers and must consider credible additional information submitted, as further described in the next paragraph, that relates to the parties' offers and the qualified IDR item or service that is the subject of a payment determination to determine if the information submitted clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate (unless the information relates to a factor that the certified IDR entity is prohibited from considering). For this purpose, the October 2021 interim final rules specify that credible information is information that upon critical analysis is worthy of belief and is trustworthy.¹⁴ Prior to vacatur in *Texas Medical Association*, the term "material difference" was defined to mean a substantial likelihood that a reasonable person with the training and qualifications of a certified IDR entity making a payment determination would consider the information important in

determining the out-of-network rate and view the information as showing that the QPA is not the appropriate out-of-network rate.¹⁵

For items and services that are not air ambulance services, in determining which offer to select, the certified IDR entity must consider the following additional information under certain circumstances:

1. The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished the qualified IDR item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act).
2. The market share held by the provider or facility or that of the plan or issuer in the geographic region in which the qualified IDR item or service was provided.
3. The acuity of the participant, beneficiary, or enrollee who received the qualified IDR item or service, or the complexity of furnishing the qualified IDR item or service to the participant, beneficiary, or enrollee.

4. The teaching status, case mix, and scope of services of the facility that furnished the qualified IDR item or service, if applicable.

5. Demonstration of good faith efforts (or lack thereof) made by the provider or facility or the plan or issuer to enter into network agreements with each other, and, if applicable, contracted rates between the provider or facility and the plan or issuer during the previous 4 plan years.

Under the October 2021 interim final rules, the certified IDR entity may only consider this information submitted by the parties if the information is credible and relates to the offer submitted by either party.¹⁶ The certified IDR entity may not consider any information submitted on the prohibited factors, including usual and customary charges (including payment or reimbursement rates expressed as a proportion of usual and customary charges); the amount that would have been billed if the provider, facility, or provider of air ambulance services were not subject to a prohibition on balance billing; and payment or reimbursement rates payable by a public payor, in whole or in part, for items and services furnished by the providers, facilities, or providers of air ambulance services.¹⁷

The October 2021 interim final rules also provided, prior to vacatur in *Texas Medical Association* and *LifeNet*, that after considering the QPA, additional information requested by the certified IDR entity from the parties, and all of the credible information submitted by the parties that is consistent with the requirements and is not prohibited information, the certified IDR entity must select the offer closest to the QPA, unless the certified IDR entity determined that the credible information submitted by the parties clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate, or if the offers are equally distant from the QPA but in opposing directions. In those cases, the October 2021 interim final rules required the certified IDR entity to select the offer that the certified IDR entity determines best represents the value of the item or service, which could be either party's offer.

Not later than 30 business days after the selection of the certified IDR entity, the certified IDR entity must notify parties to the dispute of the selection of the offer and provide a written decision,¹⁸ which must be submitted to the parties and the Departments through the Federal IDR portal.¹⁹ The October 2021 interim final rules also provided that if the certified IDR entity did not choose the offer closest to the QPA, this written decision must include an explanation of the credible information that the certified IDR entity determined demonstrated that the QPA was materially different from the appropriate out-of-network rate.

The October 2021 interim final rules also implemented the Federal IDR process for qualified IDR services that are air ambulance services. The process for a certified IDR entity to select an offer in a dispute related to qualified IDR services that are air ambulance services is essentially the same as that for other qualified IDR items or services. As with disputes related to qualified IDR items or services that are not air

by a public payor include payments or reimbursement rates under the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program under title XXI of the Social Security Act, the TRICARE program under chapter 55 of title 10, United States Code, chapter 17 of title 38, United States Code, and payment rates for demonstration projects under section 1115 of the Social Security Act.

¹⁸ 26 CFR 54.9816–8T(c)(4)(vi)(A), 29 CFR 2590.716–8(c)(4)(vi)(A), and 45 CFR 149.510(c)(4)(vi)(A).

¹⁹ The Federal IDR portal is available at <https://www.nsa-idr.cms.gov> and must be used throughout the Federal IDR process to maximize efficiency and reduce burden.

¹³ The Departments also specify an alternative method to calculate the QPA when there is insufficient information based on contracted rates. See 26 CFR 54.9816–6T(c)(2)–(4), 29 CFR 2590.716–6(c)(2)–(4), and 45 CFR 149.140(c)(2)–(4).

¹⁴ 26 CFR 54.9816–8T(a)(2)(v), 29 CFR 2590.716–8(a)(2)(v), and 45 CFR 149.510(a)(2)(v).

¹⁵ 26 CFR 54.9816–8T(a)(2)(viii), 29 CFR 2590.716–8(a)(2)(viii), and 45 CFR 149.510(a)(2)(viii).

¹⁶ This requirement was vacated by the District Court in *Texas Medical Association*.

¹⁷ 26 CFR 54.9816–8T(c)(4)(v), 29 CFR 2590.716–8(c)(4)(v), and 45 CFR 149.510(c)(4)(v). For this purpose, payment or reimbursement rates payable

ambulance services, in determining which offer to select, the No Surprises Act and October 2021 interim final rules provide that the certified IDR entity must consider the QPA for the applicable year for the qualified IDR services that are air ambulance services. The No Surprises Act and the October 2021 interim final rules likewise specified additional circumstances, in addition to the QPA, that the certified IDR entity must consider in making the payment determination for air ambulance services. With respect to air ambulance services, the certified IDR entity is required to consider, to the extent the parties provide credible information, a different set of additional circumstances:

1. The quality and outcomes measurements of the provider that furnished the services.
2. The acuity of the condition of the participant, beneficiary, or enrollee receiving the service, or the complexity of furnishing the service to the participant, beneficiary, or enrollee.
3. The training, experience, and quality of the medical personnel that furnished the air ambulance services.
4. Ambulance vehicle type, including the clinical capability level of the vehicle.
5. Population density of the point of pick-up (as defined in 42 CFR 414.605) for the air ambulance (such as urban, suburban, rural, or frontier).
6. Demonstrations of good faith efforts (or lack thereof) made by the nonparticipating provider of air ambulance services or the plan or issuer to enter into network agreements with each other and, if applicable, contracted rates between the provider of air ambulance services and the plan or issuer during the previous 4 plan years.

As with qualified IDR items or services that are not air ambulance services, the October 2021 interim final rules provide that after considering the QPA, additional information requested by the certified IDR entity from the parties, and all of the credible information submitted by the parties that is consistent with the requirements and is not prohibited information, the certified IDR entity must select the offer closest to the QPA, unless the certified IDR entity determined that the credible information submitted by the parties clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate, or if the offers are equally distant from the QPA but in opposing directions. In those cases, the October 2021 interim final rules require the certified IDR entity to select the offer that the certified IDR entity determined best represents the value of the item or

service, which could be either party's offer.

D. Public Comments Received in Response to the July 2021 and October 2021 Interim Final Rules

In response to the July 2021 and October 2021 interim final rules, the Departments received thousands of comments on many different aspects of the rules. In particular, the Departments received many comments related to a clarification in the preamble to the October 2021 interim final rules²⁰ stating that the July 2021 interim final rules do not require the plan or issuer to calculate the participant's, beneficiary's, or enrollee's cost sharing using the QPA for the service code submitted by the provider or facility, and that instead the plan or issuer could calculate the participant's, beneficiary's, or enrollee's cost sharing using the QPA for a downcoded service code that the plan or issuer determined was more appropriate. Many of these comments addressed the information required by the July 2021 interim final rules that must be shared about the QPA, the importance of this disclosure, and how additional disclosures related to the QPA would be useful in the context of the Federal IDR process, particularly when the QPA is based on a service code or modifier that is different than the one the provider or facility billed. The Departments also received many comments related to the payment determination standards under the Federal IDR process, including the provisions that govern the certified IDR entity's consideration of the enumerated factors. These final rules address only the provisions related to these comments, and they make changes in light of the decisions in *Texas Medical Association* and *LifeNet*. The Departments intend to address comments related to other provisions of the July 2021 and October 2021 interim final rules, including comments received in response to the July 2021 interim final rules related to the disclosure requirements that are not specifically related to downcoded service codes, at a later date.

1. QPA Disclosure Requirements

With respect to the information that must be shared about the QPA, the Departments received comments on both the July 2021 interim final rules and the October 2021 interim final rules supporting the disclosure requirement and emphasizing the importance of ensuring that the QPA and other information related to the item or

service are provided to providers, facilities, and providers of air ambulance services at the time of the initial payment or notice of denial of payment. Many commenters on the July 2021 interim final rules stressed that the methodology to calculate the QPA should be transparent, and that the Departments should expand the range of information that is shared with providers, facilities, and providers of air ambulance services with the QPA. Some commenters felt the degree of disclosure was insufficient, and that it provided too much power and discretion to plans and issuers. Others, however, questioned whether plans, in particular, would be able to obtain the information required under the July 2021 interim final rules, as much of the information may be in the control of vendors or other service providers. In particular, the Departments received comments in response to the July 2021 interim final rules and the October 2021 interim final rules requesting that the disclosures that must be provided with each initial payment or notice of denial of payment include additional information about how the QPA was determined to ensure that providers, facilities, and providers of air ambulance services have sufficient information when the Federal IDR process is used for a payment determination. For example, commenters requested that plans and issuers be required, without a request, to provide information on the number of contracts and the geographic region used to calculate the QPA, whether the QPA is based on downcoding²¹ of the billed claim, information about the use of modifiers in calculating the QPA, the types of specialties and subspecialties that have contracted rates included in the data set used to determine the QPA, and whether bonuses and supplemental payments were paid to in-network providers.

The manner in which items and services are coded, including the concept of downcoding claims was reflected in both the July 2021 interim final rules and the October 2021 interim final rules. The preamble to the July 2021 interim final rules noted that it is important that the QPA methodology account for modifiers that affect payment rates.²² The preamble to the

²¹ Downcode is defined in these final rules at 26 CFR 54.9816-6, 29 CFR 2590.716-6, and 45 CFR 149.30, to mean the alteration by a plan or issuer of a service code to another service code, or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed code or modifier is associated with a lower QPA than the service code or modifier billed by the provider, facility, or provider of air ambulance services.

²² The preamble to the July 2021 interim final rules also noted that modifiers affect the payment

²⁰ See 86 FR 55997-98 n.35.

October 2021 interim final rules noted that the Departments are aware that some plans and issuers review claims and alter the service code or modifier submitted by the provider or facility to another service code or modifier that the plan or issuer determines to be more appropriate (a practice commonly referred to as “downcoding” when the adjustment results in a lower reimbursement, as noted in the preamble to the October 2021 interim final rules).²³ Some commenters expressed concern that plans and issuers may calculate the QPA for a lower level service code (and/or modifier) instead of calculating the QPA for the particular service code or modifier specified in the claim submitted for reimbursement. These commenters stated that it is important for providers and facilities to know whether the plan or issuer has downcoded a particular claim that is subject to the balance billing protections in the No Surprises Act to ensure that providers receive information that may be relevant to the open negotiation process and that could inform a provider’s offer in the Federal IDR process, and which the provider has no other means of ascertaining. Several commenters requested that these final rules require plans and issuers to disclose whether the claim has been downcoded for purposes of computing the QPA and include an explanation of why the claim was downcoded, as well as what the QPA would have been had the claim not been downcoded.

2. Payment Determination Standards Under the Federal IDR Process

With respect to the payment determination standards under the Federal IDR process, the Departments received numerous comments from various stakeholders about the provisions that govern the certified IDR entity’s consideration of the statutory factors during the payment determination process. Many commenters supported the approach set forth in the October 2021 interim final rules that directs the certified IDR entity to begin with the QPA as a baseline when making a payment determination, which those commenters highlighted as an important part of the payment determination process that would ensure that the surprise billing provisions lead to lower health care costs for all consumers. Furthermore,

rate because, for example, modifiers can be used to indicate that the work required to provide a service in a particular instance was significantly greater—or significantly less—than the service typically required. See 86 FR 36891.

²³ See 86 FR 55997–98.

some commenters stated that the approach taken in the October 2021 interim final rules is crucial to achieving the budget savings the Congressional Budget Office calculated. Those commenters stated that the approach taken would shield consumers from surprise bills and ever higher insurance premium costs. Commenters stated that the October 2021 interim final rules reinforce the statutory directive that the QPA is the primary consideration for the certified IDR entity. Commenters also stated this use of the QPA represents a reasonable, market-based rate and would encourage greater participation in health plan networks.

Commenters noted that there may be circumstances in which the appropriate out-of-network rate would exceed the QPA, and that the October 2021 interim final rules properly provide a pathway for the certified IDR entity to reach that determination when it can be justified. These commenters highlighted that nothing in the October 2021 interim final rules required a certified IDR entity to default to the selection of the QPA or the offer closest to it, but rather that the rule correctly mandated that all credible information be considered. Commenters also stated that it was not unreasonable to require a party to document why the QPA is not the appropriate payment amount. Other commenters raised concerns about giving the same weight to all factors because many of the additional circumstances outlined in the rule, such as patient acuity and complexity of care, could already be incorporated into the QPA calculation. Commenters also noted that the October 2021 interim final rules provide clear guidance to certified IDR entities, which would reduce variability in payment determinations and better position the parties to settle disputes before reaching the Federal IDR process, by giving the parties a better sense of how payment determinations would be made.

Other commenters disagreed with the approach under the October 2021 interim final rules and expressed opposition to the emphasis placed on the QPA during the Federal IDR process. Many of these commenters criticized the rule as establishing a rebuttable presumption in favor of the QPA as the out-of-network rate while failing to equip the parties with the necessary information to rebut the presumption. Some commenters stated that the Departments disregarded bipartisan Congressional intent and tipped the scales in the Federal IDR process in favor of health plans and issuers. Commenters expressed concern that emphasizing the QPA ignores the

complexity of billing factors, such as modifiers and the practice of bundling multiple health care services under a single billing code, and creates an incentive for the plan or issuer to downcode claims in bad faith.

Commenters also expressed concern that the prominence of the QPA could drive down reimbursement rates for providers that are currently reimbursed above the median contracted rate, which they argued could jeopardize network adequacy and viability of physician practices and, commenters claimed, further drive down the QPA. A number of commenters stated that the emphasis given to the QPA would provide an incentive for plans and issuers to prefer out-of-network care, potentially resulting in reduced networks, because, ultimately, plans and issuers would pay the QPA rather than a market rate driven by the particular circumstances of the care delivered. Commenters also asserted that showing that the QPA is materially different from the appropriate out-of-network rate would burden providers and facilities who lack the resources to gather and submit this information during the Federal IDR process.

Commenters who disagreed with the approach set forth in the October 2021 interim final rules stated that certain provisions created a rebuttable presumption that the QPA is the appropriate out-of-network rate, and these commenters requested that the Departments remove these provisions, and instead issue rulemaking and guidance that instructs certified IDR entities to consider all permissible and relevant information submitted by the parties. Other commenters suggested alternative approaches for the provisions that govern the certified IDR entity’s consideration of the enumerated factors. Some commenters requested that equal weight be given to the QPA and the contracted rates between the provider or facility and plan or issuer during the previous 4 years. Other commenters requested that the Departments replace the QPA as the baseline in the Federal IDR process with a different amount, such as the actual amount paid to a particular out-of-network provider for the same or similar item or service or the median contracted rate based on the amount negotiated under each contract the provider has with a plan or issuer.

3. Payment Determinations for Air Ambulance Services

A majority of commenters raised similar points with regard to the Federal IDR process for both non-air ambulance items and services and air ambulance

services. Some supported the emphasis on the QPA, while others disagreed with the use of the QPA as the baseline in the Federal IDR process. These commenters raised concerns about the transparency of the calculation of the QPA, and questioned whether the QPA is the appropriate out-of-network rate. Several commenters stressed that the use of the QPA as a baseline also raises concerns that are unique to air ambulance services. Some commenters highlighted the prevalence of single-case agreements for air ambulance services, which the commenters interpreted as including settlements of post-service claims. The commenters asserted that, because of the prevalence of these agreements, the QPA does not adequately reflect market rates for air ambulance services and the QPA would be lower than appropriate. Other commenters argued that hospital-based providers of air ambulance services are subsidized by the related hospitals, so including the rates of these providers in the QPA calculation with the rates of other air ambulance providers would improperly lower the QPA and therefore the use of the QPA as a baseline would not be appropriate. Another commenter argued that the negotiated rates of the few in-network providers for air ambulance services tend to be inflated by their disproportionately large market power, leading to artificially high air ambulance rates and an inflated QPA value. These commenters proposed that the rules should direct the certified IDR entities to take into account market concentration and prices charged by non-profit affiliated air ambulance providers because air ambulance services owned by private equity and publicly-traded companies receive higher payments and subsequently generate larger and more frequent surprise bills than their non-profit-affiliated counterparts. Other commenters disagreed and stated that the Federal IDR process should not make such a distinction among providers of air ambulance services. One commenter stated that Congress clearly recognized the variation in air ambulance services in distinguishing the six “additional circumstances”²⁴

²⁴ Under section 9817(b)(5)(C) of the Code, section 717(b)(5)(C) of ERISA, and section 2799A-2(b)(5)(C) of the PHS Act, those six additional circumstances are: (1) the quality and outcomes measurements of the provider that furnished such services; (2) the acuity of the individual receiving such services or the complexity of furnishing such services to such individual; (3) the training, experience, and quality of the medical personnel that furnished such services; (4) the ambulance vehicle type, including the clinical capability level of such vehicle; (5) population density of the point of pick-up (such as urban, suburban, rural, or

specific to air ambulance services that certified IDR entities should consider.

4. The Certified IDR Entity’s Written Decision

With respect to the certified IDR entity’s written decision, several commenters supported the requirement for the certified IDR entity to provide a written decision, including the explanation of the underlying rationale for the certified IDR entity’s determination. Other commenters stressed, however, that requiring the explanation of the rationale only if the certified IDR entity determined that the QPA was materially different from the appropriate out-of-network rate could discourage certified IDR entities from considering additional factors. A few commenters requested an explanation be required when the certified IDR entity selected the amount closest to the QPA, including how the information about the other required considerations was assessed while others stated that a robust explanation should be required of the certified IDR entity in all cases. Commenters also stated that requiring an explanation in all cases would ensure that certified IDR entities considered all information submitted by the parties and allow the parties to fully understand the rationale behind the certified IDR entity’s determination. Commenters asserted that this could improve the quality and efficiency of the IDR process over time, as parties become better informed as to the types of information certified IDR entities find credible and the circumstances in which the parties should pursue the IDR process. Other commenters requested the Departments either eliminate the requirement for a written decision or require a similar analysis in all written decisions.

E. Litigation Regarding Requirements Related to Surprise Billing; Part II

On October 28, 2021, the Texas Medical Association, a trade association representing physicians, and a Texas physician filed a lawsuit against the Departments and the Office of Personnel Management (OPM), asserting that certain provisions of the October 2021 interim final rules relating to the certified IDR entities’ consideration of the QPA, as well as additional factors related to items and services that are not air ambulance services, should be

frontier); and (6) demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider and the plan or issuer, as applicable, during the previous 4 plan years.

vacated. Plaintiffs argued that the interim final rules ignored Congress’s intent that certified IDR entities weigh the QPA and other factors without favoring any factor, and they asserted that, as a result, the rules would skew IDR results in favor of plans and issuers. On February 23, 2022, the United States District Court for the Eastern District of Texas (District Court) issued a memorandum opinion and order that vacated portions of the October 2021 interim final rules governing aspects of the Federal IDR process related to non-air ambulance qualified IDR items or services including: (1) the definition of “material difference;” (2) the requirement that a certified IDR entity must select the offer closest to the QPA unless the certified IDR entity determines that credible information submitted by either party under 26 CFR 54.9816–8T(c)(4)(i), 29 CFR 2590.716–8(c)(4)(i), and 45 CFR 149.510(c)(4)(i) clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate for non-air ambulance qualified IDR items or services, or if the offers are equally distant from the QPA but in opposing directions; (3) the requirement that the certified IDR entity may only consider the additional information submitted by either party to the extent that the credible information related to the circumstances under 26 CFR 54.9816–8T(c)(4)(i), 29 CFR 2590.716–8(c)(4)(i), and 45 CFR 149.510(c)(4)(i) clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate for non-air ambulance qualified IDR items or services; (4) the dispute resolution examples; and (5) the requirement that, if the certified IDR entity does not choose the offer closest to the QPA, the certified IDR entity’s written decision must include an explanation of the credible information that the certified IDR entity determined demonstrated that the QPA was materially different from the appropriate out-of-network rate, based on the factors certified IDR entities are permitted to consider with respect to the qualified IDR item or service.²⁵

On April 27, 2022, LifeNet, Inc., a provider of air ambulance services, filed a lawsuit against the Departments and OPM seeking the vacatur of additional provisions of the October 2021 interim final rules applicable to air ambulance services. In particular, LifeNet alleged that the requirement codified in the last sentence of 26 CFR 54.9817–2T(b)(2), 29 CFR 2590.717–2(b)(2), and 45 CFR

²⁵ *Tex. Med. Ass’n, et al. v. U.S. Dept. of Health and Human Servs., et al.*, Case No. 6:21–cv–425 (E.D. Tex.).

149.520(b)(2) that the certified IDR entity may consider information submitted by a party only if the information “clearly demonstrate[s] that the qualifying payment amount is materially different from the appropriate out-of-network rate” should be vacated. On July 26, 2022, the District Court issued a memorandum opinion and order vacating this language.²⁶

F. Scope and Purpose of This Rulemaking

As discussed in more detail later in this preamble, upon review of the comments the Departments received on the information that must be shared about the QPA when a service is downcoded and with respect to the Federal IDR process, and in light of the District Court’s memorandum opinions and orders in *Texas Medical Association* and *LifeNet*, the Departments have determined that it is appropriate to issue these final rules to finalize parts of the July 2021 and October 2021 interim final rules related to the information that must be disclosed about the QPA under 26 CFR 54.9816–6T(d), 29 CFR 2590.716–6(d), and 45 CFR 149.140(d) to address downcoding; related to the certified IDR entity’s consideration of the statutory factors when making a payment determination under the Federal IDR process at 26 CFR 54.9816–8T(c)(4)(iii)–(iv) and 54.9817T–2(b), 29 CFR 2590.716–8(c)(4)(iii)–(iv) and 2590.717–2(b), and 45 CFR 149.510(c)(4)(iii)–(iv) and 149.520(b); and related to the certified IDR entity’s written decision at 26 CFR 54.9816–8T(c)(4)(vi)(B), 29 CFR 2590.716–8(c)(4)(vi)(B), and 45 CFR 149.510(c)(4)(vi)(B). These final rules also include changes to remove from the regulations the language vacated by the District Court.

This rulemaking is purposefully narrow in scope and is intended to address only certain issues critical to the implementation and effective operation of the Federal IDR process. The Departments intend to finalize the remaining provisions of the July 2021 and October 2021 interim final rules after further consideration of comments.

II. Overview of Final Rules

A. Information To Be Shared About the Qualifying Payment Amount

As described earlier in this preamble, the July 2021 interim final rules require plans and issuers to make certain disclosures with each initial payment or notice of denial of payment. When the

QPA serves as the recognized amount, or as the amount upon which cost sharing is based with respect to air ambulance services, plans and issuers must disclose the QPA and certain information related to the QPA for the item or service involved, as well as certain additional information, upon request of the provider, facility, or provider of air ambulance services for each item or service involved.²⁷

As stated in the preamble to the July 2021 interim final rules, the Departments seek to ensure transparent and meaningful disclosure of information relating to the calculation of the QPA for providers, facilities, and providers of air ambulance services, while at the same time minimizing administrative burdens on health plans and issuers and on the Federal IDR process. The Departments sought to balance those competing interests by, on the one hand, requiring plans and issuers to make certain disclosures with each initial payment or notice of denial of payment and to provide certain additional information upon request by the provider, facility, or provider of air ambulance services and, on the other hand, avoiding more wide-reaching disclosure requirements that could add to the costs and burdens of adjudicating claims subject to the surprise billing protections in the No Surprises Act.

After review of the comments submitted on the July 2021 interim final rules regarding downcoding and on the clarification in the preamble to the October 2021 interim final rules stating that, under the July 2021 interim final rules, a plan or issuer may calculate the QPA using a downcoded service code, including the comments suggesting how the disclosure requirements could be modified in light of this clarification, the Departments have concluded that additional disclosure of information about the QPA is appropriate.²⁸ This additional disclosure will ensure that providers, facilities, and providers of air ambulance services receive information regarding the QPA that aids in their meaningful participation in open negotiation and the Federal IDR process in all payment disputes that involve qualified items or services that have been subject to downcoding.

Specifically, the Departments are of the view that additional information would be helpful in cases in which the plan or issuer has downcoded the billed claim to ensure that providers, facilities, and providers of air ambulance services receive the relevant information from a

plan or issuer that is needed to engage in a productive open negotiation period. Without information on what the QPA would have been had the claim not been downcoded, the provider, facility, or provider of air ambulance services may be at a disadvantage compared to the plan or issuer. In cases in which the plan or issuer has downcoded the billed claim and asserts that the QPA that corresponds with the downcoded claim is the correct total payment amount, it is of particular importance that the provider, facility, or provider of air ambulance services knows that the item or service in question has been downcoded and has information regarding both the QPA for the downcoded claim and the amount that would have been the QPA had the service code or modifier not been downcoded. In the Departments’ view, this information may be critical to the provider, facility, or provider of air ambulance services in developing an offer or submitting information if it believes that the QPA calculated by the plan or issuer does not best represent the value of the item or service provided.

Furthermore, the requirement to disclose this additional information will increase transparency by ensuring that the provider, facility, or provider of air ambulance services has sufficient information about the QPA to submit an informed offer, including how it relates to the billed claim. This increased transparency will aid in the open negotiation process by helping providers, facilities, and providers of air ambulance services to understand how the plan or issuer arrived at the relevant QPA in relation to the billed claim. This increased transparency will inform the provider’s, facility’s, or provider of air ambulance services’ decision whether to initiate open negotiation and the Federal IDR process, as well as its determination of the amount that it submits as its offer.²⁹ Further, this requirement will help a provider, facility, or provider of air ambulance services ascertain what information to provide the certified IDR entity to demonstrate that the provider’s, facility’s, or provider of air ambulance

²⁶ *LifeNet, Inc. v. United States Department of Health and Human Services, et al.*, Case No. 6:22–cv–162 (E.D. Tex.).

²⁷ 26 CFR 54.9816–6T(d), 29 CFR 2590.716–6(d), and 45 CFR 149.140(d).

²⁸ 86 FR 55997–98 (October 7, 2021).

²⁹ The Departments understand that many plans and issuers make initial payments that are equivalent to or are informed by the corresponding QPA for the item or service at issue. As noted in the preamble to the July 2021 interim final rules, the initial payment should be an amount that the plan or issuer reasonably intends to be payment in full based on the relevant facts and circumstances, which may be higher or lower than the QPA, as required under the terms of the plan or coverage, prior to the beginning of any open negotiation or initiation of the Federal IDR process. 86 FR 36872, 36900 (July 13, 2021).

services' offer best represents the value of the item or service. If submitted for the certified IDR entity's consideration, this information will also aid the certified IDR entity in selecting the offer that best represents the value of the item or service by ensuring that the certified IDR entity will have additional pertinent information about the item or service. For example, in a dispute that concerns a qualified IDR service for which the plan or issuer downcoded the billed service code, the provider, facility, or provider of air ambulance services may present information showing that the billed service code was more appropriate than the downcoded service code. In such an instance, the certified IDR entity could determine that the QPA based on the downcoded service code does not sufficiently encompass the complexity of furnishing the qualified IDR service because it was based on a service code for a different service from the one furnished. If the certified IDR entity makes such a determination, then the amount that would have been the QPA had the service code or modifier not been downcoded may be relevant to the certified IDR entity in determining which offer best represents the value of the qualified IDR item or service.

Therefore, the Departments are issuing these final rules to add a definition for the term "downcode" to 26 CFR 54.9816-6, 29 CFR 2590.716-6, and 45 CFR 149.140; and final rules under 26 CFR 54.9816-6(d), 29 CFR 2590.716-6(d), and 45 CFR 149.140(d) to require additional information about the QPA that must be provided with an initial payment or notice of denial of payment, without a provider, facility, or provider of air ambulance services having to make a request for this information, in cases in which the plan or issuer has downcoded the billed claim. Although "downcoding" is being defined for the first time in these final rules, the concept was reflected in both sets of interim final rules. Though neither set of interim final rules specifically defines a term for this practice, the interim final rules described the practice and explained that it was permissible under certain circumstances. See 86 FR 55997-98 n.35 (clarification in October 2021 interim final rules regarding requirements of July 2021 interim final rules). Indeed, as described previously, the Departments received several comments in response to the July 2021 interim final rules and the October 2021 interim final rules requesting that the disclosures that must be provided with each initial payment or notice of denial of payment include

additional information about how the QPA was calculated to ensure that providers, facilities, and providers of air ambulance services have sufficient information when the Federal IDR process is used for a payment determination. For example, commenters requested that plans and issuers be required, without a request, to provide information on the number of contracts and the geographic region used to calculate the QPA, whether the QPA was calculated based on a downcoded billed claim, information about the use of modifiers in calculating the QPA, the types of specialties and subspecialties that have contracted rates included in the data set used to determine the QPA, and whether bonuses and supplemental payments were paid to in-network providers.

These final rules define the term "downcode," as described in the preamble to the October 2021 interim final rules, to mean the alteration by a plan or issuer of a service code to another service code, or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed code or modifier is associated with a lower QPA than the service code or modifier billed by the provider, facility, or provider of air ambulance services.

These final rules also specify that, if a QPA is based on a downcoded service code or modifier, in addition to the information already required to be provided with an initial payment or notice of denial of payment, a plan or issuer must provide a statement that the service code or modifier billed by the provider, facility, or provider of air ambulance services was downcoded; an explanation of why the claim was downcoded, including a description of which service codes were altered, if any, and which modifiers were altered, added, or removed, if any; and the amount that would have been the QPA had the service code or modifier not been downcoded.

The Departments are continuing to consider comments on the July 2021 interim final rules about whether additional disclosures related to the QPA calculation methodology should be required to be provided with an initial payment or notice of denial of payment, or upon request. The Departments note that the statute places the responsibility for monitoring the accuracy of plans' and issuers' QPA calculation methodologies with the Departments (and applicable state authorities) by requiring audits of plans' and issuers' QPA calculation methodologies,³⁰ and the Departments have committed to

conducting audits. The Departments also stress that payment determinations in the Federal IDR process should center on a determination of a total payment amount for a particular item or service based on the facts and circumstances of the dispute at issue, rather than an examination of a plan's or issuer's QPA methodology.

B. Payment Determinations Under the Federal IDR Process

The October 2021 interim final rules provide that, not later than 30 business days after the selection of the certified IDR entity, the certified IDR entity must select one of the offers submitted by the plan or issuer or the provider, facility, or provider of air ambulance services as the out-of-network rate for the qualified IDR item or service. In determining which offer to select, the October 2021 interim final rules provided, prior to *Texas Medical Association and LifeNet*, that the certified IDR entity must first look to the QPA, as it represents a reasonable market-based payment for relevant items and services, and then to additional information requested by the certified IDR entity from the parties and other additional information submitted by the parties. After considering the QPA and additional information, the October 2021 interim final rules required the certified IDR entity to select the offer closest to the QPA, unless the certified IDR entity determined that the additional information requested by the certified IDR entity and the credible information submitted by the parties demonstrated that the QPA was materially different from the appropriate out-of-network rate, or if the offers were equally distant from the QPA but in opposing directions. In instances in which the certified IDR entity determined that the credible information submitted by the parties clearly demonstrated that the QPA was materially different from the appropriate out-of-network rate, or when the offers were equally distant from the QPA but in opposing directions, the October 2021 interim final rules state that the certified IDR entity must select the offer that the certified IDR entity determined best represents the value of the item or service, which could be either party's offer.

As stated earlier in this preamble, on February 23, 2022 and July 26, 2022, the District Court in *Texas Medical Association and LifeNet* issued memorandum opinions and orders that vacated certain provisions of the October 2021 interim final rules that govern aspects of the Federal IDR process, including provisions that

³⁰ 86 FR 36872, 36899 (July 13, 2021).

provided guidance to certified IDR entities on selecting the appropriate out-of-network rate in a payment determination. In the October 2021 interim final rules, the Departments required certified IDR entities to view the QPA as an appropriate payment amount, subject to consideration of the information submitted by the parties related to the additional circumstances outlined in the statute, as a mechanism to ensure that certified IDR entities approached making payment determinations in the Federal IDR process in a consistent manner. The regulatory text required certified IDR entities to select the offer closest to the QPA unless the certified IDR entity determined that credible information submitted by a party clearly demonstrated that the QPA was materially different from the appropriate out-of-network rate. The preamble to the October 2021 interim final rules described the relevant instructions to certified IDR entities as a “rebuttable presumption” in favor of the QPA.

The District Court in *Texas Medical Association* and *LifeNet* vacated the portions of the October 2021 interim final rules that it construed as creating a rebuttable presumption in favor of the QPA. The Departments note that these final rules are not intended to impose a rebuttable presumption for payment determinations in the Federal IDR process. The regulatory text in these final rules does not include the provisions that the District Court reasoned would have the effect of imposing such a presumption.

The Departments note that, in all cases, the QPA, which is generally based on the median contracted rate for a qualified IDR item or service, will be relevant to a payment determination, as it represents the typical payment amount that a plan or issuer that is a party to a payment determination will pay in-network providers, facilities, and providers of air ambulance services for that particular qualified IDR item or service. The Departments also note that, to the extent the QPA is calculated in a manner that is consistent with the detailed rules issued under the July 2021 interim final rules, and is communicated in a way that satisfies the applicable disclosure requirements, the QPA will meet the credibility requirement that applies to the additional information and circumstances set forth in these final rules.³¹ The credibility requirement is

designed to ensure that the additional information submitted by the parties to a payment determination meet the same credibility standard that the QPA already meets through other mechanisms, by virtue of the requirements related to the QPA set forth in the July 2021 interim final rules. The Departments also note that the credibility requirement is designed to ensure that certified IDR entities have clear guidance on how to evaluate potentially voluminous and complex information in a methodical and consistent manner. Absent clear guidance on a process for evaluating the different factors, there would be no guarantee of consistency in how certified IDR entities reached determinations in different cases. The Departments are of the view that this guidance is also important because the QPA must be a quantitative figure, like the offers that will be submitted in a payment determination. Generally, these quantitative figures will be unlike the information received related to the additional circumstances, which will often be qualitative and open to subjective evaluation. Although the QPA is a quantitative figure, the amount that best represents the value of the qualified IDR items and services may be more or less than the QPA due to additional circumstances that are not easily quantifiable such as the care setting or the teaching status of the facility. It therefore is reasonable to ensure that certified IDR entities consider the QPA, a quantitative figure, and then consider the additional, likely-qualitative factors, when determining the out-of-network rate—another quantitative figure.

1. Requirement To Consider the QPA and Additional Information Submitted

In light of the *Texas Medical Association* and *LifeNet* decisions, and in response to comments received on these provisions, the Departments are finalizing rules that remove the provisions that the District Court vacated and that adopt standards for making a payment determination that are intended to achieve the statutory aims articulated earlier in this preamble.

Congress granted the Departments statutory authority to “establish by regulation one independent dispute

responsibility, not the certified IDR entity’s, to monitor the accuracy of the plan’s or issuer’s QPA calculation methodology by conducting an audit of the plan’s or issuer’s QPA calculation methodology. However, a provider or facility may always assert to the certified IDR entity that additional information points in favor of the selection of its offer as the out-of-network payment amount, even where that offer is for a payment amount that is different from the QPA.

resolution process” under which certified IDR entities determine the amount of payment for an out-of-network item or service.³² The Federal IDR process that the Departments establish under this authority is to be “in accordance with the succeeding provisions of” the cited statutory subsections,³³ including the statutory provisions describing the factors for the certified IDR entity to consider in determining the out-of-network payment amount. Under sections 9816(c)(5) and 9817(b)(5) of the Code, sections 716(c)(5) and 717(b)(5) of ERISA, and sections 2799A–1(c)(5) and 2799A–2(b)(5) of the PHS Act, the statute provides that with respect to payment determinations, the certified IDR entity must always consider the QPA without the parties specifically bringing it to the certified IDR entity’s attention. Next, the statute provides that the certified IDR entity must also consider “additional information” or “additional circumstances” submitted to the certified IDR entity.

As explained later in this preamble, the Departments are of the view that it is appropriate to exercise their authority under this provision, and that it is in accordance with these statutory provisions, to adopt a Federal IDR process that encourages a consistent methodology for evaluation of information when making a payment determination. The Departments are of the view that there is value in ensuring that all certified IDR entities approach payment determinations in a similar manner, which will promote consistency and predictability in the process, thereby lowering administrative costs and encouraging consistency in appropriate payments for out-of-network services.³⁴ The statute requires certified IDR entities to always consider the QPA when making a payment determination, as it is the one statutory consideration that will always be present in each payment determination, whereas the parties may or may not choose to submit

³² See section 9816(c)(2)(A) of the Code, section 716(c)(2)(A) of ERISA, and section 2799A–1(c)(2)(A) of the PHS Act; see also section 9817(b)(2)(A) of the Code, section 717(b)(2)(A) of ERISA, and section 2799A–2(b)(2)(A) of the PHS Act.

³³ *Id.*

³⁴ See Cong. Budget Office, *H.R. 5826, the Consumer Protections Against Surprise Medical Bills Act of 2020, as Introduced on February 10, 2020: Estimated Budgetary Effects* at 1 (Feb. 11, 2020) (arbitrators “would be instructed to look to the health plan’s median payment rate for in-network rate care,” and as a result “average payment rates for both in- and out-of-network care would move toward the median in-network rate,” thereby lowering health insurance premiums and budget deficits); see also H.R. Rep. No. 116–615, pt. I, at 57–58 (2020).

³¹ To the extent there is a question whether a plan or issuer has complied with the July 2021 interim final rules’ requirements for calculating the QPA, it is the Departments’ (or applicable State authorities’) responsibility.

information related to the additional circumstances as part of their offer. Consideration of the QPA, which is the first-listed statutory factor and a quantitative figure, will aid certified IDR entities in their consideration of each of the other statutory factors, as these entities will then be in a position to evaluate whether the “additional” factors present information that may not have already been captured in the calculation of the QPA.

As commenters noted, there may be instances in which the QPA would not adequately account for one or more of the additional factors. The Departments note that these final rules do not require certified IDR entities to default to the offer closest to the QPA or to apply a presumption in favor of that offer. The Departments are of the view that it will often be the case that the QPA represents an appropriate out-of-network rate, as the QPA is largely informed by similar information to what would be provided as information in support of the additional statutory circumstances. Nonetheless, the Departments acknowledge that the additional factors may be relevant in determining the appropriate out-of-network rate, because the QPA may not account for information specific to a particular item or service. Therefore, these final rules do not require the certified IDR entity to select the offer closest to the QPA. Rather, these final rules specify that certified IDR entities should select the offer that best represents the value of the item or service under dispute after considering the QPA and all permissible information submitted by the parties.

Accordingly, in determining which offer to select during the Federal IDR process under these final rules, the certified IDR entity must consider the QPA for the applicable year for the same or similar item or service and then must consider all additional information submitted by a party to determine which offer best reflects the appropriate out-of-network rate, provided that the information relates to the party's offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination (and does not include information that the certified IDR entity is prohibited from considering in making the payment determination under section 9816(c)(5)(D) of the Code, section 716(c)(5)(D) of ERISA, and section 2799A-1(c)(5)(D) of the PHS Act).³⁵ For this purpose, the Departments understand that information requested

by a certified IDR entity, or submitted by a party, would be information relating to a party's offer if it tends to show that the offer best represents the value of the item or service under dispute. Therefore, these rules require the certified IDR entity to evaluate whether the information relates to the offer submitted by either party for the payment amount for the qualified IDR item or service that is the subject of the payment determination. In considering this additional information, the certified IDR entity should evaluate whether information that is offered is credible and should not give weight to information that is not credible.³⁶ The appropriate out-of-network rate must be the offer that the certified IDR entity determines best represents the value of the qualified IDR item or service.

For non-air ambulance items and services, the additional information to be considered includes information related to the following factors:

1. the level of training, experience, and quality and outcomes measurements of the provider or facility that furnished the qualified IDR item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act);
2. the market share held by the provider or facility or that of the plan or issuer in the geographic region in which the qualified IDR item or service was provided;
3. the acuity of the participant, beneficiary, or enrollee receiving the qualified IDR item or service, or the complexity of furnishing the qualified IDR item or service to the participant, beneficiary, or enrollee;
4. the teaching status, case mix, and scope of services of the facility that furnished the qualified IDR item or service, if applicable; and
5. the demonstration of good faith efforts (or lack thereof) made by the provider or facility or the plan or issuer to enter into network agreements with each other, and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

Under these final rules, the certified IDR entity must also consider information related to the offer provided in response to a request from the certified IDR entity under 26 CFR 54.9816-8T(c)(4)(i)(A)(2), 29 CFR 2590.716-8(c)(4)(i)(A)(2), and 45 CFR 149.510(c)(4)(i)(A)(2).

³⁶ For this purpose, credible information is information that upon critical analysis is worthy of belief and is trustworthy. 26 CFR 54.9816-8T(a)(2)(v), 29 CFR 2590.716-8(a)(2)(v), and 45 CFR 149.510(a)(2)(v).

2. Avoidance of Double-Counting Information

When considering the additional information under 26 CFR 54.9816-8(c)(4)(iii), 29 CFR 2590.716-8(c)(4)(iii), and 45 CFR 149.510(c)(4)(iii), the certified IDR entity should evaluate the information and should not give weight to that information if it is already accounted for by any of the other information submitted by the parties. The certified IDR entity should consider whether the additional information is already accounted for in the QPA and should not give weight to information related to a factor if the certified IDR entity determines the information was already accounted for in the calculation of the QPA, to avoid weighting the same information twice. In addition, if the parties submit information related to more than one of the additional factors, the certified IDR entity should also consider whether the information submitted regarding those factors is already accounted for by information submitted relating to other credible information submitted to the certified IDR entity in relation to another factor and, if so, should not weigh this information more than once.

Numerous comments received on the October 2021 interim final rules highlighted that, in many cases, certain factors, such as patient acuity or the complexity of furnishing the qualified IDR item or service to the participant, beneficiary, or enrollee, will already be accounted for in the calculation of the QPA and should therefore not receive additional weight. For example, because the plan or issuer is required to calculate the QPA using median contracted rates for service codes, as well as modifiers (if applicable), and because service codes and modifiers in many cases reflect patient acuity and the complexity of the service provided, these factors will often already be reflected in the QPA.

Commenters also acknowledged that there could be instances in which the QPA would not adequately account for the acuity of the patient or complexity of the service: for example, if the complexity of a case is an outlier such that the time or intensity of care exceeds what is typical for a service code. A certified IDR entity may also conclude that the QPA does not already account for patient acuity or the complexity of furnishing the qualified IDR item or service in instances where the parties disagree on what service code or modifier accurately describes the qualified IDR item or service, such as when a plan or issuer has downcoded a claim and the QPA is based on the

³⁵ See also 26 CFR 54.9816-8T(c)(4)(v), 29 CFR 2590.716-8(c)(4)(v), and 45 CFR 149.510(c)(4)(v).

downcoded service code or modifier, rather than the billed service code or modifier.

The Departments agree with the commenters that, in many cases, the additional factors for the certified IDR entity to consider other than the QPA will already be reflected in the QPA. The QPA is generally calculated to include characteristics that affect costs, including medical specialty, geographic region, and patient acuity and case severity, all captured in different billing codes or the QPA calculation methodology.³⁷ Therefore, in the Departments' view, giving additional weight to information that is already incorporated into the calculation of the QPA would be redundant, possibly resulting in the selection of an offer that does not best represent the value of the qualified IDR item or service and potentially over time contributing to higher health care costs. As noted earlier in this preamble, the Departments are also aware that there are instances when certain factors related to the qualified IDR item or service may not be adequately reflected in the QPA. Under these final rules, certified IDR entities are required to consider the QPA and then must consider all additional information submitted by the parties relating to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination, but each factor should be weighted only once in the evaluation of each party's payment offer. To the extent a factor is not already reflected in the QPA, the certified IDR entity should accord that factor appropriate weight based on information related to it provided by the parties. For example, some providers and facilities that provide high-acuity care, such as level 1 trauma or neonatal care, may contend that additional factors such as their case mix and the scope of services offered were not accounted for in the QPA and could justify the selection of a higher amount as the out-of-network payment amount.

3. Examples Provided

These final rules also include examples to illustrate the consideration of factors when making a payment determination, including whether and how to give weight to additional information submitted by a party. Each example assumes that the Federal IDR process applies for purposes of

determining the out-of-network rate, that both parties have submitted the information parties are required to submit as part of the Federal IDR process, including the applicable QPA(s), and the submitted information does not include information on the prohibited factors.

In the first new example, a level 1 trauma center that is a nonparticipating emergency facility submits an offer that is higher than the QPA. Along with the offer, the nonparticipating emergency facility submits additional written information showing that the scope of services available at the nonparticipating emergency facility was critical to the delivery of care for the qualified IDR item or service provided, given the particular patient's acuity, and the information is determined to be credible by the certified IDR entity. The nonparticipating emergency facility also submits information showing that the contracted rates used to calculate the QPA were based on a level of service that is typical in cases in which the services are delivered by a facility that is not a level 1 trauma center and that does not have the capability to provide the scope of services provided by a level 1 trauma center. This information is also determined to be credible by the certified IDR entity. The issuer submits an offer equal to the QPA. No additional information is submitted by either party. The certified IDR entity determines that the information submitted by the nonparticipating emergency facility relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination. If the certified IDR entity determines that it is appropriate to give weight to the additional credible information submitted by the nonparticipating emergency facility and that this information demonstrates that the facility's offer best represents the value of the qualified IDR item or service, the certified IDR entity should select the facility's offer.

In the second new example, a nonparticipating provider submits an offer that is higher than the QPA. Along with the offer, the nonparticipating provider submits additional written information regarding the level of training and experience of the provider, and the information is determined to be credible by the certified IDR entity, but the certified IDR entity finds that the provider does not demonstrate that the level of training and experience relates to the offer for the appropriate payment amount for the qualified IDR item or service that is the subject of the payment determination (for example,

the information does not show that the level of training and experience was necessary to provide the qualified IDR service or that the training or experience made an impact on the care that was provided). The nonparticipating provider does not submit any additional information. The issuer submits an amount equal to the QPA as its offer, with no additional information. Even if the certified IDR entity determines that the additional information regarding the level of training and experience is credible, if the certified IDR entity determines that the information does not relate to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination, the certified IDR entity should not give weight to the additional information. In the absence of any other credible information that relates to a party's offer, the certified IDR entity should select the issuer's offer as the offer that best represents the value of the qualified IDR service.

In the third new example, in connection with an emergency department visit for the evaluation and management of a patient, a nonparticipating provider submits an offer that is higher than the QPA. Along with the offer, the nonparticipating provider submits additional written information showing that the acuity of the patient's condition and the complexity of the qualified IDR service required the taking of a comprehensive history, a comprehensive examination, and medical decision making of high complexity, and the information is determined to be credible by the certified IDR entity. The issuer submits an offer equal to the QPA for Current Procedural Terminology (CPT) code 99285, which is the CPT code for an emergency department visit for the evaluation and management of a patient requiring a comprehensive history, a comprehensive examination, and medical decision making of high complexity. The issuer also submits additional written information showing that this CPT code accounts for the acuity of the patient's condition, and the information is determined to be credible by the certified IDR entity. The certified IDR entity determines that this information relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination. Neither party submits any additional information. If the certified IDR entity determines the information on the acuity of the patient and complexity of the service is already accounted for in the calculation of the QPA, the certified IDR entity should not

³⁷ Plans and issuers are required to calculate separate QPAs for the same service code by provider specialty if the plan or issuer has contracted rates for the service code that vary based on provider specialty. See 26 CFR 54.9816-6T(b)(3), 29 CFR 2590.716-6(b)(3), and 45 CFR 149.140(b)(3).

give weight to the additional information provided by the nonparticipating provider. If, after evaluating the information submitted by the parties, the IDR entity determines that the issuer's offer best represents the value of the qualified IDR service, then the certified IDR entity should select the issuer's offer.

In the fourth new example, the issuer submits an offer that is higher than the QPA and that is equal to the nonparticipating emergency facility's prior contracted rate (adjusted for inflation) with the issuer for the previous year for the qualified IDR service. Although the facility is not participating in the issuer's network this year, it was a participating facility in the issuer's network in the previous 4 plan years. Along with the offer, the issuer submits additional written information showing that the contracted rates between the nonparticipating facility and the issuer during the previous 4 plan years were higher than the QPA, and that these prior contracted rates took into account the case mix and scope of services typically furnished at the facility. The certified IDR entity determines that the information is credible and that it relates to the offer submitted by the facility for the payment amount for the qualified IDR service that is the subject of the payment determination. The nonparticipating emergency facility submits an offer that is higher than both the QPA and the prior contracted rate (adjusted for inflation) and submits additional written information intending to show that the case mix and scope of services available at the facility that furnished the qualified IDR service were integral to the services provided. The certified IDR entity determines this information is credible and relates to the offer submitted by the facility for the payment amount for the qualified IDR service that is the subject of the payment determination. If the certified IDR entity determines that the information submitted by the facility regarding the case mix and scope of services available at the facility includes information that is also accounted for in the information that the issuer submitted regarding prior contracted rates, then that same information that has been submitted twice should be weighted only once by the certified IDR entity. The certified IDR entity also should not give weight to the same information provided by the nonparticipating emergency facility in relation to any other factor. If the certified IDR entity determines that the issuer's offer best represents the value of

the qualified IDR service, the certified IDR entity should select the issuer's offer.

In the fifth new example, regarding a qualified IDR service for which the issuer downcoded the service code that the provider billed, the issuer submits an offer equal to the QPA (which was calculated using the downcoded service code). The issuer also submits the additional written information that it was required to disclose to the nonparticipating provider at the time of the initial payment. The certified IDR entity determines the additional information to be credible and that it relates to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination. The nonparticipating provider submits an offer equal to the amount that would have been the QPA had the service code not been downcoded. The nonparticipating provider submits additional written information that includes the same documentation provided by the issuer, as well as information that explains why the billed service code was more appropriate than the downcoded service code, as evidence that the provider's offer best represents the value of the service furnished, given its complexity. Neither party submits any additional information. The certified IDR entity determines that the information submitted by the provider is credible and that it is related to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination. If the certified IDR entity determines that it is appropriate to give weight to the additional credible information submitted by the provider and that this information demonstrates that the provider's offer best represents the value of the qualified IDR service, the certified IDR entity should select the provider's offer.

The Departments note that the statute and the October 2021 interim final rules continue to provide that when making a payment determination, a certified IDR entity must not consider information on the prohibited factors, such as the usual and customary charges (including payment or reimbursement rates expressed as a proportion of usual and customary charges); the amount that would have been billed by the provider, facility, or provider of air ambulance services with respect to the qualified IDR item or service had the balance billing provisions of 45 CFR 149.410, 149.420, and 149.440 (as applicable) not applied; or the payment or reimbursement rate for items and services furnished by the provider,

facility, or provider of air ambulance services payable by a public payor.^{38 39} In considering all the permissible information submitted by the parties, the Departments expect that the certified IDR entity will conduct a thorough review of the information submitted to evaluate whether the information includes any of the prohibited factors, so as to ensure that prohibited factors are not considered in any payment determinations. In conducting this review, the certified IDR entity may request additional information from the disputing parties, including confirmation that information submitted does not include information on the prohibited factors.

The Departments are committed to establishing a fair, cost-effective, and reasonable IDR payment determination process that does not have an inflationary impact on health care costs. To that end, the Departments will monitor the effects of these payment determination requirements and make appropriate adjustments as necessary to achieve the intended goals articulated in this preamble.

C. Payment Determinations Under the Federal IDR Process for Air Ambulance Services

As discussed in section I.C of this preamble, the process for a certified IDR entity to select an offer in a dispute

³⁸ Contracted rates are frequently based on a percentage of rates payable by a public payor, such as Medicare. In these cases, because contracting parties have chosen to set their rates in this way, the contracted rates represent an independent decision by contracting parties. Thus, if a party submits information on such rates to a certified IDR entity, consideration of these contracted rates does not violate the prohibition on considering the factors described in 26 CFR 54.9816-8T(c)(4)(v), 29 CFR 2590.716-8(c)(4)(v), and 45 CFR 149.510(c)(4)(v). In contrast, if a party submits evidence showing that its offer was a percentage of the rates paid by Medicare, a certified IDR entity is prohibited from considering such information.

³⁹ Under 5 U.S.C. 8904(b), in the case of a retired individual who is over age 65 and enrolled in the Federal Employees Health Benefits (FEHB) Program but not covered by Medicare part A or B, fee-for-service FEHB carriers may not pay a charge imposed by a hospital provider for inpatient services or a physician to the extent that charge exceeds applicable Medicare limits. The Departments, after consulting with OPM, clarify that a certified IDR entity is not considered to violate the prohibition on considering the payment or reimbursement rate for items and services furnished by the provider, facility, or provider of air ambulance services payable by a public payor to the extent the certified IDR entity's selection of an offer is made to allow compliance with 5 U.S.C. 8904(b) and 5 CFR part 890, subpart I. That is, if 5 U.S.C. 8904(b) applies, and either offer exceeds the applicable Medicare limit referenced in 5 U.S.C. 8904(b), the certified IDR entity must ensure that the payment determination does not exceed the applicable Medicare limit. A certified IDR entity would not be considered to violate the prohibition on considering Medicare reimbursement rates when it selects an offer on this basis.

related to qualified IDR services that are air ambulance services is generally the same as the process applicable to disputes related to qualified IDR items or services that are not air ambulance services. However, section 9817(b)(5)(C) of the Code, section 717(b)(5)(C) of ERISA, section 2799A–2(b)(5)(C) of the PHS Act, and the October 2021 interim final rules specify different additional circumstances, in addition to the QPA, that the certified IDR entity must consider in making the payment determination for air ambulance services. Upon review of the comments the Departments received on the Federal IDR process, and in light of the District Court's memorandum opinions and orders in *Texas Medical Association* and *LifeNet*, the Departments have determined that it is appropriate to issue the final rules under the Federal IDR process for air ambulance services.

As for non-air ambulance items and services, these final rules provide that in determining which offer to select in a dispute related to air ambulance services, the certified IDR entity must consider certain additional information submitted by a party. Also, for non-air ambulance items and services, these final rules for air ambulance services provide that the certified IDR entity must consider the QPA for the applicable year for the same or similar service and then consider all additional permissible information to determine the appropriate out-of-network rate. For air ambulance services, this information includes information related to the following factors:

1. quality and outcomes measurements of the provider that furnished the services;
2. the acuity of the condition of the participant, beneficiary, or enrollee receiving the service, or the complexity of furnishing the service to the participant, beneficiary, or enrollee;
3. training, experience, and quality of the medical personnel that furnished the air ambulance service;
4. ambulance vehicle type, including the clinical capability level of the vehicle;
5. population density of the point of pick-up; and
6. demonstrations of good faith efforts (or lack thereof) by the disputing parties to enter into network agreements with each other, as well as, if applicable, contracted rates between the parties during the previous 4 plan years.

Additionally, as with non-air ambulance disputes, the certified IDR entity must also consider information related to the offer provided in a response to the certified IDR entity's request under 26 CFR 54.9816–

8T(c)(4)(i)(A)(2), 29 CFR 2590.716–8(c)(4)(i)(A)(2), and 45 CFR 149.510(c)(4)(i)(A)(2). The certified IDR entity must also consider other information provided by the parties under 26 CFR 54.9816–8(c)(4)(iii)(D), 29 CFR 2590.716–8(c)(4)(iii)(D), and 45 CFR 149.510(c)(4)(iii)(D).

As with non-air ambulance disputes, the certified IDR entity should evaluate whether each piece of submitted information is credible, relates to the offer for the payment amount for the qualified IDR service submitted by either party, and does not include information on factors described in 26 CFR 54.9816–8T(c)(4)(v), 29 CFR 2590.716–8(c)(4)(v), or 45 CFR 149.510(c)(4)(v) (regarding prohibited considerations). When considering the additional information listed above, the certified IDR entity should not give weight to the information to the extent it is not credible, does not relate to either party's offer for the payment amount for the qualified IDR service, or is included in the QPA calculation or other credible information. The Departments note that these final rules do not require certified IDR entities to default to the offer closest to the QPA or to apply a presumption in favor of that offer. Rather, these final rules specify that certified IDR entities should select the offer that best represents the value of the air ambulance service under dispute after considering the QPA and all permissible information submitted by the parties.

D. The Certified IDR Entity's Written Decision

Under section 9816(c)(7) of the Code, section 716(c)(7) of ERISA, and section 2799A–1(c)(7) of the PHS Act, the Departments are required to publish a variety of information relating to the Federal IDR process, including the number of times a payment amount determined or agreed to under this process exceeds the QPA; the amount of each offer submitted in the Federal IDR process expressed as a percentage of the QPA; and any other information specified by the Departments. The statute also instructs certified IDR entities to submit to the Departments such information as the Departments determine necessary to carry out the provisions of section 9816(c) of the Code, section 716(c) of ERISA, and section 2799A–1(c) of the PHS Act, which include these reporting requirements as well as the Departments' obligations to establish and oversee the Federal IDR process. The Departments have determined it is necessary under this provision to require certified IDR entities to submit

certain information, including a written statement of the certified IDR entity's reasons for a particular determination of an out-of-network rate.

Under the October 2021 interim final rules, the certified IDR entity must explain its payment determination and the underlying rationale in a written decision submitted to the parties and the Departments, in a form and manner specified by the Departments. The October 2021 interim final rules also required the certified IDR entity to include in its written decision an explanation of the credible information that the certified IDR entity determined demonstrated that the QPA was materially different from the appropriate out-of-network rate if the certified IDR entity did not choose the offer closest to the QPA.

As stated earlier in this preamble, on February 23, 2022, the District Court in *Texas Medical Association* issued a memorandum opinion and order that invalidated the requirement to provide an explanation of the credible information that the certified IDR entity determined demonstrated that the QPA was materially different from the appropriate out-of-network rate (but not the general requirement that a certified IDR entity issue a written decision). The Departments are of the view that, in all cases, a written decision with a comprehensive discussion of the rationale for the decision is important to ensure that the parties understand the outcome of a payment determination under the Federal IDR process. The Departments note that commenters generally supported the requirement that certified IDR entities provide a written rationale for determinations. The Departments agree with commenters' assertions that the certified IDR entity should be required to provide an explanation for its decision in all cases, and not only when the offer furthest from the QPA is determined to best represent the value of the qualified IDR item or service. This requirement will ensure that all parties understand the certified IDR entity's payment determination and how the various information was considered.

The Departments are finalizing standards for the written decision that are intended to achieve transparency and consistency in the Federal IDR process. Accordingly, similar to the October 2021 interim final rules these final rules require that the certified IDR entity explain in all cases its determination in a written decision provided to the parties and the Departments, in a form and manner specified by the Departments in separate guidance. Additionally, these final rules

continue to require that the rationale be included in the written decision. In response to comments requesting additional transparency and explanation, these final rules also provide that the certified IDR entity's written decision must include an explanation of its determination, including what information the certified IDR entity determined demonstrated that the offer selected as the out-of-network rate is the offer that best represents the value of the qualified IDR item or service, including the weight given to the QPA and any additional credible information submitted in accordance with these final rules. This requirement will help ensure that certified IDR entities carefully evaluate all credible information and promote transparency with respect to payment determinations. These final rules also provide that, if the certified IDR entity relies on additional information or additional circumstances in selecting an offer, its written decision must include an explanation of why the certified IDR entity concluded that this information was not already reflected in the QPA. The Departments are of the view that, in these cases, the certified IDR entity should provide this additional explanation so that the Departments may fulfill their statutory functions to monitor and to report on how often, and why, an offer that is selected exceeds the QPA for a given qualified IDR item or service. Additionally, this requirement will provide the Departments with valuable information to inform future policy making, in particular, policy making related to the QPA methodology. As stated elsewhere in this preamble, the Departments are committed to establishing a reasonable and fair Federal IDR process.

Finally, the Departments are also including two technical corrections to address a regulatory cross-references in the provisions that set forth the requirements for the certified IDR entity to include a rationale for its written decision for both air ambulance and non-air ambulance qualified IDR items and services in monthly reporting to the Departments, and to clarify that the certified IDR entity should report to the Departments the extent to which the decision relied on 26 CFR 54.9816–8(c)(4)(iii)(B)–(D), 29 CFR 2590.716–8(c)(4)(iii)(B)–(D), and 45 CFR 149.510(c)(4)(iii)(B)–(D). This requirement aligns the reporting requirement with the requirement for the written decision, and with the intent of the October 2021 interim final rules to gather such information.

III. Applicability of the Final Rules

These rules finalize certain provisions of the July 2021 and October 2021 interim final rules and address the decisions in *Texas Medical Association* and *LifeNet*. The July 2021 and October 2021 interim final rules apply for plan years (in the individual market, policy years) beginning on or after January 1, 2022, except to the extent provided below.

The final rules that implement the requirements related to the additional information that must be provided with each initial payment or notice of denial of payment if the QPA is based on a downcoded service code or modifier are applicable with respect to items or services furnished on or after October 25, 2022, for plan years (in the individual market, policy years) beginning on or after January 1, 2022.

With respect to the additional information that must be provided with each initial payment or notice of denial of payment if a QPA is based on a downcoded service code or modifier, the Departments recognize that plans and issuers often provide these notices through an automated or other streamlined system for efficiency and that plans and issuers may need additional time to update their operating systems to amend the notices that are currently generated to satisfy the QPA disclosure requirements under the July 2021 interim final rules. Plans and issuers may use reasonable methods to provide this additional disclosure with the initial payment or notice of denial of payment while plan or issuer systems and procedures are updated to provide the additional notice in a more streamlined and automated manner. Even when using other reasonable methods, plans and issuers must provide the required information starting on the date these final rules are applicable to the relevant plan or policy and in accordance with the timeframes specified in the July 2021 interim final rules. The Departments expect that plans and issuers will work to make sure that systems are updated in a timely fashion, and the Departments may provide additional guidance, as warranted.

For requirements that finalize certain provisions of the October 2021 interim final rules, the final rules addressing the payment determination standards for certified IDR entities, written decisions, and reporting are applicable with respect to items or services provided or furnished on or after October 25, 2022, for plan years (in the individual market, policy years) beginning on or after January 1, 2022. This approach will

ensure uniformity and predictability in standards for qualified IDR items and services (including between non-air ambulance items and services and air ambulance services, to the extent applicable), and will allow time for the Departments to provide updated guidance to certified IDR entities and stakeholders.

If any provision in this rulemaking is held to be invalid or unenforceable facially, or as applied to any person, plaintiff, or circumstance, the provision shall be severable from the remainder of this rulemaking, and shall not affect the remainder thereof, and the invalidation of any specific application of a provision shall not affect the application of the provision to other persons or circumstances.

IV. Regulatory Impact Analysis

A. Summary

The Departments have examined the effects of these final rules as required by Executive Order 12866,⁴⁰ Executive Order 13563,⁴¹ the Paperwork Reduction Act of 1995,⁴² the Regulatory Flexibility Act,⁴³ section 202 of the Unfunded Mandates Reform Act of 1995,⁴⁴ Executive Order 13132,⁴⁵ and the Congressional Review Act.⁴⁶

B. Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health, and safety effects; distributive impacts; and equity). Executive Order 13563 emphasizes the importance of quantifying costs and benefits, reducing costs, harmonizing rules, and promoting flexibility.

Under Executive Order 12866, “significant” regulatory actions are subject to review by the Office of Management and Budget (OMB). Section 3(f) of the Executive order defines a “significant regulatory action” as an action that is likely to result in a rule: (1) having an annual effect on the economy of \$100 million or more, or adversely and materially affecting a sector of the economy, productivity,

⁴⁰ Regulatory Planning and Review, 58 FR 51735 (Oct. 4, 1993).

⁴¹ Improving Regulation and Regulatory Review, 76 FR 3821 (Jan. 18, 2011).

⁴² 44 U.S.C. 3506(c)(2)(A) (1995).

⁴³ 5 U.S.C. 601 *et seq.* (1980).

⁴⁴ 2 U.S.C. 1501 *et seq.* (1995).

⁴⁵ Federalism, 64 FR 153 (Aug. 4, 1999).

⁴⁶ 5 U.S.C. 804(2) (1996).

competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive order. Based on the Departments’ estimates, OMB’s Office of Information and Regulatory Affairs has determined this rulemaking is “economically significant” under section 3(f)(1) of Executive Order 12866 as measured by the \$100 million threshold.⁴⁷ Therefore, the Departments have prepared a Regulatory Impact Analysis that presents the costs, benefits, and transfers associated with this rulemaking. Pursuant to the Congressional Review Act, OMB has designated these final rules as a “major rule,” as defined by 5 U.S.C. 804(2).

C. Need for Regulatory Action

On December 27, 2020, the CAA, which includes the No Surprises Act, was enacted.⁴⁸ The No Surprises Act provides Federal protections against surprise billing by limiting out-of-network cost sharing and prohibiting balance billing in many of the circumstances in which surprise bills arise most frequently.

On July 13, 2021, the Departments published the July 2021 interim final rules.⁴⁹ The July 2021 interim final rules implemented provisions of the No Surprises Act to protect participants, beneficiaries, and enrollees in group health plans and group and individual health insurance coverage from surprise medical bills when they receive emergency services, non-emergency services furnished by nonparticipating providers with respect to patient visits to certain participating facilities, and air ambulance services provided by nonparticipating providers of air ambulance services.

On October 7, 2021, the Departments published the October 2021 interim

final rules.⁵⁰ The October 2021 interim final rules build on the July 2021 interim final rules and implement the Federal IDR process.⁵¹ The October 2021 interim final rules generally apply to group health plans and health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans) with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022; and to health care providers and facilities, providers of air ambulance services, and certified IDR entities beginning on January 1, 2022 with respect to items and services furnished during a plan year (in the individual market, policy year) beginning on or after January 1, 2022.

On February 23, 2022, the District Court in *Texas Medical Association* issued a memorandum opinion and order that vacated portions of the October 2021 interim final rules governing aspects of the Federal IDR process, as discussed earlier in this preamble. On July 26, 2022, the District Court in *LifeNet* issued a memorandum opinion and order that vacated additional portions of the October 2021 interim final rules, as discussed earlier in this preamble.

In response to the decisions in *Texas Medical Association* and *LifeNet* and comments received on the October 2021 interim final rules and July 2021 interim final rules, these final rules address certain issues critical to the implementation and effective operation of the Federal IDR process, including the disclosure requirements relating to information that group health plans and health insurance issuers offering group or individual health insurance coverage must share about the QPA, and certain requirements related to consideration of information when a certified IDR entity makes a payment determination under the Federal IDR process.

i. Final Rules on Information To Be Shared About the Qualifying Payment Amount

As described earlier in this preamble, the July 2021 interim final rules require plans and issuers to make certain disclosures with each initial payment or notice of denial of payment in cases in which the recognized amount with

respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility, or the amount upon which cost sharing is based for air ambulance services furnished by a nonparticipating provider of air ambulance services, is the QPA. After review of the comments on the July 2021 interim final rules and October 2021 interim final rules, the Departments are finalizing parts of the July 2021 interim final rules to add a new definition and make changes to require additional information about the QPA that is provided by a plan or issuer with an initial payment or notice of denial of payment in certain cases. These disclosures are required in cases in which the recognized amount with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility, or the amount upon which cost sharing is based for air ambulance services furnished by a nonparticipating provider of air ambulance services, is the QPA. Specifically, these final rules provide a definition of the term “downcode” to mean the alteration by a plan or issuer of a service code to another service code, or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed code or modifier is associated with a lower QPA than the service code or modifier billed by the provider, facility, or provider of air ambulance services. These final rules also specify that when a QPA is calculated based on a downcoded service code or modifier, in addition to the information already required to be provided with an initial payment or notice of denial of payment under the July 2021 interim final rules, a plan or issuer must provide a statement that the claim was downcoded; an explanation of why the claim was downcoded, including a description of which service codes were altered, if applicable, and a description of which modifiers were altered, added, or removed, if applicable; and the amount that would have been the QPA had the service code or modifier not been downcoded. The Departments are of the view that this additional disclosure of information about the QPA will be helpful to ensure that providers, facilities, and providers of air ambulance services receive the information regarding the QPA that may assist in their meaningful participation in open negotiation and in the Federal IDR process in all payment disputes that involve qualified items or services that have been subject to downcoding. In particular, in cases in which the plan or issuer has downcoded the billed claim, it is of particular importance that the

⁴⁷ This rulemaking builds on the July 2021 and October 2021 interim final rules described in this preamble. The interim final rules were deemed to be economically significant. The economic analyses for each of these interim final rules can be found in the *Federal Register* at 86 FR 36872 and 86 FR 55980.

⁴⁸ Pub. L. 116–260 (Dec. 27, 2020).

⁴⁹ 86 FR 36872 (July 13, 2021).

⁵⁰ 86 FR 55980 (October 7, 2021).

⁵¹ The July 2021 and October 2021 interim final rules also include interim final regulations under 5 U.S.C. 8902(p) issued by OPM that specify how certain provisions of the No Surprises Act apply to health benefit plans offered by carriers under the Federal Employees Health Benefits Act. The rules apply to carriers in the FEHB Program with respect to contract years beginning on or after January 1, 2022.

provider, facility, or provider of air ambulance services has information regarding both the QPA (based on the downcoded service code or modifier) and the amount that would have been the QPA had the service code or modifier not been downcoded in order to ascertain what information will demonstrate that the provider's, facility's, or provider of air ambulance services' offer best represents the value of the item or service and aid the certified IDR entity in selecting an offer that best represents the value of the item or service provided.

ii. Final Rules on Payment Determinations Under the Federal IDR Process

As discussed earlier in this preamble, the October 2021 interim final rules provided that, not later than 30 business days after the selection of the certified IDR entity, the certified IDR entity must select one of the offers submitted by the plan or issuer or the provider, facility, or provider of air ambulance services to be the out-of-network rate for the qualified IDR item or service. In determining which offer to select, the October 2021 interim final rules provided that the certified IDR entity must select the offer closest to the QPA unless the certified IDR entity were to determine that additional permissible information demonstrated that the QPA is materially different from the appropriate out-of-network rate, or if the offers are equally distant from the QPA but in opposing directions. A key goal in facilitating consistency in the Federal IDR process through the October 2021 interim final rules was to ensure a level of predictability in outcomes in the Federal IDR process. In the Departments' view, greater predictability in the Federal IDR process would encourage parties to settle disputes through open negotiation or earlier through the offer and acceptance of an adequate initial payment, which would increase efficiencies in how disputes are handled and ultimately lead to lower administrative costs associated with health care. As articulated earlier in this preamble, in light of the *Texas Medical Association* and *LifeNet* decisions, and in response to comments received on these provisions, the Departments are finalizing standards for making payment determinations that are intended to lead to greater predictability and regularity in the Federal IDR process. Accordingly, these final rules require that, in determining which offer to select during the Federal IDR process, the certified IDR entity must consider the QPA for the applicable year for the same or

similar item or service. The certified IDR entity must then consider all additional information submitted by a party to determine which offer best reflects the appropriate out-of-network rate, provided that the information relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination and does not include information that the certified IDR entity is prohibited from weighing in making the payment determination. In considering this additional information, the certified IDR entity should evaluate whether information that is offered is credible and should not give weight to information that is not credible. The appropriate out-of-network rate must be the offer that the certified IDR entity determines best represents the value of the qualified IDR item or service.

For non-air ambulance items and services, this information includes information related to the following factors: (1) the level of training, experience, and quality and outcomes measurements of the provider or facility that furnished the qualified IDR item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act); (2) the market share held by the provider or facility or that of the plan or issuer in the geographic region in which the qualified IDR item or service was provided; (3) the acuity of the participant, beneficiary, or enrollee receiving the qualified IDR item or service, or the complexity of furnishing the qualified IDR item or service to the participant, beneficiary, or enrollee; (4) the teaching status, case mix, and scope of services of the facility that furnished the qualified IDR item or service, if applicable; and (5) demonstration of good faith efforts (or lack thereof) made by the provider or facility or the plan or issuer to enter into network agreements with each other, and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

Under these final rules, the certified IDR entity must also consider information related to the offer provided in a response to a request from the certified IDR entity. The certified IDR entity must also consider additional information submitted by a party, provided the information relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination and does not include information that the certified IDR entity is prohibited from weighing in making the payment

determination under section 9816(c)(5)(D) of the Code, section 716(c)(5)(D) of ERISA, and section 2799A-1(c)(5)(D) of the PHS Act. In considering either form of information, the certified IDR entity should evaluate whether the information is credible and should not give weight to information that is not credible.

When considering the additional credible information under 26 CFR 54.9816-8(c)(4)(iii), 29 CFR 2590.716-8(c)(4)(iii), and 45 CFR 149.510(c)(4)(iii), the certified IDR entity should evaluate whether the information is already accounted for by any of the other credible information submitted by the parties. Because the certified IDR entity must consider the QPA, the certified IDR entity should always consider whether the additional credible information is already accounted for by the QPA and should avoid giving weight to information related to a factor if the certified IDR entity determines the information was already accounted for in the calculation of the QPA, to avoid weighting the same information twice. In addition, if the parties submit credible information related to more than one of the additional factors, the certified IDR entity should also consider whether the information submitted regarding those factors is already accounted for by information submitted relating to other credible information already before the certified IDR entity in relation to another factor and, if so, should not weigh the information more than once.

Regarding air ambulance services, these final rules state that the certified IDR entity must consider the QPA for the applicable year for the same or similar service and then consider all additional permissible information to determine the appropriate out-of-network rate. In considering this additional information, the certified IDR entity should evaluate whether information that is offered is credible and should not give weight to information that is not credible. For air ambulance services, this information includes information related to the following factors: (1) quality and outcomes measurements of the provider that furnished the air ambulance services; (2) the acuity of the condition of the participant or beneficiary receiving the air ambulance service, or the complexity of furnishing the service to the participant or beneficiary; (3) training, experience, and quality of the medical personnel that furnished the air ambulance services; (4) ambulance vehicle type, including the clinical capability level of the vehicle; (5) population density of the point of pick-

up; and (6) demonstrations of good faith efforts (or lack thereof) by the disputing parties to enter into network agreements with each other, as well as, if applicable, contracted rates between the parties during the previous 4 plan years.

After the certified IDR entity has reviewed and selected the offer it determines best represents the value of the qualified IDR item or service as the out-of-network rate, the certified IDR entity must explain its determination in a written decision submitted to the parties and the Departments, in a form and manner specified by the Departments. These final rules require that the certified IDR entity's written decision must include an explanation of what information the certified IDR entity determined demonstrated that the offer selected as the out-of-network rate is the offer that best represents the value of the qualified IDR item or service, including the weight given to the QPA and any additional credible information submitted in accordance with these final rules. If the certified IDR entity relies on any additional information in selecting an offer, the written decision must include an explanation of why the certified IDR entity concluded that this information was not already reflected in the QPA.

iii. Summary of Impacts

Plans, issuers, third-party administrators (TPAs), Federal Employees Health Benefits (FEHB) Program carriers, health care providers, facilities, providers of air ambulance services, and certified IDR entities will incur costs to comply with the requirements in these final rules. However, these final rules will help ensure that the payment determination in the Federal IDR process is a more

consistent process for providers, facilities, providers of air ambulance services, plans, and issuers. These final rules will improve transparency in the Federal IDR process. This increased transparency will aid in the open negotiation process, the decision whether to initiate the Federal IDR process, and the determination of the amount a provider, facility, or provider of air ambulance services submits as an offer. Therefore, the Departments have determined the benefits of these final rules justify the costs.

This regulatory action finalizes certain provisions in the July 2021 interim final rules and the October 2021 interim final rules, including changes to remove the language vacated by the District Court in *Texas Medical Association* and *LifeNet*. This cost-benefit analysis focuses on the incremental costs of complying with the requirements that are included in these final rules. One baseline assumption for this analysis is the existence of the requirements of the July 2021 and October 2021 interim final rules, with a second baseline assumption being the use of a comparison with a hypothetical state of the world absent those interim final rules. As discussed in the analysis of the July 2021 interim final rules, the total annualized cost associated with the July 2021 interim final rules is \$2,252 million, using the 7 percent discount rate.⁵² As discussed in the analysis of the October 2021 interim final rules, the total annualized cost associated with the October 2021 interim final rules is \$517 million, using the 7 percent discount rate.⁵³ The Departments consider these cost estimates to be reflected in the analytic baseline of these final rules and to form a subset of total costs of these

final rules for the purposes of this cost-benefit analysis relative to the hypothetical state of the world absent the July 2021 and October 2021 interim final rules.⁵⁴ As noted in Table 1 (Accounting Statement) the Departments estimate the additional total annualized cost associated with the parts these final rules to be \$5.9 million, using the 7 percent discount rate.

To avoid repeating the analysis of the July 2021 and October 2021 interim final rules, only a short summary of the benefits and costs is provided, and readers are directed to the analysis in the July 2021 and October 2021 interim final rules for more detail. Numbers in this analysis may not match numbers in the analysis for the July 2021 and October 2021 interim final rules because the estimates have been updated with the most current data. However, the methodology remains the same, except for the calculation of the burden to prepare the certified IDR entity's written decision for payment determinations, as explained later in this section. The Departments also discuss the impacts of changes made by these final rules in this section.

In accordance with OMB Circular A-4, Table 1 depicts an accounting statement summarizing the Departments' assessment of the benefits, costs, and transfers associated with this regulatory action. The Departments are unable to quantify all benefits, costs, and transfers associated with this regulatory action, but have sought, where possible, to describe these non-quantified impacts. The effects in Table 1 reflect non-quantified impacts and estimated direct monetary costs resulting from the provisions of these final rules.

TABLE 1—ACCOUNTING STATEMENT

Benefits:

- These final rules will increase transparency in the Federal IDR process.
- These final rules will help a provider, facility, or provider of air ambulance services ascertain what information will demonstrate that the provider's, facility's, or provider of air ambulance services' offer best represents the value of the item or service and aid the certified IDR entity in selecting an offer that best represents the value of the item or service.
- These final rules will promote more consistent payment determinations in the Federal IDR process for providers, facilities, providers of air ambulance services, plans, and issuers.
- These final rules will promote transparency with respect to the certified IDR entity's payment determination and will help to ensure that the determination of a total payment amount for a particular item or service is based on the facts and circumstances of the dispute at issue in each case.

⁵² As discussed in the analysis of the July 2021 interim final rules, the total annualized cost associated with the July 2021 interim final rules is \$2,177 million, using the 3 percent discount rate. The Departments note that these cost estimates have not been updated.

⁵³ As discussed in the analysis of the October 2021 interim final rules, the total annualized cost associated with the October 2021 interim final rules is \$491 million, using the 3 percent discount rate. The Departments note that these cost estimates have not been updated.

⁵⁴ The Departments are accounting for the additional costs associated with these final rules due to parts of the July 2021 interim final rules and October 2021 interim final rules being finalized. For those parts being finalized, the *Texas Medical Association* and *LifeNet* decisions do not impact the quantified costs.

TABLE 1—ACCOUNTING STATEMENT—Continued

Costs	Estimate	Year dollar	Discount rate (%)	Period covered
Annualized Monetized (\$million/Year)	\$5.9	2021	7	2022–2031
	5.9	2021	3	2022–2031

Quantified Costs: The Departments estimate the total annual cost associated with these final rules to be \$5.9 million, with \$4.3 million annually attributable to the additional information plans and issuers will be required to provide related to the QPAs, \$1.2 million annually attributable to the preparation of IDR payment determination notices by certified IDR entities for nonparticipating providers or emergency facility claims, and \$0.3 million annually attributable to the preparation of IDR payment determination notices by certified IDR entities for nonparticipating air ambulance providers' claims.

Transfers: These final rules make no changes that impact the transfers as described in the July 2021 and October 2021 interim final rules.

D. Affected Entities

These final rules will affect health care providers, health care facilities, providers of air ambulance services, group health plans, issuers, TPAs, FEHB carriers, and certified IDR entities.

Based on data from 2020, CMS estimated that there were 1,477 issuers in the U.S. health insurance market, of which 1,212 served the individual market, 6 served the student health insurance market, 623 served the small group market, and 784 served the large group market.⁵⁵ Further, of the plans that filed a Form 5500 in 2019, 30,181 plans were self-insured.⁵⁶ Additionally, in the October 2021 interim final rules, the Departments previously estimated that there are 205 TPAs.⁵⁷ The Departments also estimate that there are 44 FEHB carriers. While there is a significant amount of research that demonstrates the prevalence of surprise billing, the Departments do not have data on the percentage of surprise bills covered by health insurance issuers and self-insured plans. However, given the size of health insurance issuers and the scope of their activities, the Departments assume that all health insurance issuers, TPAs, and FEHB carriers will be affected by these final rules.

In 2019, 183 million individuals had employer-sponsored coverage and 33.2 million had other private insurance, including individual market insurance.⁵⁸ The Departments do not

expect that these final rules will directly affect individuals with private health coverage who visit an emergency room, visit a health care facility,⁵⁹ or are transported by an air ambulance, as these final rules contain only provisions that affect the relationships among plans and issuers; providers, facilities, and providers of air ambulance services; and certified IDR entities. However, the Departments estimate that these final rules will indirectly affect covered individuals, as the outcomes of payment disputes will have implications for premiums.

In the October 2021 interim final rules, the Departments estimated that there are 16,992 emergency and other health care facilities, including 6,090 hospitals,⁶⁰ 29,227 diagnostic and medical laboratories,⁶¹ 270 independent freestanding emergency departments,⁶² 9,280 ambulatory surgical centers,⁶³ and 1,352 critical access hospitals.⁶⁴ These entities will also be affected by these final rules.

In the October 2021 interim final rules, the Departments also estimated that in 2018, the current year for which data are available, there were 1,114 air ambulance bases in the United States.⁶⁵

⁵⁹ Health care facility is defined in the July 2021 interim final rules. See 26 CFR 54.9816–3T; 29 CFR 2590.716–3; and 45 CFR 149.30.

⁶⁰ American Hospital Association. “Fast Facts on U.S. Hospitals, 2021.” (January 2021). <https://www.aha.org/statistics/fast-facts-us-hospitals>.

⁶¹ IBIS World. Definitive Healthcare. “Diagnostic & Medical Laboratories Industry in the US—Market Research Report?” (May 2021). <https://www.ibisworld.com/industry-statistics/number-of-businesses/diagnostic-medical-laboratories-united-states/>.

⁶² Emergency Medicine Network. “2018 National Emergency Department Inventory.” (2021). <https://www.emnet-usa.org/research/studies/medi/medi2018/>.

⁶³ Definitive Healthcare. “How Many Ambulatory Surgery Centers are in the US?” (April 2019). <https://www.definitivehc.com/blog/how-many-ascs-are-in-the-us>.

⁶⁴ Flex Monitoring Team. “Historical CAH Data.” <https://www.flexmonitoring.org/historical-cah-data->

⁶⁵ Assistant Secretary for Planning and Evaluation (ASPE) Office of Health Policy. “Air Ambulance Use and Surprise Billing” (September 2021). <https://aspe.hhs.gov/sites/default/files/2021-09/aspe-air-ambulance-ib-09-10-2021.pdf>.

The Departments do not have data on the number of providers of air ambulance services that submit out-of-network claims; however, given the prevalence of out-of-network billing among providers of air ambulance services, the Departments assume that all businesses in the industry will be affected by these final rules.

Furthermore, in the October 2021 interim final rules, the Departments estimated that 140,270 physicians, on average, bill on an out-of-network basis and will be affected by these final rules.⁶⁶ These final rules are also expected to affect non-physician providers who bill on an out-of-network basis. The Departments lack data on the number of non-physician providers who would be impacted.

Finally, there are currently 11 certified IDR entities that will be affected by these final rules.⁶⁷ The number of certified IDR entities may increase or decrease due to new IDR entities applying for certification or the Departments revoking certification because of noncompliance with the certification requirements or a certified IDR entity's inability to handle its caseload.

E. Benefits

These final rules will require plans and issuers to provide additional information about the QPA with an initial payment or notice of denial of payment in cases involving downcoding, without the provider, facility, or provider of air ambulance services having to ask for this information. These final rules will be helpful to the provider, facility, or provider of air ambulance services in developing an offer or submitting information if it believes that the QPA

⁶⁶ Please see the October 2021 interim final rules for more information on how these estimates were obtained.

⁶⁷ As of July 31, 2022, there are 11 certified IDR entities. Center for Medicare and Medicaid Services. “List of Certified Independent Dispute Resolution Entities.” <https://www.cms.gov/nosurprises/Help-resolve-payment-disputes/certified-IDRE-list>.

⁵⁵ Centers for Medicare and Medicaid Services. “Medical Loss Ratio Data and System Resources” (2020). <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr>.

⁵⁶ Employee Benefits Security Administration. “Group Health Plans Report.” (July 2021). <https://www.dol.gov/sites/dolgov/files/EBSA/researchers/statistics/retirement-bulletins/annual-report-on-self-insured-group-health-plans-2022-appendix-a.pdf>.

⁵⁷ Non-issuer TPAs based on data derived from the 2016 Benefit Year reinsurance program contributions.

⁵⁸ Employee Benefits Security Administration. “Health Insurance Coverage Bulletin.” (March 2020). <https://www.dol.gov/sites/dolgov/files/EBSA/researchers/data/health-and-welfare/health-insurance-coverage-bulletin-2020.pdf>.

calculated by the plan or issuer does not best represent the value of the item or service. Furthermore, the requirement to disclose this additional information will increase transparency in the Federal IDR process. This increased transparency will aid in the open negotiation process, the decision whether to initiate the Federal IDR process, and the determination of the amount a provider, facility, or provider of air ambulance services submits as an offer. Further, these final rules will help a provider, facility, or provider of air ambulance services ascertain what information will demonstrate that the provider's, facility's, or provider of air ambulance services' offer best represents the value of the item or service and aid the certified IDR entity in selecting an offer that best represents the value of the item or service.

In addition, these final rules require that certified IDR entities must consider the QPA and then must consider all additional permissible information submitted by a party to determine which offer best reflects the appropriate out-of-network rate, provided the information relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination and does not include information that the certified IDR entity is prohibited from weighing in making the payment determination under section 9816(c)(5)(D) of the Code, section 716(c)(5)(D) of ERISA, and section 2799A–1(c)(5)(D) of the PHS Act. In considering this additional information, the certified IDR entity should evaluate whether information that is offered is credible and should not give weight to information that is not credible. The appropriate out-of-network rate must be the offer that the certified IDR entity determines best represents the value of the qualified IDR item or service.

Because the certified IDR entity must consider the QPA, the certified IDR entity should always consider whether the additional credible information is already accounted for by the QPA and should not give weight to information related to a factor if the certified IDR entity determines the information was already accounted for in the calculation of the QPA, to avoid weighting the same information twice. In addition, if the parties submit credible information related to more than one of the additional factors, the certified IDR entity should also consider whether the information submitted regarding each of those factors is already accounted for by information submitted relating to other credible information already before the certified IDR entity in relation to

another factor and, if so, should not weigh such information more than once. These final rules will help ensure that the payment determination in the Federal IDR process is a consistent process for providers, facilities, providers of air ambulance services, plans, and issuers.

The certified IDR entity's written decision must include an explanation of what information the certified IDR entity determined demonstrated that the offer selected as the out-of-network rate is the offer that best represents the value of the qualified IDR item or service, including the weight given to the QPA and any additional credible information submitted in accordance with these final rules. If the certified IDR entity relies on any additional information in selecting an offer, the written decision must include an explanation of why the certified IDR entity concluded that this information was not already reflected in the qualifying payment amount. These final rules will help ensure that certified IDR entities carefully evaluate all credible non-duplicative information. These final rules will also promote transparency with respect to the certified IDR entity's payment determination.

F. Costs

This regulatory action seeks to minimize costs to providers, facilities, providers of air ambulance services, plans, issuers, TPAs, and certified IDR entities.

i. Federal IDR Process for Nonparticipating Providers or Nonparticipating Emergency Facilities

As explained in the analysis provided in the October 2021 interim final rules, the Departments estimate that there will be approximately 17,435 claims submitted to the Federal IDR process each year.⁶⁸

After the selected certified IDR entity has reviewed the offers, the certified IDR entity must notify the provider or facility and the plan, issuer, or FEHB carrier and the Departments of the payment determination and the reason for such determination, in a form and manner specified by the Departments.⁶⁹ The Departments estimate that the annual cost to prepare the notice of the certified IDR entity's determination is \$1.2 million. For more information on this calculation, please refer to the

⁶⁸ For more details, please refer to the Paperwork Reduction Act analysis, found in section V of this preamble.

⁶⁹ IDR Payment Determination Notification (section 716(c)(5)(A) of ERISA).

Paperwork Reduction Act analysis, found in section V of this preamble.

In addition to the information already required to be provided with an initial payment or notice of denial of payment under the July 2021 interim final rules, including the QPA, these final rules require that a plan or issuer must provide, if applicable, an acknowledgement if all or any portion of the claim was downcoded; an explanation of why the claim was downcoded, including a description of which service codes were altered, if any, and a description of any modifiers that were altered, added, or removed, if any; and the amount that would have been the QPA had the service code or modifier not been downcoded. In the July 2021 interim final rules, the Departments estimated that plans and issuers will be required to provide documents related to the QPA along with the initial payment or notice of denial of payment for approximately 5,068,512 claims annually from nonparticipating providers or facilities.⁷⁰ The Departments assume that approximately 10 percent of those claims will involve downcoding and estimate that the annual cost to prepare the required documentation and attach it to each initial payment or notice of denial of payment sent to the nonparticipating provider or facility is \$4.3 million. For more information on this calculation, please refer to the Paperwork Reduction Act analysis, found in section V of this preamble.

In total, the Departments estimate that certified IDR entities, TPAs, and issuers will incur costs of approximately \$5.5 million annually to provide, as applicable, payment determination notifications and the additional QPA information required under these rules.

ii. Federal IDR Process for Nonparticipating Providers of Air Ambulance Services

As explained in the October 2021 interim final rules, the Departments assume that 10 percent of out-of-network claims for air ambulance services will be submitted to the Federal IDR process,⁷¹ which would result in nearly 5,000 annual air ambulance payment determinations via the Federal IDR process.⁷²

⁷⁰ See 86 FR 36872 for more information on this estimate.

⁷¹ The Departments utilize 10 percent as an assumption to estimate the overall number of providers of air ambulance services billing out-of-network at least once in a year.

⁷² The Departments estimate that of the 216.2 million individuals with employer-sponsored and other private health coverage (183 million

Continued

After the certified IDR entity has reviewed and selected the offer, the certified IDR entity must notify the provider of air ambulance services and the plan, issuer, or FEHB carrier and the Departments of the payment determination and include the written decision explaining such determination.⁷³ The Departments estimate that the annual cost to prepare this notice of the certified IDR entity's determination for air ambulance claims is \$0.3 million. For more details, please refer to the Paperwork Reduction Act analysis, found in section V of this document.

Similar to these final rules' provisions related to the disclosure of downcoded claims for nonparticipating providers and nonparticipating emergency facilities, these final rules require that a plan or issuer must provide, if applicable, an acknowledgement if all or any portion of the claim pertaining to air ambulance services was downcoded; an explanation of why the claim was downcoded, including a description of which service codes were altered, if any, and a description of any modifiers that were altered, added, or removed, if any; and the amount that would have been the QPA had the service code or modifier not been downcoded. The Departments estimate that plans and issuers will be required to provide these documents for approximately 49,676 claims annually from providers of air ambulance services.⁷⁴ The Departments assume that approximately 10 percent of those claims will involve downcoding and estimate that the annual cost to prepare the required documentation and attach it to each initial payment or notice of denial of payment sent to the providers of air ambulance service is approximately \$42,000. For more details, please refer to the Paperwork Reduction Act analysis, found in section V of this preamble.

In total, the Departments estimate that certified IDR entities, TPAs, and issuers will incur costs of approximately \$0.4

million annually to provide payment determination notifications and the additional QPA information required under these final rules.

iii. Summary

The Departments estimate the total annual cost associated with these final rules to be \$5.9 million with \$4.3 million annually attributable to the additional information related to the QPAs, \$1.2 million annually attributable to the certified IDR entity's payment determination for nonparticipating provider and emergency facility claims, and \$0.3 million annually attributable to the certified IDR entity's payment determination notification for nonparticipating provider of air ambulance service claims.

G. Transfers

These final rules make no changes that impact the transfers as described in the July 2021 and October 2021 interim final rules.

H. Uncertainty

These final rules make no changes that impact the uncertainties as described in the July 2021 and October 2021 interim final rules.

I. Regulatory Alternatives

Section 6(a)(3)(C)(iii) of Executive Order 12866 requires an economically significant regulation, and encourages other regulations, to include an assessment of the costs and benefits of potentially effective and reasonable alternatives to the planned regulation. A discussion of the regulatory alternatives is included in this section.

As described in Section I.E. of this preamble, the District Court in *Texas Medical Association and LifeNet* vacated provisions in the October 2021 interim final rules addressing how certified IDR entities were to weigh the QPA and the additional factors. The Departments considered the possibility of not replacing the provisions vacated by the District Court. However, in the Departments' view, this would have resulted in uncertainty regarding the Federal IDR process, because certain aspects of the process would be governed by the October 2021 interim final rules as published in the **Federal Register**, while others would not. This approach could result in confusion on the part of the public and certified IDR entities, likely making the decisions of certified IDR entities less predictable, adding to the uncertainty and the costs of the Federal IDR process. Therefore, the Departments are of the view that it is more appropriate to make changes to the Federal IDR process for both non-air

ambulance and air ambulance items and services in these final rules.

The Departments considered finalizing the additional factors other than the QPA that a certified IDR entity may consider when submitted by one of the disputing parties without addressing the possibility that these factors may already have been accounted for in the QPA. Numerous comments received on the October 2021 interim final rules highlighted that in many cases, certain factors, such as patient acuity or the complexity of furnishing the qualified IDR item or service to the participant, beneficiary, or enrollee, will already be accounted for in the calculation of the QPA. Commenters acknowledged, however, that there could be instances in which the QPA would not adequately account for the acuity of the patient or complexity of the service: for example, if the complexity of a case is an outlier such that the time or intensity of care exceeds what is typical for the service code. The Departments are of the view that, in many cases, factors that a certified IDR entity may consider other than the QPA will already be reflected in the QPA. The QPA is generally calculated to include characteristics that can affect costs, including medical specialty, geographic region, and patient acuity and case severity, all captured in different billing codes or aspects of the methodology that plans and issuers are required to follow in calculating the QPA. Therefore, weighting additional information that is already taken into account in the calculation of the QPA would be redundant and in the Departments' view, would result in increased administrative burden to the certified IDR entity, potentially resulting in the selection of an offer that does not best reflect the most appropriate value insofar as additional weight would be given to information related to a factor that is already accounted for in the QPA, effectively weighting that information twice. Under these final rules, certified IDR entities must consider the QPA and then must consider all additional information submitted by the parties. To help ensure that the Federal IDR process results in determinations that accurately reflect the fair value of a given item or service, the certified IDR entity should consider all additional information submitted by the parties but should not give weight to information if it is already accounted for by any of the other information submitted by the parties.

J. Conclusion and Summary of Economic Impacts

The Departments are of the view that these final rules will promote

individuals with employer-sponsored health coverage and 33.2 million individuals with other private coverage), there are 33.3 air transports per 100,000 individuals, of which 69 percent result in out-of-network bills. The Departments assume that 10 percent of the out-of-network bills will end up in the Federal IDR process. This is calculated as: $216,200,000 \text{ individuals} \times 0.000333 \text{ air transports per individual} \times 69\% \times 10\% = 4,968$.

⁷³ IDR Payment Determination Notification (section 716(c)(5)(A) of ERISA).

⁷⁴ The Departments estimate that of the 216.2 million individuals with employer-sponsored and other private health coverage, there are 33.3 air transports per 100,000 individuals, of which 69 percent result in an out-of-network bill. The number of air ambulance claims is estimated as: $216,200,000 \text{ individuals} \times 0.000333 \text{ air transports per individual} \times 69\% = 49,676$.

transparency, consistency, and predictability in the Federal IDR process. These final rules provide a market-based approach that will help encourage plans and issuers, and providers, facilities, and providers of air ambulance services to arrive at reasonable payment rates.

The Departments estimate that these final rules will impose incremental annual costs of approximately \$5.9 million. Over 10 years, the associated costs will be approximately \$44.1 million with an annualized cost of \$5.9 million, using a 7 percent discount rate.⁷⁵

V. Paperwork Reduction Act

In accordance with the Paperwork Reduction Act of 1995 (PRA 95) (44 U.S.C. 3506(c)(2)(A)), the Departments solicited comments concerning the information collection requirements (ICRs) included in the July 2021 and October 2021 interim final rules. At the same time, the Departments also submitted ICRs to OMB, in accordance with 44 U.S.C. 3507(d).

The Departments received comments that specifically addressed the paperwork burden analysis of the information collection requirements contained in the July 2021 and October 2021 interim final rules. The Departments reviewed these public comments in developing the paperwork burden analysis discussed here.

The changes made by these final rules affect the existing OMB control number, 1210-0169. A copy of the ICR for OMB Control Number 1210-0169 may be obtained by contacting the PRA addressee listed in the following sentence or at www.RegInfo.gov. For additional information, contact James Butikofer, Office of Research and Analysis, U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue NW, Room N-5718, Washington, DC 20210; or sent to ebbsa.opr@dol.gov.

The OMB will consider all written comments that they receive on or before September 26, 2022. Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to www.reginfo.gov/public/do/PRAMain. Find this particular information collection by selecting “Currently under 30-day Review—Open for Public Comments” or by using the search function.

⁷⁵ The costs would be \$51.5 million over 10-year period with an annualized cost of \$5.9 million, applying a 3 percent discount rate.

Comments are invited on: (1) whether the collection of information is necessary for the proper performance of the functions of the Departments, including whether the information will have practical utility; (2) if the information will be processed and used in a timely manner; (3) the accuracy of the Departments' estimates of the burden and cost of the collection of information, including the validity of the methodology and assumptions used; (4) ways to enhance the quality, utility, and clarity of the information collection; and (5) ways to minimize the burden of the collection of information on those who are to respond, including the use of automated collection techniques or other forms of information technology.

Group health plans, health insurance issuers, FEHB carriers, and certified IDR entities are responsible for ensuring compliance with these final rules. Accordingly, the Departments refer to costs incurred by plans, issuers, FEHB carriers, and certified IDR entities. However, it is expected that most self-insured group health plans will work with a TPA to meet the requirements of these final rules. The Departments recognize the potential that some of the largest self-insured plans may seek to meet the requirements of these final rules in-house and not use a TPA or other third party. In these cases, those plans will incur the estimated hour burden and cost directly.

These final rules add additional burdens to the ICR presented in the October 2021 interim final rules. The following discussion covers the changes being made to the ICR and the additional burden these changes impose, followed by a summary of the ICR. Copies of the ICR may be obtained by contacting the PRA addressee.

A. ICRs Regarding Additional Information To Be Shared With the Initial Payment or Notice of Denial of Payment (26 CFR 54.9816-6(d), 29 CFR 2590.716-6(d), and 45 CFR 149.140(d); OMB Control Number: 1210-0169)

These final rules specify that where a QPA is calculated based on a downcoded service code, in addition to the information already required to be provided with an initial payment or notice of denial of payment under the July 2021 interim final rules, a plan or issuer must provide, if applicable, a statement that all or a portion of the claim was downcoded; an explanation of why the claim was downcoded, including a description of which service codes were altered, if any, and a description of any modifiers that were altered or added, if any; and the amount that would have been the QPA had the

service codes or modifiers not been downcoded.

The Departments assume that TPAs will provide this information on behalf of self-insured plans. In addition, the Departments assume that issuers and TPAs will automate the process of preparing and providing this information in a format similar to an explanation of benefits as part of the system to calculate the QPA. The Departments estimate that a total of 1,477 issuers and 205 TPAs will incur a burden to comply with this provision.

In the July 2021 interim final rules, the Departments estimated that plans and issuers will be required to provide documents related to QPAs along with the initial payment or notice of denial of payment for approximately 5,068,512 claims annually from nonparticipating providers or facilities.⁷⁶ Additionally, the Departments estimated that plans and issuers will be required to provide these documents for approximately 49,676 claims annually from nonparticipating providers of air ambulance services.⁷⁷ In the absence of data, the Departments assume that approximately 10 percent, or 511,819, of claims from nonparticipating providers, facilities, and nonparticipating providers of air ambulance services will involve downcoding and that it will take a medical secretary 10 minutes (at an hourly rate of \$50.76⁷⁸) to prepare the required documentation and include it with each initial payment or notice of denial of payment sent to the nonparticipating provider, facility, or provider of air ambulance services.

The Departments estimate the additional QPA information will be provided for approximately 506,851 claims from nonparticipating providers or facilities. The annual burden to prepare the required documentation and attach it to each initial payment or notice of denial of payment sent to the nonparticipating providers or facilities will be approximately 84,475 hours annually, with an associated equivalent

⁷⁶ See 86 FR 36872 for more information on this estimate.

⁷⁷ The Departments estimate that of the 216.2 million individuals with employer-sponsored and other private health coverage, there are 33.3 air transports per 100,000 individuals, of which 69 percent result in an out-of-network bill. The number of air ambulance claims is estimated as: 216,200,000 individuals × 0.000333 air transports per individual × 0.69% = 49,676 claims.

⁷⁸ Internal DOL calculation based on 2021 labor cost data. For a description of DOL's methodology for calculating wage rates, see <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/rules-and-regulations/technical-appendices/labor-cost-inputs-used-in-ebbsa-opr-ria-and-pra-burden-calculations-june-2019.pdf>

cost of \$4.3 million.⁷⁹ The Departments estimate that the additional QPA information will be provided for approximately 4,968 claims from providers of air ambulance services. The annual burden to prepare the required documentation and attach it to each initial payment or notice of denial of payment sent to providers of air ambulance services will be approximately 828 hours annually, with an associated equivalent cost of

\$42,029.⁸⁰ Thus, the total estimated burden to provide the additional QPA information with initial payments or notices of denial of payment sent to the nonparticipating providers, facilities, and providers of air ambulance services, for all issuers and TPAs, will be approximately 85,303 hours annually, with an associated equivalent cost of approximately \$4.3 million.⁸¹ As shown in Table 2, the Departments share jurisdiction, and it is estimated that 50

percent of the burden will be accounted for by HHS, 25 percent of the burden will be accounted for by DOL, and 25 percent will be accounted for by Department of the Treasury. Thus, HHS will account for approximately 42,652 hours with an equivalent cost of approximately \$2,164,990. DOL and the Department of the Treasury will each account for approximately 21,326 hours with an equivalent cost of approximately \$1,082,495.

TABLE 2—SUMMARY ANNUAL COST AND BURDEN REGARDING INFORMATION TO BE SHARED ABOUT QPA STARTING IN 2022

Department	Estimated number of responses	Total annual burden (hours)	Estimated dollar value of labor hours
HHS	255,910	42,652	\$2,164,990
DOL	127,955	21,326	1,082,495
Treasury	127,955	21,326	1,082,495

B. ICRs Regarding the Certified IDR Entity's Payment Determination Written Decision in the Federal IDR Process for Nonparticipating Providers or Nonparticipating Emergency Facilities (26 CFR 54.9816–8T, 26 CFR 54.9816–8, 29 CFR 2590.716–8, and 45 CFR 149.510; OMB Control Number: 1210–0169)

The Departments estimate that 17,435 claims will be submitted as part of the Federal IDR process each year.⁸² After the certified IDR entity has reviewed the offers and credible information submitted by the parties and selected an offer, the certified IDR entity must notify the provider, facility, or provider of air ambulance services and the plan, issuer, or FEHB carrier and the Departments of the payment determination and the reason for such determination, in a form and manner specified by the Departments.⁸³ The certified IDR entity's written decision must include an explanation of the additional non-prohibited information that the certified IDR entity determined

demonstrated that the offer selected is the out-of-network rate that best represents the value of the qualified IDR item or service, including the weight given to the QPA and any additional credible information submitted in accordance with these final rules. If the certified IDR entity relies on any additional information in selecting an offer, the written decision must include an explanation of why the certified IDR entity concluded that this information was not already reflected in the qualifying payment amount.

The Departments estimate that, on average, it will take a physician and medical billing specialist 0.5 hours to prepare the notice at a composite hourly wage rate of \$136.81.⁸⁴ The burden for each certified IDR entity will be 0.5 hours, with an equivalent cost of approximately \$69.24. Thus, the total cost burden for all certified IDR entities to prepare this notice for Federal IDR claims will be \$1.2 million.⁸⁵

The total annual cost burden for certified IDR entities to provide the

payment determination notices regarding Federal IDR claims will be \$1,192,641. As shown in Table 3, the Departments and OPM share jurisdiction, and it is estimated that 45 percent of the burden will be accounted for by HHS, 25 percent will be accounted for by DOL, 25 percent of the burden will be accounted for by the Department of the Treasury, and 5 percent will be accounted for by OPM. Thus, HHS will account for a cost burden of \$536,689. DOL and the Department of the Treasury will each account for a cost burden of \$298,160. OPM will account for a cost burden of \$59,632.

⁷⁹ This is calculated as: (5,068,512 documents for nonparticipating providers or facilities) × (10%) × (10 minutes) = 84,475 hours. 84,475 hours × \$50.76 = \$4,287,951.

⁸⁰ This is calculated as: (49,676 documents for nonparticipating providers of air ambulance services) × (10%) × (10 minutes) = 828 hours. 828 hours × \$50.76 = \$42,029.

⁸¹ This is calculated as: (5,068,512 documents for nonparticipating providers or facilities + 49,676 documents for nonparticipating providers of air ambulance services) × (10%) × (10 minutes) = 85,303 hours. 85,303 hours × \$50.76 = \$4,329,980.

⁸² In 2020, 10.7 million individuals had employer-sponsored coverage and 1.7 million individuals had other private coverage in New York State, while 183 million individuals had employer-sponsored coverage and 33.2 million individuals had other private coverage nationally. The

Departments estimate that New York accounts for 5.7 percent of the private insurance market ((10.7 + 1.7)/(183 + 33.2) = 5.7 percent). (See Employee Benefits Security Administration. "Health Insurance Coverage Bulletin." (March 2020).) In 2018, New York State had 1,014 IDR decisions, up from 650 in 2017 and 396 in 2016. (See Adler, Loren. "Experience with New York's Arbitration Process for Surprise Out-of-Network Bills." U.S.C.-Brookings Schaeffer on Health Policy. (October 2019).) For purposes of this analysis, the Departments assume that, going forward, New York State will continue to see 1,000 IDR cases each year and that the number of Federal IDR cases will be proportional to that in New York State by share of covered individuals in the private health coverage market. The number of claims in the Federal IDR process is calculated in the following manner: 1,000/0.057 = 17,435.

⁸³ IDR Payment Determination Notification (section 716(c)(5)(A) of ERISA).

⁸⁴ The Departments use a composite wage rate because different professionals will review different types of claims and groups of individuals. The wage rate of a physician is \$192.37, and the wage rate of a medical billing specialist is \$109.03. (Internal DOL calculation based on 2021 labor cost data. For a description of DOL's methodology for calculating wage rates, see <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/rules-and-regulations/technical-appendices/labor-cost-inputs-used-in-ebsa-opr-ria-and-pra-burden-calculations-june-2019.pdf>.) The composite wage rate is estimated in the following manner: (\$192.37 × (1/3) + \$109.03 × (2/3)) = \$136.81.

⁸⁵ 17,453 claims × 0.5 hours × \$136.81 as the composite wage rate for a physician and medical billing specialist = \$1,192,641.

TABLE 3—SUMMARY ANNUAL COST AND BURDEN STARTING IN 2022 REGARDING CERTIFIED IDR ENTITY'S PAYMENT DETERMINATION WRITTEN DECISION IN THE FEDERAL IDR PROCESS FOR NONPARTICIPATING PROVIDERS OR NONPARTICIPATING EMERGENCY FACILITIES CLAIMS

Department	
HHS	\$536,689
DOL	298,160
Treasury	298,160
OPM	59,632

C. ICRs Regarding the Certified IDR Entity's Payment Determination Written Decision in the Federal IDR Process for Nonparticipating Providers of Air Ambulance Services (26 CFR 54.9817–2T, 26 CFR 54.9817–2, 29 CFR 2590.717–2, and 45 CFR 149.520; OMB Control Number: 1210–0169)

The Departments estimate there will be 4,968 claims for air ambulance services submitted to the Federal IDR process each year.⁸⁶ After the certified IDR entity has reviewed the offers and any submitted credible information, and selected an offer, the certified IDR entity must notify the provider of air ambulance services and the plan, issuer, or FEHB carrier and the Departments of the payment determination and include the written decision explaining such determination.⁸⁷ The certified IDR entity's written decision must include an explanation of what information that the certified IDR entity determined demonstrated that the offer selected is the out-of-network rate that best represents the value of the qualified IDR service. This explanation must include the weight given to the QPA and any additional non-prohibited, credible information submitted in accordance with these final rules. If the certified IDR entity relies on any additional information in selecting an offer, the written decision must include an explanation of why the certified IDR entity concluded that this information was not already reflected in the qualifying payment amount.

⁸⁶ The Departments estimate that of the 183 million individuals with employment-related health insurance and 33.2 million individuals with other private coverage, there are 33.3 air transports per 100,000 individuals, of which 69 percent result in an out-of-network bill. The Departments assume that 10 percent of the out-of-network bills will end up in the Federal IDR process. The number of air ambulance service claims is calculated in the following manner: (183,000,000 individuals + 33,200,000 individuals) × 0.000333 air transports per individual × 69% × 10% = 4,968 claims.

⁸⁷ IDR Payment Determination Notification (section 716(c)(5)(A) of ERISA).

The Departments estimate that, on average, it will take a physician and medical billing specialist working for the certified IDR entity 0.5 hour to prepare the notice of the certified IDR entity's determination at a composite hourly wage rate of \$136.81.⁸⁸ The burden for each certified IDR entity will be 0.5 hours, with an equivalent cost of approximately \$69.24. Thus, the total cost burden for certified IDR entities to provide this notice for air ambulance claims will be \$0.3 million.⁸⁹

The total annual cost burden for the certified IDR entities to provide the payment determination notices regarding air ambulance claims will be \$339,836. As shown in Table 4, the Departments and OPM share jurisdiction, and it is estimated that 45 percent of the burden will be accounted for by HHS, 25 percent will be accounted for by DOL, 25 percent of the burden will be accounted for by the Department of the Treasury, and 5 percent will be accounted for by OPM. Thus, HHS will account for a cost burden of \$152,926. DOL and the Department of the Treasury will each account for a cost burden of \$84,959. OPM will account for a cost burden of \$16,992.

TABLE 4—SUMMARY ANNUAL COST AND BURDEN STARTING IN 2022 REGARDING CERTIFIED IDR ENTITY'S PAYMENT DETERMINATION WRITTEN DECISION IN THE FEDERAL IDR PROCESS FOR AIR AMBULANCE CLAIMS

Department	Estimated number of responses	Total estimated cost
HHS	2,235	\$152,926
DOL	1,242	84,959
Treasury	1,242	84,959
OPM	248	16,992

Summary

The total annual cost burden for certified IDR entities to provide payment determination notices regarding non-air ambulance and air

⁸⁸ The Departments use a composite wage rate because different professionals will review different types of claims and groups of individuals. The wage rate of a physician is \$192.37, and the wage rate of a medical billing specialist is \$109.03. (Internal DOL calculation based on 2021 labor cost data. For a description of DOL's methodology for calculating wage rates, see <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/rules-and-regulations/technical-appendices/labor-cost-inputs-used-in-ebsa-opr-ria-and-pra-burden-calculations-june-2019.pdf>.) The composite wage rate is estimated in the following manner: (\$192.37 × (1/3)) + (\$109.03 × (2/3)) = \$136.81).

⁸⁹ 4,968 air ambulance claims × 0.5 hours × \$136.81 as the composite wage rate for a physician and medical billing specialist = \$339,836.

ambulance claims will be \$1,532,477. As shown in Table 5, HHS will account for a cost burden of approximately \$689,615. DOL and the Department of the Treasury will each account for a cost burden of approximately \$383,119. OPM will account for a cost burden of approximately \$76,624.

TABLE 5—SUMMARY ANNUAL COST AND BURDEN STARTING IN 2022 REGARDING CERTIFIED IDR ENTITY'S PAYMENT DETERMINATION WRITTEN DECISION IN THE FEDERAL IDR PROCESS FOR NON-AIR AMBULANCE AND AIR AMBULANCE CLAIMS

Department	Estimated number of responses	Total estimated cost
HHS	10,145	\$689,615
DOL	5,636	383,119
Treasury	5,636	383,119
OPM	1,127	76,624

These paperwork burden estimates are summarized as follows:

Agency: Employee Benefits Security Administration, Department of Labor.

Type of Review: Revision of existing collection.

Title: Requirements Related to Surprise Billing; Payment Determination.

OMB Control Number: 1210–0169.

Affected Public: Private Sector—Businesses or other for-profits; not-for-profit institutions.

Estimated Number of Respondents: 22,828

Estimated Number of Annual Responses: 163,542

Frequency of Response: Occasionally.

Estimated Total Annual Burden Hours: 89,521

Estimated Total Annual Burden Cost: \$555,427

VI. Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA)⁹⁰ imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (APA) and are not likely to have a significant economic impact on a substantial number of small entities. Unless the head of an agency determines that a final rule is not likely to have a significant economic impact on a substantial number of small entities, section 604⁹¹ of the RFA requires the agency to present a final regulatory flexibility analysis of these final rules.

The Departments certify that these final rules would not have a significant

⁹⁰ 5 U.S.C. 601 *et seq.* (1980).

⁹¹ 5 U.S.C. 604 (1980).

impact on a substantial number of small entities during the first year. The Departments have prepared a justification for this determination below.

A. Affected Small Entities

The Small Business Administration (SBA), pursuant to the Small Business Act,⁹² defines small businesses and issues size standards by industry. These final rules will affect all health insurance issuers, TPAs, and certified IDR entities.

For purposes of analysis under the RFA, the Departments consider an employee benefit plan with fewer than 100 participants to be a small entity.⁹³ The basis of this definition is found in section 104(a)(2) of ERISA, which permits the Secretary of Labor to prescribe simplified annual reports for plans that cover fewer than 100 participants. Under section 104(a)(3) of ERISA, the Secretary may also provide for exemptions or simplified annual reporting and disclosure for welfare benefit plans. Pursuant to the authority of section 104(a)(3), DOL has previously issued simplified reporting provisions and limited exemptions from reporting and disclosure requirements for small plans, including unfunded or insured welfare plans, which cover fewer than 100 participants and satisfy certain requirements. See 29 CFR 2520.104–20, 2520.104–21, 2520.104–41, 2520.104–46, and 2520.104b–10. While some large employers have small plans, small plans are maintained generally by small employers. Thus, the Departments are of the view that assessing the impact of these final rules on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business based on size standards promulgated by the SBA⁹⁴ pursuant to the Small Business Act.⁹⁵

As discussed in the regulatory impact analysis, these final rules will affect health insurance issuers and TPAs. In 2020, there were 205 TPAs⁹⁶ and 1,477 issuers in the U.S. health insurance market.⁹⁷ Most TPAs would be

classified under the North American Industry Classification System (NAICS) code 524292 (Third Party Administration of Insurance and Pension Funds). According to SBA size standards,⁹⁸ entities with average annual receipts of \$40 million or less are considered small entities. By this standard, the Departments estimate that 63.5 percent of TPAs (130 TPAs) are small under the SBA's size standards.⁹⁹ Most health insurance issuers would be classified under the NAICS code 524114 (Direct Health and Medical Insurance Carriers). According to SBA size standards,¹⁰⁰ entities with average annual receipts of \$41.5 million or less are considered small entities. By this standard, the Departments estimate that 8.5 percent of issuers (125 issuers), are small under the SBA's size standards.¹⁰¹

This estimate may overstate the actual number of small health insurance issuers that may be affected. The Departments expect that few insurance issuers underwriting comprehensive health insurance coverage fall below these size thresholds. Based on data from medical loss ratio (MLR) annual report¹⁰² submissions for the 2020 MLR reporting year, approximately 78 out of 481 issuers of health insurance coverage nationwide had total premium revenue of \$41.5 million or less. This estimate may overstate the actual number of small health insurance issuers that may be affected, since over 72 percent of these small issuers belong to larger holding groups, and many, if not all, of these small issuers are likely to have non-health lines of business that will result in their revenues exceeding \$41.5 million. However, to produce a conservative estimate, for the purposes of this analysis, the Departments assume

8.5 percent, (125 issuers) are considered small entities.

These final rules will also affect health care providers because the Departments assume that the cost of preparing and delivering the notice of the certified IDR entity's determination is included in the certified IDR entity fees paid by providers, facilities, providers of air ambulance services, plans, issuers, and FEHB carriers. The Departments estimate that 140,270 physicians, on average, bill on an out-of-network basis. The number of small physicians is estimated based on the SBA's size standards. The size standard applied for providers is NAICS 62111 (Offices of Physicians), for which a business with less than \$14 million in receipts is considered to be small. By this standard, the Departments estimate that 45.8 percent (64,232 physicians) are considered small under the SBA's size standards.¹⁰³ These final rules are also expected to affect non-physician providers who bill on an out-of-network basis. The Departments lack data on the number of non-physician providers who would be impacted.

The Departments do not have the same level of data for the air ambulance sub-sector. In 2020, the total revenue of providers of air ambulance services is estimated to be \$4.2 billion with 1,114 air ambulance bases.¹⁰⁴ This results in an industry average of \$3.8 million per air ambulance base. Accordingly, the Departments are of the view that most providers of air ambulance services are likely to be small entities.

B. Impact of the Final Rules

In addition to the information already required to be provided with an initial payment or notice of denial of payment under the July 2021 interim final rules, including the QPA, these final rules require that a plan or issuer must provide, if applicable, an acknowledgement if all or any portion of the claim was downcoded; an explanation of why the claim was

(2020). <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr>.

⁹⁸ Available at <https://www.sba.gov/document/support-table-size-standards>.

⁹⁹ Based on data from the NAICS Association for NAICS code 524292, the Departments estimate the percent of businesses within the industry of Third Party Administration of Insurance and Pension Funds with less than \$40 million in annual sales. (See NAICS Association. "Market Analysis Profile: NAICS Code & Annual Sales." <https://www.naics.com/business-lists/counts-by-naics-code/>)

¹⁰⁰ Available at <https://www.sba.gov/document/support-table-size-standards>.

¹⁰¹ Based on data from the NAICS Association for NAICS code 524114, the Departments estimate the percent of businesses within the industry of Direct Health and Medical Insurer Carriers with less than \$41.5 million in annual sales. (See NAICS Association. "Market Analysis Profile: NAICS Code & Annual Sales." <https://www.naics.com/business-lists/counts-by-naics-code/>)

¹⁰² Available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html>.

¹⁰³ Based on data from the NAICS Association for NAICS code 62111, the Departments estimate the percent of businesses within the industry of Offices of Physicians with less than \$14 million in annual sales. (See NAICS Association. "Market Analysis Profile: NAICS Code & Annual Sales." <https://www.naics.com/business-lists/counts-by-naics-code/>)

¹⁰⁴ ASPE Office of Health Policy. "Air Ambulance Use and Surprise Billing" (September 2021). <https://aspe.hhs.gov/sites/default/files/2021-09/aspe-air-ambulance-ib-09-10-2021.pdf>. U.S. Small Business Administration. "Table of Small Business Size Standards Matched to North American Industry Classification System Codes." <https://www.naics.com/business-lists/counts-by-naics-code/>. https://www.sba.gov/sites/default/files/2022-05/Table%20of%20Size%20StandardsEffective%20May%202022_Final.pdf.

⁹² 15 U.S.C. 631 *et seq.*

⁹³ The Departments consulted with the Small Business Administration Office of Advocacy in making this determination, as required by 5 U.S.C. 603(c) and 13 CFR 121.903(c) in a memo dated June 4, 2020.

⁹⁴ 13 CFR 121.201 (2011).

⁹⁵ 15 U.S.C. 631 *et seq.* (2011).

⁹⁶ Non-issuer TPAs based on data derived from the 2016 Benefit Year reinsurance program contributions.

⁹⁷ Centers for Medicare and Medicaid Services. "Medical Loss Ratio Data and System Resources"

downcoded, including a description of which service codes were altered, if any, and a description of any modifiers that were altered, added, or removed, if any; and the amount that would have been the QPA had the service code or modifier not been downcoded. The total annual burden for all issuers and TPAs for providing the additional information related to the QPA is estimated to be 85,303 hours with an equivalent cost of approximately \$4.3 million. For more details, please refer to the Paperwork Reduction Act analysis, found in section VI of this preamble.

In addition, after the certified IDR entity has reviewed the offers and selected an offer, the certified IDR entity must explain its determination in a written decision submitted to the parties and the Departments, in a form and manner specified by the Departments. The certified IDR entity's written decision must include an explanation of what information the certified IDR entity determined demonstrated that the offer selected is the out-of-network rate that best represents the value of the qualified IDR item or service. This explanation must include the weight given to the QPA and any additional non-prohibited, credible information submitted in accordance with these final rules. If the certified IDR entity relies on any additional information in selecting an offer, the written decision must include an explanation of why the certified IDR entity concluded that this information was not already reflected in the qualifying payment amount. The total estimated annual cost burden for certified IDR entities to provide payment determination notices regarding non-air ambulance Federal IDR claims is estimated to be \$1.2 million and the total estimated annual cost burden for certified IDR entities to provide payment determination notices regarding air ambulance Federal IDR claims is estimated to be \$0.3 million. The Departments assume for this calculation that half of the cost will fall on the providers, providers of air ambulance services, and facilities and the remaining half will fall on plans, issuers, and FEHB carriers. For more details, please refer to the Paperwork Reduction Act analysis, found in section V of this preamble.

To estimate the proportion of the total costs that would fall onto small entities, the Departments assume that the proportion of costs is proportional to the industry receipts. The Departments are of the view that this assumption is reasonable because the number of providers, facilities, and providers of air ambulance services that receive initial and additional information about the

QPA is likely to be proportional to the amount of business in which the entity is involved. Applying data from the Census Bureau of receipts by size for each industry, the Departments estimate that small issuers will incur 0.2 percent of the total costs incurred by all issuers and small providers will incur 37 percent of the total cost by all providers.¹⁰⁵

Accordingly, the Departments estimate that small issuers and TPAs will incur an annual cost of \$4,330 associated with disclosing additional information about the QPA.¹⁰⁶ For each small issuer and TPA, this results in an estimated annual cost of \$16.98.¹⁰⁷

For the payment determination notice regarding disputes involving non-air ambulance claims, the Departments estimate that the total annual cost for all small issuers will be \$1,193 and the total annual cost for small providers will be \$219,446.¹⁰⁸ This results in a per-entity annual cost of \$9.54 for small issuers and a per-entity annual cost of \$3.42 for small providers that are not providers of air ambulance services.¹⁰⁹

For the payment determination notice regarding a dispute involving air ambulance claims, the Departments estimate that the total annual cost for small issuers will be \$344 and the total annual cost for all small providers of air ambulance services will be \$62,530.¹¹⁰ This results in a per-entity annual cost of \$2.72 for small issuers and a per-entity annual cost of \$56.13 for small providers of air ambulance services.¹¹¹

The number of impacted small health plans is not a significant number of plans compared to the total universe of 1.9 million small health plans. Assuming that 17,435 non-air ambulance claims and 4,968 air

ambulance claims are submitted to the Federal IDR process each year, only one percent of small health plans will be impacted.¹¹² The number of impacted plans and issuers may be even smaller, if some plans and issuers have multiple disputes that are batched in the Federal IDR process. By batching qualified IDR items and services, there may be a reduction in the per-service cost of the Federal IDR process, and potentially the aggregate administrative costs, because the Federal IDR process is likely to exhibit at least some economies of scale.¹¹³

VII. Unfunded Mandates Reform Act

Title II of the Unfunded Mandates Reform Act of 1995 (UMRA) requires each Federal agency to prepare a written statement assessing the effects of any Federal mandate in a proposed agency rule, or a finalization of such a proposal, that may result in an expenditure of \$100 million or more (adjusted annually for inflation with the base year 1995) in any one year by State, local, and tribal governments, in the aggregate, or by the private sector.¹¹⁴ In 2022, that threshold is approximately \$165 million. For purposes of the UMRA, these final rules do not include any Federal mandate that the Departments expect to result in such expenditures by State, local, or tribal governments.

VIII. Federalism Statement

Executive Order 13132 outlines fundamental principles of federalism and requires Federal agencies to adhere to specific criteria when formulating and implementing policies that have "substantial direct effects" on the States, the relationship between the National Government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have federalism implications must consult with State and local officials and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to these final rules.

In the Departments' view, these final rules have federalism implications

¹⁰⁵ Census Bureau. "2017 SUSB Annual Data Tables by Establishment Industry, Data by Enterprise Receipt Size." (May 2021). <https://www.census.gov/data/tables/2017/econ/susb/2017-susb-annual.html>.

¹⁰⁶ The annual cost is estimated as: $\$4,329,980 \times 0.5 \times 0.2\% = \$4,330$.

¹⁰⁷ The cost is estimated as: $\$4,330 / (125 \text{ Issuers} + 130 \text{ TPAs}) = \$16.98$.

¹⁰⁸ The annual cost for issuers is estimated as: $\$1,192,641 \times 0.5 \times 0.2\% = \$1,193$. The annual cost for small physicians is estimated as: $\$1,192,641 \times 0.5 \times 36.8\% = \$219,446$.

¹⁰⁹ The annual per-claim cost for issuers is estimated as: $\$1,193 / 125 \text{ Issuers} = \$9.54$. The annual per-claim cost for small physicians is estimated as: $\$219,446 / 64,232 \text{ small physicians} = \$3.42$.

¹¹⁰ The annual cost for issuers is estimated as: $\$339,836 \times 0.5 \times 0.2\% = \$340$. The annual cost for small providers of air ambulance services is estimated as: $\$339,836 \times 0.5 \times 36.8\% = \$62,530$.

¹¹¹ The annual per-claim cost for issuers is estimated as: $\$340 / 125 \text{ Issuers} = \$2.72$. The annual per-claim cost for small providers of air ambulance services is estimated as: $\$62,530 / 1,114 \text{ providers of air ambulance services} = \$56.13$.

¹¹² $(17,435 \text{ claims} + 4,968 \text{ air ambulance claims}) / 1,927,786 \text{ ERISA health plans} = 1\%$ (Source: 2020 Medical Expenditure Panel Survey-Insurance Component).

¹¹³ Matthew Fiedler, Loren Adler, and Benedic Ippolito, "Recommendations for Implementing the No Surprises Act," U.S.C.-Brookings Schaeffer on Health Policy. (March 2021). <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/03/16/recommendations-for-implementing-the-no-surprises-act/>.

¹¹⁴ 2 U.S.C. 1501 *et seq.* (1995).

because they have direct effects on the States, the relationship between the National Government and the States, or the distribution of power and responsibilities among various levels of government. State and local government providers, facilities, and health plans may be subject to the Federal IDR process or an All-Payer Model Agreement or a specified State law. Additionally, the No Surprises Act authorizes States to enforce the new requirements, including those related to balance billing, with respect to issuers, providers, facilities, and providers of air ambulance services, with HHS enforcing only in cases in which the State has notified HHS that the State does not have the authority to enforce or is otherwise not enforcing, or HHS has made a determination that a State has failed to substantially enforce the requirements. However, in the Departments' view, the federalism implications of these final rules are substantially mitigated because the Departments expect that some States will have their own process for determining the total amount payable under a plan or coverage. Where a State does not have an applicable All-Payer Model Agreement, but does have such a specified State law, the State law, rather than the Federal IDR process, will apply. The Departments anticipate that some States with their own IDR processes or other mechanism for determining the out-of-network rate may want to change their laws or adopt new laws in response to these final rules. The Departments anticipate that these States will incur a small incremental cost when making changes to their laws.

In general, section 514 of ERISA preempts state laws to the extent that they relate to any private covered employee benefit plan, including covered group health plans, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, the preemption provisions of section 731 of ERISA and section 2724 of the PHS Act (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that requirements of Part 7 of ERISA and title XXVII of the PHS Act (including those of the No Surprises Act) are not to be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement

prevents the application of a requirement" of a Federal standard. The conference report accompanying the Health Insurance Portability and Accountability Act of 1996 (HIPAA) indicates that this is intended to be the "narrowest" preemption of State laws.¹¹⁵ Additionally, the No Surprises Act requires that when a State law determines the total amount payable under such a plan, coverage, or issuer for emergency services or to nonparticipating providers related to patient visits to participating facilities for nonemergency services, the State law will apply, rather than the Federal IDR process specified in these final rules.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy-making discretion of the States, the Departments engaged in efforts to consult with and work cooperatively with affected States, including participating in conference calls with and attending conferences of the NAIC and consulting with State insurance officials on a state-by-state basis. In addition, the Departments consulted with the NAIC, as required by the No Surprises Act, to establish the geographic regions to be used in the methodology for calculating the QPA as detailed in the July 2021 interim final rules.

In developing these final rules, the Departments attempted to balance the States' interests in regulating health insurance issuers, providers, and facilities with the need to ensure at least the minimum Federal consumer protections in every State. By doing so, the Departments complied with the requirements of Executive Order 13132.

List of Subjects

26 CFR Part 54

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Part 149

Balance billing, Health care, Health insurance, Reporting and recordkeeping requirements, Surprise billing, State

regulation of health insurance, Transparency in coverage.

Douglas W. O'Donnell,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Lily L. Batchelder,

Assistant Secretary of the Treasury (Tax Policy).

Ali Khawar,

Acting Assistant Secretary, Employee Benefits Security Administration, U.S. Department of Labor.

Xavier Becerra,

Secretary, Department of Health and Human Services.

Department of the Treasury

Internal Revenue Service

Adoption of the Amendments to the Regulations

Accordingly, the Treasury Department and the IRS adopts as final the temporary regulations adding 26 CFR 54.9816-6T and 54.9817-2T, published at 86 FR 36872 (July 13, 2021), and 26 CFR 54.9816-8T, published at 86 FR 55980 (October 7, 2021), with the following changes to 26 CFR part 54:

PART 54—PENSION EXCISE TAXES

■ 1. The authority citation for part 54 continues to read in part as follows:

Authority: 26 U.S.C. 7805, unless otherwise noted.

* * * * *

■ 2. Section 54.9816-6 is added to read as follows:

§ 54.9816-6 Methodology for calculating qualifying payment amount.

(a) For further guidance see § 54.9816-6T(a) introductory text through (a)(17).

(1)–(17) [Reserved]

(18) *Downcode* means the alteration by a plan or issuer of a service code to another service code, or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed code or modifier is associated with a lower qualifying payment amount than the service code or modifier billed by the provider, facility, or provider of air ambulance services.

(b)–(c) For further guidance see § 54.9816-6T(b) and (c).

(d) For further guidance see § 54.9816-6T(d) introductory text through (d)(1)(i).

(1) [Reserved]

(i) [Reserved]

(ii) If the qualifying payment amount is based on a downcoded service code or modifier—

(A) A statement that the service code or modifier billed by the provider,

¹¹⁵ See House Conf. Rep. No. 104-736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018.

facility, or provider of air ambulance services was downcoded;

(B) An explanation of why the claim was downcoded, which must include a description of which service codes were altered, if any, and a description of which modifiers were altered, added, or removed, if any; and

(C) The amount that would have been the qualifying payment amount had the service code or modifier not been downcoded.

(iii)–(v) For further guidance see § 54.9816–6T(d)(1)(iii) through (v).

(2) For further guidance see § 54.9816–6T(d)(2).

(e)–(f) For further guidance see § 54.9816–6T(e) and (f).

(g) *Applicability date.* The provisions of this section are applicable for plan years beginning on or after January 1, 2022, except that paragraph (a)(18) of this section regarding the definition of the term “downcode” and paragraph (d)(1)(ii) of this section regarding additional information that must be provided if the qualifying payment amount is based on a downcoded service code or modifier are applicable with respect to items or services provided or furnished on or after October 25, 2022, for plan years beginning on or after January 1, 2022.

■ 3. Section 54.9816–6T is amended by:

■ a. Adding paragraph (a)(18);

■ b. Redesignating paragraphs (d)(1)(ii) through and (iv) as paragraphs (d)(1)(iii) through (v), respectively; and

■ c. Adding a new paragraph (d)(1)(ii).

The additions read as follows:

§ 54.9816–6T Methodology for calculating qualifying payment amount (temporary).

(a) * * *

(18) For further guidance see § 54.9816–6(a)(18).

* * * * *

(d) * * *

(1) * * *

(ii) For further guidance see § 54.9816–6(d)(1)(ii);

* * * * *

■ 4. Section 54.9816–8 is added to read as follows:

§ 54.9816–8 Independent dispute resolution process.

(a)–(b) For further guidance see § 54.9816–8T(a) and (b).

(c) For further guidance see § 54.9816–8T(c) introductory text through (c)(3).

(1)–(3) [Reserved]

(4) For further guidance see § 54.9816–8T(c)(4) introductory text through (c)(4)(ii) introductory text.

(i) [Reserved]

(ii) [Reserved]

(A) Select as the out-of-network rate for the qualified IDR item or service one of the offers submitted under § 54.9816–8T(c)(4)(i), weighing only the considerations specified in paragraph (c)(4)(iii) of this section (as applied to the information provided by the parties pursuant to § 54.9816–8T(c)(4)(i)). The certified IDR entity must select the offer that the certified IDR entity determines best represents the value of the qualified IDR item or service as the out-of-network rate.

(B) For further guidance see

§ 54.9816–8T(c)(4)(ii)(B).

(iii) *Considerations in determination.*

In determining which offer to select:

(A) The certified IDR entity must consider the qualifying payment amount(s) for the applicable year for the same or similar item or service.

(B) The certified IDR entity must then consider information submitted by a party that relates to the following circumstances:

(1) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished the qualified IDR item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act).

(2) The market share held by the provider or facility or that of the plan or issuer in the geographic region in which the qualified IDR item or service was provided.

(3) The acuity of the participant or beneficiary receiving the qualified IDR item or service, or the complexity of furnishing the qualified IDR item or service to the participant or beneficiary.

(4) The teaching status, case mix, and scope of services of the facility that furnished the qualified IDR item or service, if applicable.

(5) Demonstration of good faith efforts (or lack thereof) made by the provider or facility or the plan or issuer to enter into network agreements with each other, and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

(C) The certified IDR entity must also consider information provided by a party in response to a request by the certified IDR entity under § 54.9816–8T(c)(4)(i)(A)(2) that relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination and that does not include information on factors described in § 54.9816–8T(c)(4)(v).

(D) The certified IDR entity must also consider additional information submitted by a party that relates to the

offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination and that does not include information on factors described in § 54.9816–8T(c)(4)(v).

(E) In weighing the considerations described in paragraphs (c)(4)(iii)(B) through (D) of this section, the certified IDR entity should evaluate whether the information is credible and relates to the offer submitted by either party for the payment amount for the qualified IDR item or service that is the subject of the payment determination. The certified IDR entity should not give weight to information to the extent it is not credible, it does not relate to either party's offer for the payment amount for the qualified IDR item or service, or it is already accounted for by the qualifying payment amount under paragraph (c)(4)(iii)(A) of this section or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section.

(iv) *Examples.* The rules of paragraph (c)(4)(iii) of this section are illustrated in the following paragraphs. Each example assumes that the Federal IDR process applies for purposes of determining the out-of-network rate, that both parties have submitted the information parties are required to submit as part of the Federal IDR process, and that the submitted information does not include information on factors described in paragraph (c)(4)(v) of this section:

(A) *Example 1—(1) Facts.* A level 1 trauma center that is a nonparticipating emergency facility and an issuer are parties to a payment determination in the Federal IDR process. The facility submits an offer that is higher than the qualifying payment amount. The facility also submits additional written information showing that the scope of services available at the facility was critical to the delivery of care for the qualified IDR item or service provided, given the particular patient's acuity. This information is determined to be credible by the certified IDR entity. Further, the facility submits additional information showing the contracted rates used to calculate the qualifying payment amount for the qualified IDR item or service were based on a level of service that is typical in cases in which the services are delivered by a facility that is not a level 1 trauma center and that does not have the capability to provide the scope of services provided by a level 1 trauma center. This information is also determined to be credible by the certified IDR entity. The issuer submits an offer equal to the qualifying payment amount. No additional information is submitted by

either party. The certified IDR entity determines that all the information submitted by the nonparticipating emergency facility relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination.

(2) *Conclusion.* In this paragraph (c)(4)(iv)(A) (*Example 1*), the certified IDR entity must consider the qualifying payment amount. The certified IDR entity then must consider the additional information submitted by the nonparticipating emergency facility, provided the information relates to circumstances described in paragraphs (c)(4)(iii)(B) through (D) of this section and relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination. If the certified IDR entity determines that it is appropriate to give weight to the additional credible information submitted by the nonparticipating emergency facility and that the additional credible information submitted by the facility demonstrates that the facility's offer best represents the value of the qualified IDR item or service, the certified IDR entity should select the facility's offer.

(B) *Example 2—(1) Facts.* A nonparticipating provider and an issuer are parties to a payment determination in the Federal IDR process. The provider submits an offer that is higher than the qualifying payment amount. The provider also submits additional written information regarding the level of training and experience the provider possesses. This information is determined to be credible by the certified IDR entity, but the certified IDR entity finds that the information does not demonstrate that the provider's level of training and experience relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination (for example, the information does not show that the provider's level of training and experience was necessary for providing the qualified IDR service that is the subject of the payment determination to the particular patient, or that the training or experience made an impact on the care that was provided). The nonparticipating provider does not submit any additional information. The issuer submits an offer equal to the qualifying payment amount, with no additional information.

(2) *Conclusion.* In this paragraph (c)(4)(iv)(B) (*Example 2*), the certified IDR entity must consider the qualifying payment amount. The certified IDR entity must then consider the additional information submitted by the

nonparticipating provider, provided the information relates to circumstances described in paragraphs (c)(4)(iii)(B) through (D) of this section and relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination. In addition, the certified IDR entity should not give weight to information to the extent it is already accounted for by the qualifying payment amount or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity determines that the additional information submitted by the provider is credible but does not relate to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination, and determines that the issuer's offer best represents the value of the qualified IDR service, in the absence of any other credible information that relates to either party's offer, the certified IDR entity should select the issuer's offer.

(C) *Example 3—(1) Facts.* A nonparticipating provider and an issuer are parties to a payment determination in the Federal IDR process involving an emergency department visit for the evaluation and management of a patient. The provider submits an offer that is higher than the qualifying payment amount. The provider also submits additional written information showing that the acuity of the patient's condition and complexity of the qualified IDR service furnished required the taking of a comprehensive history, a comprehensive examination, and medical decision making of high complexity. This information is determined to be credible by the certified IDR entity. The issuer submits an offer equal to the qualifying payment amount for CPT code 99285, which is the CPT code for an emergency department visit for the evaluation and management of a patient requiring a comprehensive history, a comprehensive examination, and medical decision making of high complexity. The issuer also submits additional written information showing that this CPT code accounts for the acuity of the patient's condition. This information is determined to be credible by the certified IDR entity. The certified IDR entity determines that the information provided by the provider and issuer relates to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination. Neither party submits any additional information.

(2) *Conclusion.* In this paragraph (c)(4)(iv)(C) (*Example 3*), the certified IDR entity must consider the qualifying

payment amount. The certified IDR entity then must consider the additional information submitted by the parties, but the certified IDR entity should not give weight to information to the extent it is already accounted for by the qualifying payment amount or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity determines the additional information on the acuity of the patient and complexity of the service is already accounted for in the calculation of the qualifying payment amount, the certified IDR entity should not give weight to the additional information provided by the provider. If the certified IDR entity determines that the issuer's offer best represents the value of the qualified IDR service, the certified IDR entity should select the issuer's offer.

(D) *Example 4—(1) Facts.* A nonparticipating emergency facility and an issuer are parties to a payment determination in the Federal IDR process. Although the facility is not participating in the issuer's network during the relevant plan year, it was a participating facility in the issuer's network in the previous 4 plan years. The issuer submits an offer that is higher than the qualifying payment amount and that is equal to the facility's contracted rate (adjusted for inflation) for the previous year with the issuer for the qualified IDR service. The issuer also submits additional written information showing that the contracted rates between the facility and the issuer during the previous 4 plan years were higher than the qualifying payment amount submitted by the issuer, and that these prior contracted rates account for the case mix and scope of services typically furnished at the nonparticipating facility. The certified IDR entity determines this information is credible and that it relates to the offer submitted by the issuer for the payment amount for the qualified IDR service that is the subject of the payment determination. The facility submits an offer that is higher than both the qualifying payment amount and the contracted rate (adjusted for inflation) for the previous year with the issuer for the qualified IDR service. The facility also submits additional written information, with the intent to show that the case mix and scope of services available at the facility were integral to the service provided. The certified IDR entity determines this information is credible and that it relates to the offer submitted by the facility for the payment amount for the qualified IDR service that is the subject of the

payment determination. Neither party submits any additional information.

(2) *Conclusion.* In this paragraph (c)(4)(iv)(D) (*Example 4*), the certified IDR entity must consider the qualifying payment amount. The certified IDR entity then must consider the additional information submitted by the parties, but should not give weight to information to the extent it is already accounted for by the qualifying payment amount or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity determines that the information submitted by the facility regarding the case mix and scope of services available at the facility includes information that is also accounted for in the information the issuer submitted regarding prior contracted rates, then the certified IDR entity should give weight to that information only once. The certified IDR entity also should not give weight to the same information provided by the nonparticipating emergency facility in relation to any other factor. If the certified IDR entity determines that the issuer's offer best represents the value of the qualified IDR service, the certified IDR entity should select the issuer's offer.

(E) *Example 5—(1) Facts.* A nonparticipating provider and an issuer are parties to a payment determination in the Federal IDR process regarding a qualified IDR service for which the issuer downcoded the service code that the provider billed. The issuer submits an offer equal to the qualifying payment amount (which was calculated using the downcoded service code). The issuer also submits additional written information that includes the documentation disclosed to the nonparticipating provider under § 54.9816–6(d)(1)(ii) at the time of the initial payment (which describes why the service code was downcoded). The certified IDR entity determines this information is credible and that it relates to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination. The provider submits an offer equal to the amount that would have been the qualifying payment amount had the service code not been downcoded. The provider also submits additional written information that includes the documentation disclosed to the nonparticipating provider under § 54.9816–6(d)(1)(ii) at the time of the initial payment. Further, the provider submits additional written information that explains why the billed service code was more appropriate than the downcoded service code, as evidence that the provider's offer, which is equal

to the amount the qualifying payment amount would have been for the service code that the provider billed, best represents the value of the service furnished, given its complexity. The certified IDR entity determines this information to be credible and that it relates to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination. Neither party submits any additional information.

(2) *Conclusion.* In this paragraph (c)(4)(iv)(E) (*Example 5*), the certified IDR entity must consider the qualifying payment amount, which is based on the downcoded service code. The certified IDR entity then must consider whether to give weight to additional information submitted by the parties. If the certified IDR entity determines that the additional credible information submitted by the provider demonstrates that the nonparticipating provider's offer, which is equal to the qualifying payment amount for the service code that the provider billed, best represents the value of the qualified IDR service, the certified IDR entity should select the nonparticipating provider's offer.

(v) For further guidance see § 54.9816–8T(c)(4)(v) through (c)(4)(vi)(A).

(vi) [Reserved]

(A) [Reserved]

(B) The certified IDR entity's written decision must include an explanation of their determination, including what information the certified IDR entity determined demonstrated that the offer selected as the out-of-network rate is the offer that best represents the value of the qualified IDR item or service, including the weight given to the qualifying payment amount and any additional credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity relies on information described under paragraphs (c)(4)(iii)(B) through (D) of this section in selecting an offer, the written decision must include an explanation of why the certified IDR entity concluded that this information was not already reflected in the qualifying payment amount.

(vii)–(ix) For further guidance see § 54.9816–8T(c)(4)(vii) through (ix).

(d)–(e) For further guidance see § 54.9816–8T(d) through (e).

(f) For further guidance see § 54.9816–8T(f) introductory text through (f)(1)(iv).

(1) [Reserved]

(i)–(iv) [Reserved]

(v) For further guidance see § 54.9816–8T(f)(1)(v) introductory text through (f)(1)(v)(E).

(A)–(E) [Reserved]

(F) The rationale for the certified IDR entity's decision, including the extent to which the decision relied on the criteria in paragraphs (c)(4)(iii)(B) through (D) of this section.

(G)–(I) For further guidance see § 54.9816–8T(f)(1)(v)(G) through (I).

(vi) For further guidance see § 54.9816–8T(f)(1)(vi).

(2) [Reserved]

(g) For further guidance see § 54.9816–8T(g).

(h) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022, except that paragraphs (c)(4)(ii) through (iv) of this section regarding payment determinations, paragraph (c)(4)(vi)(B) of this section regarding written decisions, and paragraph (f)(1)(v)(F) of this section regarding reporting of information relating to the Federal IDR process are applicable with respect to items or services provided or furnished on or after October 25, 2022, for plan years beginning on or after January 1, 2022.

■ 5. Section 54.9816–8T is amended by:

■ a. Removing paragraph (a)(2)(viii);

■ b. Redesignating paragraphs (a)(2)(ix) through (xiii) as paragraphs (a)(2)(viii) through (xii), respectively; and

■ c. Revising paragraphs (c)(4)(ii)(A), (c)(4)(iii) and (iv), (c)(4)(vi)(B), (f)(1)(v)(F), and (h).

The revisions read as follows:

§ 54.9816–8T Independent dispute resolution process (temporary).

* * * * *

(c) * * *

(4) * * *

(ii) * * *

(A) For further guidance see § 54.9816–8(c)(4)(ii)(A).

* * * * *

(iii) For further guidance see § 54.9816–8(c)(4)(iii).

(iv) For further guidance see § 54.9816–8(c)(4)(iv).

* * * * *

(vi) * * *

(B) For further guidance see § 54.9816–8(c)(4)(vi)(B).

* * * * *

(f) * * *

(1) * * *

(v) * * *

(F) For further guidance see § 54.9816–8(f)(1)(v)(F);

* * * * *

(h) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022, except that the provisions regarding IDR entity certification at paragraphs (a) and (e) of

this section are applicable beginning on October 7, 2021; and paragraphs (c)(4)(ii) through (iv) of this section regarding payment determinations, paragraph (c)(4)(vi)(B) of this section regarding written decisions, and paragraph (f)(1)(v)(F) of this section regarding reporting of information relating to the Federal IDR process are applicable with respect to items or services provided or furnished on or after October 25, 2022, for plan years beginning on or after January 1, 2022.

■ 6. Section 54.9817–2 is added to read as follows:

§ 54.9817–2 Independent dispute resolution process for air ambulance services

(a) For further guidance see § 54.9817–2T(a).

(b) For further guidance see § 54.9817–2T(b) introductory text.

(1) *In general.* Except as provided in paragraphs (b)(2) and (3) of this section and § 54.9817–2T(b)(2) and (4), in determining the out-of-network rate to be paid by group health plans and health insurance issuers offering group health insurance coverage for out-of-network air ambulance services, plans and issuers must comply with the requirements of §§ 54.9816–8T and 54.9816–8, except that references in §§ 54.9816–8T and 54.9816–8 to the additional circumstances in § 54.9816–8(c)(4)(iii)(B) shall be understood to refer to paragraph (b)(2) of this section and § 54.9817–2T(b)(2).

(2) *Considerations for air ambulance services.* In determining which offer to select, in addition to considering the applicable qualifying payment amount(s), the certified IDR entity must consider information submitted by a party that relates to the following circumstances:

(i)–(vi) For further guidance see § 54.9817–2T(b)(2)(i) through (vi).

(3) *Weighing considerations.* In weighing the considerations described in paragraph (b)(2) of this section and § 54.9817–2T(b)(2), the certified IDR entity should evaluate whether the information is credible and relates to the offer submitted by either party for the payment amount for the qualified IDR service that is the subject of the payment determination. The certified IDR entity should not give weight to information to the extent it is not credible, it does not relate to either party's offer for the payment amount for the qualified IDR service, or it is already accounted for by the qualifying payment amount under § 54.9816–8(c)(4)(iii)(A) or other credible information under § 54.9816–8(c)(4)(iii)(B) through (D), except that the additional circumstances

in § 54.9816–8(c)(4)(iii)(B) shall be understood to refer to paragraph (b)(2) of this section and § 54.9817–2T(b)(2).

(4) For further guidance see § 54.9817–2T(b)(4) introductory text through (b)(4)(iii).

(i)–(iii) [Reserved]

(iv) For further guidance see § 54.9817–2T(b)(4)(iv) introductory text through (b)(4)(iv)(E).

(A)–(E) [Reserved]

(F) The rationale for the certified IDR entity's decision, including the extent to which the decision relied on the criteria in paragraph (b)(2) of this section and § 54.9816–8(c)(4)(iii)(C) and (D).

(G)–(I) For further guidance see § 54.9817–2T(b)(4)(iv)(G) through (I).

(c) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022, except that paragraphs (b)(1), (2), and (3) and (b)(4)(iv)(F) of this section regarding payment determinations are applicable with respect to services provided or furnished on or after October 25, 2022, for plan years beginning on or after January 1, 2022.

■ 7. Section 54.9817–2T is amended by:

■ a. Revising paragraphs (b)(1) and (2);

■ b. Redesignating paragraph (b)(3) as paragraph (b)(4);

■ c. Adding a new paragraph (b)(3); and

■ d. Revising newly redesignated paragraph (b)(4)(iv)(F) and paragraph (c).

The revisions and addition read as follows:

§ 54.9817–2T Independent dispute resolution process for air ambulance services (temporary).

* * * * *

(b) * * *

(1) For further guidance see § 54.9817–2T(b)(1).

(2) For further guidance see § 54.9817–2T(b)(2).

(3) For further guidance see § 54.9817–2T(b)(3).

(4) * * *

(iv) * * *

(F) For further guidance see § 54.9817–2T(b)(4)(iv)(F);

* * * * *

(c) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022, except that paragraphs (b)(1), (2), and (3) and (b)(4)(iv)(F) of this section regarding payment determinations are applicable with respect to services provided or furnished on or after October 25, 2022, for plan years beginning on or after January 1, 2022.

Department of Labor

Employee Benefits Security Administration

29 CFR Chapter XXV

For the reasons set forth in the preamble, the Department of Labor adopts as final the interim rules adding 29 CFR 2590.716–6, published at 86 FR 36872 (July 13, 2021), and 29 CFR 2590.716–8 and 2590.717–2, published at 86 FR 55980 (October 7, 2021), with the following changes:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ 8. The authority citation for part 2590 continues to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a–n, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L. 104–191, 110 Stat. 1936; sec. 401(b), Pub. L. 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111–148, 124 Stat. 119, as amended by Pub. L. 111–152, 124 Stat. 1029; Division M, Pub. L. 113–235, 128 Stat. 2130; Pub. L. 116–260 134 Stat. 1182; Secretary of Labor's Order 1–2011, 77 FR 1088 (Jan. 9, 2012).

■ 9. Section 2590.716–6 is amended by:

■ a. Adding paragraph (a)(18);

■ b. Redesignating paragraphs (d)(1)(ii) through (iv) as paragraphs (d)(1)(iii) through (v), respectively;

■ c. Adding a new paragraph (d)(1)(ii); and

■ d. Revising paragraph (f).

The revisions and additions read as follows:

§ 2590.716–6 Methodology for calculating qualifying payment amount.

(a) * * *

(18) *Downcode* means the alteration by a plan or issuer of a service code to another service code, or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed code or modifier is associated with a lower qualifying payment amount than the service code or modifier billed by the provider, facility, or provider of air ambulance services.

* * * * *

(d) * * *

(1) * * *

(ii) If the qualifying payment amount is based on a downcoded service code or modifier—

(A) A statement that the service code or modifier billed by the provider, facility, or provider of air ambulance services was downcoded;

(B) An explanation of why the claim was downcoded, which must include a

description of which service codes were altered, if any, and a description of which modifiers were altered, added, or removed, if any; and

(C) The amount that would have been the qualifying payment amount had the service code or modifier not been downcoded;

* * * * *

(f) *Applicability date.* The provisions of this section are applicable for plan years beginning on or after January 1, 2022, except that paragraph (a)(18) of this section regarding the definition of the term “downcode” and paragraph (d)(1)(ii) of this section regarding additional information that must be provided if the qualifying payment amount is based on a downcoded service code or modifier are applicable with respect to items or services provided or furnished on or after October 25, 2022, for plan years beginning on or after January 1, 2022.

■ 10. Section 2590.716–8 is amended by:

- a. Removing paragraph (a)(2)(viii);
- b. Redesignating paragraphs (a)(2)(ix) through (xiii) as paragraphs (a)(2)(viii) through (xii), respectively; and
- c. Revising paragraphs (c)(4)(ii)(A), (c)(4)(iii) and (iv), (c)(4)(vi)(B), (f)(1)(v)(F), and (h).

The revisions read as follows:

§ 2590.716–8 Independent dispute resolution process.

* * * * *

- (c) * * *
- (4) * * *
- (ii) * * *

(A) Select as the out-of-network rate for the qualified IDR item or service one of the offers submitted under paragraph (c)(4)(i) of this section, weighing only the considerations specified in paragraph (c)(4)(iii) of this section (as applied to the information provided by the parties pursuant to paragraph (c)(4)(i) of this section). The certified IDR entity must select the offer that the certified IDR entity determines best represents the value of the qualified IDR item or service as the out-of-network rate.

* * * * *

(iii) *Considerations in determination.* In determining which offer to select:

(A) The certified IDR entity must consider the qualifying payment amount(s) for the applicable year for the same or similar item or service.

(B) The certified IDR entity must then consider information submitted by a party that relates to the following circumstances:

(1) The level of training, experience, and quality and outcomes

measurements of the provider or facility that furnished the qualified IDR item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act).

(2) The market share held by the provider or facility or that of the plan or issuer in the geographic region in which the qualified IDR item or service was provided.

(3) The acuity of the participant or beneficiary receiving the qualified IDR item or service, or the complexity of furnishing the qualified IDR item or service to the participant or beneficiary.

(4) The teaching status, case mix, and scope of services of the facility that furnished the qualified IDR item or service, if applicable.

(5) Demonstration of good faith efforts (or lack thereof) made by the provider or facility or the plan or issuer to enter into network agreements with each other, and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

(C) The certified IDR entity must also consider information provided by a party in response to a request by the certified IDR entity under paragraph (c)(4)(i)(A)(2) of this section that relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination and that does not include information on factors described in paragraph (c)(4)(v) of this section.

(D) The certified IDR entity must also consider additional information submitted by a party that relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination and that does not include information on factors described in paragraph (c)(4)(v) of this section.

(E) In weighing the considerations described in paragraphs (c)(4)(iii)(B) through (D) of this section, the certified IDR entity should evaluate whether the information is credible and relates to the offer submitted by either party for the payment amount for the qualified IDR item or service that is the subject of the payment determination. The certified IDR entity should not give weight to information to the extent it is not credible, it does not relate to either party's offer for the payment amount for the qualified IDR item or service, or it is already accounted for by the qualifying payment amount under paragraph (c)(4)(iii)(A) of this section or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section.

(iv) *Examples.* The rules of paragraph (c)(4)(iii) of this section are illustrated in the following paragraphs. Each example assumes that the Federal IDR process applies for purposes of determining the out-of-network rate, that both parties have submitted the information parties are required to submit as part of the Federal IDR process, and that the submitted information does not include information on factors described in paragraph (c)(4)(v) of this section:

(A) *Example 1—(1) Facts.* A level 1 trauma center that is a nonparticipating emergency facility and an issuer are parties to a payment determination in the Federal IDR process. The facility submits an offer that is higher than the qualifying payment amount. The facility also submits additional written information showing that the scope of services available at the facility was critical to the delivery of care for the qualified IDR item or service provided, given the particular patient's acuity. This information is determined to be credible by the certified IDR entity. Further, the facility submits additional information showing the contracted rates used to calculate the qualifying payment amount for the qualified IDR item or service were based on a level of service that is typical in cases in which the services are delivered by a facility that is not a level 1 trauma center and that does not have the capability to provide the scope of services provided by a level 1 trauma center. This information is also determined to be credible by the certified IDR entity. The issuer submits an offer equal to the qualifying payment amount. No additional information is submitted by either party. The certified IDR entity determines that all the information submitted by the nonparticipating emergency facility relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination.

(2) *Conclusion.* In this paragraph (c)(4)(iv)(A) (*Example 1*), the certified IDR entity must consider the qualifying payment amount. The certified IDR entity then must consider the additional information submitted by the nonparticipating emergency facility, provided the information relates to circumstances described in paragraphs (c)(4)(iii)(B) through (D) of this section and relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination. If the certified IDR entity determines that it is appropriate to give weight to the additional credible information submitted by the nonparticipating emergency facility and that the

additional credible information submitted by the facility demonstrates that the facility's offer best represents the value of the qualified IDR item or service, the certified IDR entity should select the facility's offer.

(B) *Example 2—(1) Facts.* A nonparticipating provider and an issuer are parties to a payment determination in the Federal IDR process. The provider submits an offer that is higher than the qualifying payment amount. The provider also submits additional written information regarding the level of training and experience the provider possesses. This information is determined to be credible by the certified IDR entity, but the certified IDR entity finds that the information does not demonstrate that the provider's level of training and experience relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination (for example, the information does not show that the provider's level of training and experience was necessary for providing the qualified IDR service that is the subject of the payment determination to the particular patient, or that the training or experience made an impact on the care that was provided). The nonparticipating provider does not submit any additional information. The issuer submits an offer equal to the qualifying payment amount, with no additional information.

(2) *Conclusion.* In this paragraph (c)(4)(iv)(B) (*Example 2*), the certified IDR entity must consider the qualifying payment amount. The certified IDR entity must then consider the additional information submitted by the nonparticipating provider, provided the information relates to circumstances described in paragraphs (c)(4)(iii)(B) through (D) of this section and relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination. In addition, the certified IDR entity should not give weight to information to the extent it is already accounted for by the qualifying payment amount or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity determines that the additional information submitted by the provider is credible but does not relate to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination, and determines that the issuer's offer best represents the value of the qualified IDR service, in the absence of any other credible information that relates to either party's offer, the certified IDR entity should select the issuer's offer.

(C) *Example 3—(1) Facts.* A nonparticipating provider and an issuer are parties to a payment determination in the Federal IDR process involving an emergency department visit for the evaluation and management of a patient. The provider submits an offer that is higher than the qualifying payment amount. The provider also submits additional written information showing that the acuity of the patient's condition and complexity of the qualified IDR service furnished required the taking of a comprehensive history, a comprehensive examination, and medical decision making of high complexity. This information is determined to be credible by the certified IDR entity. The issuer submits an offer equal to the qualifying payment amount for CPT code 99285, which is the CPT code for an emergency department visit for the evaluation and management of a patient requiring a comprehensive history, a comprehensive examination, and medical decision making of high complexity. The issuer also submits additional written information showing that this CPT code accounts for the acuity of the patient's condition. This information is determined to be credible by the certified IDR entity. The certified IDR entity determines that the information provided by the provider and issuer relates to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination. Neither party submits any additional information.

(2) *Conclusion.* In this paragraph (c)(4)(iv)(C) (*Example 3*), the certified IDR entity must consider the qualifying payment amount. The certified IDR entity then must consider the additional information submitted by the parties, but the certified IDR entity should not give weight to information to the extent it is already accounted for by the qualifying payment amount or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity determines the additional information on the acuity of the patient and complexity of the service is already accounted for in the calculation of the qualifying payment amount, the certified IDR entity should not give weight to the additional information provided by the provider. If the certified IDR entity determines that the issuer's offer best represents the value of the qualified IDR service, the certified IDR entity should select the issuer's offer.

(D) *Example 4—(1) Facts.* A nonparticipating emergency facility and an issuer are parties to a payment determination in the Federal IDR

process. Although the facility is not participating in the issuer's network during the relevant plan year, it was a participating facility in the issuer's network in the previous 4 plan years. The issuer submits an offer that is higher than the qualifying payment amount and that is equal to the facility's contracted rate (adjusted for inflation) for the previous year with the issuer for the qualified IDR service. The issuer also submits additional written information showing that the contracted rates between the facility and the issuer during the previous 4 plan years were higher than the qualifying payment amount submitted by the issuer, and that these prior contracted rates account for the case mix and scope of services typically furnished at the nonparticipating facility. The certified IDR entity determines this information is credible and that it relates to the offer submitted by the issuer for the payment amount for the qualified IDR service that is the subject of the payment determination. The facility submits an offer that is higher than both the qualifying payment amount and the contracted rate (adjusted for inflation) for the previous year with the issuer for the qualified IDR service. The facility also submits additional written information, with the intent to show that the case mix and scope of services available at the facility were integral to the service provided. The certified IDR entity determines this information is credible and that it relates to the offer submitted by the facility for the payment amount for the qualified IDR service that is the subject of the payment determination. Neither party submits any additional information.

(2) *Conclusion.* In this paragraph (c)(4)(iv)(D) (*Example 4*), the certified IDR entity must consider the qualifying payment amount. The certified IDR entity then must consider the additional information submitted by the parties, but should not give weight to information to the extent it is already accounted for by the qualifying payment amount or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity determines that the information submitted by the facility regarding the case mix and scope of services available at the facility includes information that is also accounted for in the information the issuer submitted regarding prior contracted rates, then the certified IDR entity should give weight to that information only once. The certified IDR entity also should not give weight to the same information provided by the nonparticipating emergency facility in

relation to any other factor. If the certified IDR entity determines that the issuer's offer best represents the value of the qualified IDR service, the certified IDR entity should select the issuer's offer.

(E) *Example 5—(1) Facts.* A nonparticipating provider and an issuer are parties to a payment determination in the Federal IDR process regarding a qualified IDR service for which the issuer downcoded the service code that the provider billed. The issuer submits an offer equal to the qualifying payment amount (which was calculated using the downcoded service code). The issuer also submits additional written information that includes the documentation disclosed to the nonparticipating provider under § 2590.716–6(d)(1)(ii) at the time of the initial payment (which describes why the service code was downcoded). The certified IDR entity determines this information is credible and that it relates to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination. The provider submits an offer equal to the amount that would have been the qualifying payment amount had the service code not been downcoded. The provider also submits additional written information that includes the documentation disclosed to the nonparticipating provider under § 2590.716–6(d)(1)(ii) at the time of the initial payment. Further, the provider submits additional written information that explains why the billed service code was more appropriate than the downcoded service code, as evidence that the provider's offer, which is equal to the amount the qualifying payment amount would have been for the service code that the provider billed, best represents the value of the service furnished, given its complexity. The certified IDR entity determines this information to be credible and that it relates to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination. Neither party submits any additional information.

(2) *Conclusion.* In this paragraph (c)(4)(iv)(E) (*Example 5*), the certified IDR entity must consider the qualifying payment amount, which is based on the downcoded service code. The certified IDR entity then must consider whether to give weight to additional information submitted by the parties. If the certified IDR entity determines that the additional credible information submitted by the provider demonstrates that the nonparticipating provider's offer, which is equal to the qualifying payment amount for the service code

that the provider billed, best represents the value of the qualified IDR service, the certified IDR entity should select the nonparticipating provider's offer.

* * * * *

(vi) * * *

(B) The certified IDR entity's written decision must include an explanation of their determination, including what information the certified IDR entity determined demonstrated that the offer selected as the out-of-network rate is the offer that best represents the value of the qualified IDR item or service, including the weight given to the qualifying payment amount and any additional credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity relies on information described under paragraphs (c)(4)(iii)(B) through (D) of this section in selecting an offer, the written decision must include an explanation of why the certified IDR entity concluded that this information was not already reflected in the qualifying payment amount.

* * * * *

(f) * * *

(1) * * *

(v) * * *

(F) The rationale for the certified IDR entity's decision, including the extent to which the decision relied on the criteria in paragraphs (c)(4)(iii)(B) through (D) of this section;

* * * * *

(h) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022, except that the provisions regarding IDR entity certification at paragraphs (a) and (e) of this section are applicable beginning on October 7, 2021; and paragraphs (c)(4)(ii) through (iv) of this section regarding payment determinations, paragraph (c)(4)(vi)(B) of this section regarding written decisions, and paragraph (f)(1)(v)(F) of this section regarding reporting of information relating to the Federal IDR process are applicable with respect to items or services provided or furnished on or after October 25, 2022, for plan years beginning on or after January 1, 2022.

■ 11. Section 2590.717–2 is amended by:

- a. Revising paragraphs (b)(1) and (b)(2) introductory text;
- b. Redesignating paragraph (b)(3) as paragraph (b)(4);
- c. Adding a new paragraph (b)(3); and
- d. Revising newly redesignated paragraph (b)(4)(iv)(F) and paragraph (c).

The addition and revisions read as follows:

§ 2590.717–2 Independent dispute resolution process for air ambulance services.

* * * * *

(b) * * *

(1) *In general.* Except as provided in paragraphs (b)(2) and (3) of this section, in determining the out-of-network rate to be paid by group health plans and health insurance issuers offering group health insurance coverage for out-of-network air ambulance services, plans and issuers must comply with the requirements of § 2590.716–8, except that references in § 2590.716–8 to the additional circumstances in § 2590.716–8(c)(4)(iii)(B) shall be understood to refer to paragraph (b)(2) of this section.

(2) *Considerations for air ambulance services.* In determining which offer to select, in addition to considering the applicable qualifying payment amount(s), the certified IDR entity must consider information submitted by a party that relates to the following circumstances:

* * * * *

(3) *Weighing considerations.* In weighing the considerations described in paragraph (b)(2) of this section, the certified IDR entity should evaluate whether the information is credible and relates to the offer submitted by either party for the payment amount for the qualified IDR service that is the subject of the payment determination. The certified IDR entity should not give weight to information to the extent it is not credible, it does not relate to either party's offer for the payment amount for the qualified IDR service, or it is already accounted for by the qualifying payment amount under § 2590.716–8(c)(4)(iii)(A) or other credible information under § 2590.716–8(c)(4)(iii)(B) through (D), except that the additional circumstances in § 2590.716–8(c)(4)(iii)(B) shall be understood to refer to paragraph (b)(2) of this section.

(4) * * *

(iv) * * *

(F) The rationale for the certified IDR entity's decision, including the extent to which the decision relied on the criteria in paragraph (b)(2) of this section and § 2590.716–8(c)(4)(iii)(C) and (D);

* * * * *

(c) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022, except that paragraphs (b)(1), (2), and (3) and (b)(4)(iv)(F) of this section regarding payment determinations are applicable with respect to services provided or furnished on or after October 25, 2022, for plan years beginning on or after January 1, 2022.

Department of Health and Human Services**45 CFR Subtitle A, Subchapter B**

For the reasons set forth in the preamble, the Department of Health and Human Services adopts as final the interim rules adding 45 CFR 149.140, published at 86 FR 36872 (July 13, 2021), and 45 CFR 149.510 and 149.520, published at 86 FR 55980 (October 7, 2021), with the following changes to 45 CFR part 149:

PART 149—SURPRISE BILLING AND TRANSPARENCY REQUIREMENTS

■ 12. The authority citation for part 149 continues to read as follows:

Authority: 42 U.S.C. 300gg–92 and 300gg–111 through 300gg–139, as amended.

■ 13. Section 149.140 is amended by:

■ a. Adding paragraph (a)(18);

■ b. Redesignating paragraphs (d)(1)(ii) through (iv) as paragraphs (d)(1)(iii) through (v), respectively;

■ c. Adding a new paragraph (d)(1)(ii); and

■ d. Revising paragraph (g).

The revisions and additions read as follows:

§ 149.140 Methodology for calculating qualifying payment amount.

(a) * * *

(18) *Downcode* means the alteration by a plan or issuer of a service code to another service code, or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed code or modifier is associated with a lower qualifying payment amount than the service code or modifier billed by the provider, facility, or provider of air ambulance services.

* * * * *

(d) * * *

(1) * * *

(ii) If the qualifying payment amount is based on a downcoded service code or modifier—

(A) A statement that the service code or modifier billed by the provider, facility, or provider of air ambulance services was downcoded;

(B) An explanation of why the claim was downcoded, which must include a description of which service codes were altered, if any, and a description of which modifiers were altered, added, or removed, if any; and

(C) The amount that would have been the qualifying payment amount had the service code or modifier not been downcoded;

* * * * *

(g) *Applicability date.* The provisions of this section are applicable for plan years or in the individual market, policy

years beginning on or after January 1, 2022, except that paragraph (a)(18) of this section regarding the definition of the term “downcode” and paragraph (d)(1)(ii) of this section regarding additional information that must be provided if the qualifying payment amount is based on a downcoded service code or modifier are applicable with respect to items or services provided or furnished on or after October 25, 2022, for plan years or in the individual market, policy years beginning on or after January 1, 2022.

■ 14. Section 149.510 is amended by:

■ a. Removing paragraph (a)(2)(viii);

■ b. Redesignating paragraphs (a)(2)(ix) through (xiii) as paragraphs (a)(2)(viii) through (xii), respectively; and

■ c. Revising paragraphs (c)(4)(ii)(A), (c)(4)(iii) and (iv), (c)(4)(vi)(B), (f)(1)(v)(F), and (h).

The revisions read as follows:

§ 149.510 Independent dispute resolution process.

* * * * *

(c) * * *

(4) * * *

(ii) * * *

(A) Select as the out-of-network rate for the qualified IDR item or service one of the offers submitted under paragraph (c)(4)(i) of this section, weighing only the considerations specified in paragraph (c)(4)(iii) of this section (as applied to the information provided by the parties pursuant to paragraph (c)(4)(i) of this section). The certified IDR entity must select the offer that the certified IDR entity determines best represents the value of the qualified IDR item or service as the out-of-network rate.

* * * * *

(iii) *Considerations in determination.* In determining which offer to select:

(A) The certified IDR entity must consider the qualifying payment amount(s) for the applicable year for the same or similar item or service.

(B) The certified IDR entity must then consider information submitted by a party that relates to the following circumstances:

(1) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished the qualified IDR item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act).

(2) The market share held by the provider or facility or that of the plan or issuer in the geographic region in which the qualified IDR item or service was provided.

(3) The acuity of the participant, beneficiary, or enrollee receiving the

qualified IDR item or service, or the complexity of furnishing the qualified IDR item or service to the participant, beneficiary, or enrollee.

(4) The teaching status, case mix, and scope of services of the facility that furnished the qualified IDR item or service, if applicable.

(5) Demonstration of good faith efforts (or lack thereof) made by the provider or facility or the plan or issuer to enter into network agreements with each other, and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

(C) The certified IDR entity must also consider information provided by a party in response to a request by the certified IDR entity under paragraph (c)(4)(i)(A)(2) of this section that relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination and that does not include information on factors described in paragraph (c)(4)(v) of this section.

(D) The certified IDR entity must also consider additional information submitted by a party that relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination and that does not include information on factors described in paragraph (c)(4)(v) of this section.

(E) In weighing the considerations described in paragraphs (c)(4)(iii)(B) through (D) of this section, the certified IDR entity should evaluate whether the information is credible and relates to the offer submitted by either party for the payment amount for the qualified IDR item or service that is the subject of the payment determination. The certified IDR entity should not give weight to information to the extent it is not credible, it does not relate to either party's offer for the payment amount for the qualified IDR item or service, or it is already accounted for by the qualifying payment amount under paragraph (c)(4)(iii)(A) of this section or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section.

(iv) *Examples.* The rules of paragraph (c)(4)(iii) of this section are illustrated in the following paragraphs. Each example assumes that the Federal IDR process applies for purposes of determining the out-of-network rate, that both parties have submitted the information parties are required to submit as part of the Federal IDR process, and that the submitted information does not include information on factors described in paragraph (c)(4)(v) of this section:

(A) *Example 1—(1) Facts.* A level 1 trauma center that is a nonparticipating emergency facility and an issuer are parties to a payment determination in the Federal IDR process. The facility submits an offer that is higher than the qualifying payment amount. The facility also submits additional written information showing that the scope of services available at the facility was critical to the delivery of care for the qualified IDR item or service provided, given the particular patient's acuity. This information is determined to be credible by the certified IDR entity. Further, the facility submits additional information showing the contracted rates used to calculate the qualifying payment amount for the qualified IDR item or service were based on a level of service that is typical in cases in which the services are delivered by a facility that is not a level 1 trauma center and that does not have the capability to provide the scope of services provided by a level 1 trauma center. This information is also determined to be credible by the certified IDR entity. The issuer submits an offer equal to the qualifying payment amount. No additional information is submitted by either party. The certified IDR entity determines that all the information submitted by the nonparticipating emergency facility relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination.

(2) *Conclusion.* In this paragraph (c)(4)(iv)(A) (*Example 1*), the certified IDR entity must consider the qualifying payment amount. The certified IDR entity then must consider the additional information submitted by the nonparticipating emergency facility, provided the information relates to circumstances described in paragraphs (c)(4)(iii)(B) through (D) of this section and relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination. If the certified IDR entity determines that it is appropriate to give weight to the additional credible information submitted by the nonparticipating emergency facility and that the additional credible information submitted by the facility demonstrates that the facility's offer best represents the value of the qualified IDR item or service, the certified IDR entity should select the facility's offer.

(B) *Example 2—(1) Facts.* A nonparticipating provider and an issuer are parties to a payment determination in the Federal IDR process. The provider submits an offer that is higher than the qualifying payment amount. The

provider also submits additional written information regarding the level of training and experience the provider possesses. This information is determined to be credible by the certified IDR entity, but the certified IDR entity finds that the information does not demonstrate that the provider's level of training and experience relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination (for example, the information does not show that the provider's level of training and experience was necessary for providing the qualified IDR service that is the subject of the payment determination to the particular patient, or that the training or experience made an impact on the care that was provided). The nonparticipating provider does not submit any additional information. The issuer submits an offer equal to the qualifying payment amount, with no additional information.

(2) *Conclusion.* In this paragraph (c)(4)(iv)(B) (*Example 2*), the certified IDR entity must consider the qualifying payment amount. The certified IDR entity must then consider the additional information submitted by the nonparticipating provider, provided the information relates to circumstances described in paragraphs (c)(4)(iii)(B) through (D) of this section and relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination. In addition, the certified IDR entity should not give weight to information to the extent it is already accounted for by the qualifying payment amount or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity determines that the additional information submitted by the provider is credible but does not relate to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination, and determines that the issuer's offer best represents the value of the qualified IDR service, in the absence of any other credible information that relates to either party's offer, the certified IDR entity should select the issuer's offer.

(C) *Example 3—(1) Facts.* A nonparticipating provider and an issuer are parties to a payment determination in the Federal IDR process involving an emergency department visit for the evaluation and management of a patient. The provider submits an offer that is higher than the qualifying payment amount. The provider also submits additional written information showing that the acuity of the patient's condition and complexity of the qualified IDR

service furnished required the taking of a comprehensive history, a comprehensive examination, and medical decision making of high complexity. This information is determined to be credible by the certified IDR entity. The issuer submits an offer equal to the qualifying payment amount for CPT code 99285, which is the CPT code for an emergency department visit for the evaluation and management of a patient requiring a comprehensive history, a comprehensive examination, and medical decision making of high complexity. The issuer also submits additional written information showing that this CPT code accounts for the acuity of the patient's condition. This information is determined to be credible by the certified IDR entity. The certified IDR entity determines that the information provided by the provider and issuer relates to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination. Neither party submits any additional information.

(2) *Conclusion.* In this paragraph (c)(4)(iv)(C) (*Example 3*), the certified IDR entity must consider the qualifying payment amount. The certified IDR entity then must consider the additional information submitted by the parties, but the certified IDR entity should not give weight to information to the extent it is already accounted for by the qualifying payment amount or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity determines the additional information on the acuity of the patient and complexity of the service is already accounted for in the calculation of the qualifying payment amount, the certified IDR entity should not give weight to the additional information provided by the provider. If the certified IDR entity determines that the issuer's offer best represents the value of the qualified IDR service, the certified IDR entity should select the issuer's offer.

(D) *Example 4—(1) Facts.* A nonparticipating emergency facility and an issuer are parties to a payment determination in the Federal IDR process. Although the facility is not participating in the issuer's network during the relevant plan year, it was a participating facility in the issuer's network in the previous 4 plan years. The issuer submits an offer that is higher than the qualifying payment amount and that is equal to the facility's contracted rate (adjusted for inflation) for the previous year with the issuer for the qualified IDR service. The issuer also submits additional written

information showing that the contracted rates between the facility and the issuer during the previous 4 plan years were higher than the qualifying payment amount submitted by the issuer, and that these prior contracted rates account for the case mix and scope of services typically furnished at the nonparticipating facility. The certified IDR entity determines this information is credible and that it relates to the offer submitted by the issuer for the payment amount for the qualified IDR service that is the subject of the payment determination. The facility submits an offer that is higher than both the qualifying payment amount and the contracted rate (adjusted for inflation) for the previous year with the issuer for the qualified IDR service. The facility also submits additional written information, with the intent to show that the case mix and scope of services available at the facility were integral to the service provided. The certified IDR entity determines this information is credible and that it relates to the offer submitted by the facility for the payment amount for the qualified IDR service that is the subject of the payment determination. Neither party submits any additional information.

(2) *Conclusion.* In this paragraph (c)(4)(iv)(D) (*Example 4*), the certified IDR entity must consider the qualifying payment amount. The certified IDR entity then must consider the additional information submitted by the parties, but should not give weight to information to the extent it is already accounted for by the qualifying payment amount or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity determines that the information submitted by the facility regarding the case mix and scope of services available at the facility includes information that is also accounted for in the information the issuer submitted regarding prior contracted rates, then the certified IDR entity should give weight to that information only once. The certified IDR entity also should not give weight to the same information provided by the nonparticipating emergency facility in relation to any other factor. If the certified IDR entity determines that the issuer's offer best represents the value of the qualified IDR service, the certified IDR entity should select the issuer's offer.

(E) *Example 5—(1) Facts.* A nonparticipating provider and an issuer are parties to a payment determination in the Federal IDR process regarding a qualified IDR service for which the issuer downcoded the service code that the provider billed. The issuer submits

an offer equal to the qualifying payment amount (which was calculated using the downcoded service code). The issuer also submits additional written information that includes the documentation disclosed to the nonparticipating provider under § 149.140(d)(1)(ii) at the time of the initial payment (which describes why the service code was downcoded). The certified IDR entity determines this information is credible and that it relates to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination. The provider submits an offer equal to the amount that would have been the qualifying payment amount had the service code not been downcoded. The provider also submits additional written information that includes the documentation disclosed to the nonparticipating provider under § 149.140(d)(1)(ii) at the time of the initial payment. Further, the provider submits additional written information that explains why the billed service code was more appropriate than the downcoded service code, as evidence that the provider's offer, which is equal to the amount the qualifying payment amount would have been for the service code that the provider billed, best represents the value of the service furnished, given its complexity. The certified IDR entity determines this information to be credible and that it relates to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination. Neither party submits any additional information.

(2) *Conclusion.* In this paragraph (c)(4)(iv)(E) (*Example 5*), the certified IDR entity must consider the qualifying payment amount, which is based on the downcoded service code. The certified IDR entity then must consider whether to give weight to additional information submitted by the parties. If the certified IDR entity determines that the additional credible information submitted by the provider demonstrates that the nonparticipating provider's offer, which is equal to the qualifying payment amount for the service code that the provider billed, best represents the value of the qualified IDR service, the certified IDR entity should select the nonparticipating provider's offer.

* * * * *

(vi) * * *

(B) The certified IDR entity's written decision must include an explanation of their determination, including what information the certified IDR entity determined demonstrated that the offer selected as the out-of-network rate is the

offer that best represents the value of the qualified IDR item or service, including the weight given to the qualifying payment amount and any additional credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity relies on information described under paragraphs (c)(4)(iii)(B) through (D) of this section in selecting an offer, the written decision must include an explanation of why the certified IDR entity concluded that this information was not already reflected in the qualifying payment amount.

* * * * *

(f) * * *

(1) * * *

(v) * * *

(F) The rationale for the certified IDR entity's decision, including the extent to which the decision relied on the criteria in paragraphs (c)(4)(iii)(B) through (D) of this section;

* * * * *

(h) *Applicability date.* The provisions of this section are applicable with respect to plan years or in the individual market policy years beginning on or after January 1, 2022, except that the provisions regarding IDR entity certification at paragraphs (a) and (e) of this section are applicable beginning on October 7, 2021; and paragraphs (c)(4)(ii) through (iv) of this section regarding payment determinations, paragraph (c)(4)(vi)(B) of this section regarding written decisions, and paragraph (f)(1)(v)(F) of this section regarding reporting of information relating to the Federal IDR process are applicable with respect to items or services provided or furnished on or after October 25, 2022, for plan years or in the individual market policy years beginning on or after January 1, 2022.

■ 15. Section 149.520 is amended by:

- a. Revising paragraphs (b)(1) and (b)(2) introductory text;
- b. Redesignating paragraph (b)(3) as paragraph (b)(4);
- c. Adding a new paragraph (b)(3); and
- d. Revising newly redesignated paragraph (b)(4)(iv)(F) and paragraph (c).

The addition and revisions read as follows:

§ 149.520 Independent dispute resolution process for air ambulance services.

* * * * *

(b) * * *

(1) *In general.* Except as provided in paragraphs (b)(2) and (3) of this section, in determining the out-of-network rate to be paid by group health plans and health insurance issuers offering group

or individual health insurance coverage for out-of-network air ambulance services, plans and issuers must comply with the requirements of § 149.510, except that references in § 149.510 to the additional circumstances in § 149.510(c)(4)(iii)(B) shall be understood to refer to paragraph (b)(2) of this section.

(2) *Considerations for air ambulance services.* In determining which offer to select, in addition to considering the applicable qualifying payment amount(s), the certified IDR entity must consider information submitted by a party that relates to the following circumstances:

* * * * *

(3) *Weighing considerations.* In weighing the considerations described in paragraph (b)(2) of this section, the

certified IDR entity should evaluate whether the information is credible and relates to the offer submitted by either party for the payment amount for the qualified IDR service that is the subject of the payment determination. The certified IDR entity should not give weight to information to the extent it is not credible, it does not relate to either party's offer for the payment amount for the qualified IDR service, or it is already accounted for by the qualifying payment amount under § 149.510(c)(4)(iii)(A) or other credible information under § 149.510(c)(4)(iii)(B) through (D), except that the additional circumstances in § 149.510(c)(4)(iii)(B) shall be understood to refer to paragraph (b)(2) of this section.

(4) * * *

(iv) * * *

(F) The rationale for the certified IDR entity's decision, including the extent to which the decision relied on the criteria in paragraph (b)(2) of this section and § 149.510(c)(4)(iii)(C) and (D);

* * * * *

(c) *Applicability date.* The provisions of this section are applicable with respect to plan years, or in the individual market, policy years, beginning on or after January 1, 2022, except that paragraphs (b)(1), (2), and (3) and (b)(4)(iv)(F) of this section regarding payment determinations are applicable with respect to services provided or furnished on or after October 25, 2022, for plan years or in the individual market policy years beginning on or after January 1, 2022.

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116TH CONGRESS } HOUSE OF REPRESENTATIVES { REPT. 116-615
2d Session } Part 1

BAN SURPRISE BILLING ACT

DECEMBER 2, 2020.—Ordered to be printed

Mr. SCOTT of Virginia, from the Committee on Education and Labor, submitted the following

R E P O R T

[To accompany H.R. 5800]

[Including cost estimate of the Congressional Budget Office]

The Committee on Education and Labor, to whom was referred the bill (H.R. 5800) to end surprise medical billing and increase transparency in health coverage, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the “Ban Surprise Billing Act”.

SEC. 2. PREVENTING SURPRISE MEDICAL BILLS.

(a) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—Section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a) is amended—

(1) by amending subsection (b) to read as follows:

“(b) COVERAGE OF EMERGENCY SERVICES.—

“(1) IN GENERAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)), the plan or issuer shall cover emergency services (as defined in paragraph (3)(C))—

“(A) without the need for any prior authorization determination;

“(B) whether the health care provider furnishing such services is a participating provider or a participating emergency facility, as applicable, with respect to such services;

“(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee by a nonparticipating provider or a nonparticipating emergency facility—

“(i) such services will be provided without imposing any requirement under the plan or coverage for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities with respect to such plan or coverage, respectively;

“(ii) the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;

“(iii) such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to the recognized amount (as defined in paragraph (3)(H)) for such services, plan or coverage, and year;

“(iv) the group health plan or health insurance issuer, respectively, pays to such provider or facility, respectively the amount by which the recognized amount for such services and year involved exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)) and year; and

“(v) any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage, respectively (and such in-network deductible and out-of-pocket maximums shall be applied) in the same manner as if such cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility; and

“(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2704 of this Act, including as incorporated pursuant to section 715 of the Employee Retirement Income Security Act of 1974 and section 9815 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

“(2) AUDIT PROCESS AND REGULATIONS FOR MEDIAN CONTRACTED RATES.—

“(A) AUDIT PROCESS.—

“(i) IN GENERAL.—Not later than July 1, 2021, the Secretary, in consultation with appropriate State agencies and the Secretary of Labor and the Secretary of the Treasury, shall establish through rulemaking a process, in accordance with clause (ii), under which group health plans and health insurance issuers offering health insurance coverage in the group or individual market are audited by the Secretary or applicable State authority to ensure that—

“(I) such plans and coverage are in compliance with the requirement of applying a median contracted rate under this section; and

“(II) such median contracted rate so applied satisfies the definition under paragraph (3)(E) with respect to the year involved, including with respect to a group health plan or health insurance issuer described in clause (ii) of such paragraph (3)(E).

“(ii) AUDIT SAMPLES.—Under the process established pursuant to clause (i), the Secretary—

“(I) shall conduct audits described in such clause, with respect to a year (beginning with 2022), of a sample with respect to such year of claims data from not more than 25 group health plans and health insurance issuers offering health insurance coverage in the group or individual market; and

“(II) may audit any group health plan or health insurance issuer offering health insurance coverage in the group or individual market if the Secretary has received any complaint about such plan or coverage, respectively, that involves the compliance of the plan or coverage, respectively, with either of the requirements described in subclauses (I) and (II) of such clause.

“(iii) REPORTS.—Beginning for 2022, the Secretary shall annually submit to Congress a report on the number of plans and issuers with respect to which audits were conducted during such year pursuant to this subparagraph.

“(B) RULEMAKING.—Not later than July 1, 2021, the Secretary, in consultation with the Secretary of Labor and the Secretary of the Treasury, shall establish through rulemaking—

“(i) the methodology the group health plan or health insurance issuer offering health insurance coverage in the group or individual market shall use to determine the median contracted rate, differentiating by line of business;

“(ii) the information such plan or issuer, respectively, shall share with the nonparticipating provider or nonparticipating facility, as applicable, when making such a determination;

“(iii) the geographic regions applied for purposes of this subparagraph, taking into account access to items and services in rural and underserved areas, including health professional shortage areas, as defined in section 332; and

“(iv) a process to receive complaints of violations of the requirements described in subclauses (I) and (II) of subparagraph (A)(i) by group health plans and health insurance issuers offering health insurance coverage in the group or individual market.

Such rulemaking shall take into account payments that are made by such plan or issuer, respectively, that are not on a fee-for-service basis. Such methodology may account for relevant payment adjustments that take into account quality or facility type (including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities. In carrying out clause (iii), the Secretary shall consult with the National Association of Insurance Commissioners to establish the geographic regions under such clause and shall periodically update such regions, as appropriate.

“(3) DEFINITIONS.—In this part:

“(A) EMERGENCY DEPARTMENT OF A HOSPITAL.—The term ‘emergency department of a hospital’ includes a hospital outpatient department that provides emergency services.

“(B) EMERGENCY MEDICAL CONDITION.—The term ‘emergency medical condition’ means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

“(C) EMERGENCY SERVICES.—

“(i) IN GENERAL.—The term ‘emergency services’, with respect to an emergency medical condition, means—

“(I) a medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

“(II) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of such Act, or as would

be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient.

“(ii) INCLUSION OF CERTAIN SERVICES OUTSIDE OF EMERGENCY DEPARTMENT.—

“(I) IN GENERAL.—For purposes of this subsection and section 2799A–1, in the case of an individual enrolled in a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market who is furnished services described in clause (i) by a participating or nonparticipating provider or a participating or nonparticipating emergency facility to stabilize such individual with respect to an emergency medical condition, the term ‘emergency services’ shall include, unless each of the conditions described in subclause (II) are met, in addition to the items and services described in clause (i), items and services for which benefits are provided or covered under the plan or coverage, respectively, furnished by a nonparticipating provider or nonparticipating facility, regardless of the department of the hospital in which such individual is furnished such items or services, if, after such stabilization but during such visit in which such individual is so stabilized, the provider or facility determines that such items or services are needed.

“(II) CONDITIONS.—For purposes of subclause (I), the conditions described in this subclause, with respect to an individual who is stabilized and furnished additional items and services described in subclause (I) after such stabilization by a provider or facility described in subclause (I), are the following:

“(aa) Such a provider or facility determines such individual is able to travel using nonmedical transportation or non-emergency medical transportation.

“(bb) Such provider furnishing such additional items and services satisfies the notice and consent criteria of section 2799A–2(d) with respect to such items and services.

“(cc) Such an individual is in a condition to receive (as determined in accordance with guidance issued by the Secretary) the information described in section 2799A–2 and to provide informed consent under such section, in accordance with applicable State law.

“(D) INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT.—The term ‘independent freestanding emergency department’ means a facility that—

“(i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

“(ii) provides any emergency services (as defined in subparagraph (C)).

“(E) MEDIAN CONTRACTED RATE.—

“(i) IN GENERAL.—The term ‘median contracted rate’ means, subject to clauses (ii) and (iii), with respect to a sponsor of a group health plan and health insurance issuer offering health insurance coverage in the group or individual market—

“(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan or issuer, respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same line of business as the plan or coverage) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan or issuer, respectively) under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2)(B), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

“(II) for an item or service furnished during 2023 or a subsequent year, the median contracted rate determined under this clause for such an item or service furnished in the previous year, increased by the percentage increase in the consumer price index for all

urban consumers (United States city average) over such previous year.

“(ii) NEW PLANS AND COVERAGE.—The term ‘median contracted rate’ means, with respect to a sponsor of a group health plan or health insurance issuer offering health insurance coverage in the group or individual market in a geographic region in which such sponsor or issuer, respectively, did not offer any group health plan or health insurance coverage during 2019—

“(I) for the first year in which such group health plan or health insurance coverage, respectively, is offered in such region, a rate (determined in accordance with a methodology established by the Secretary) for items and services that are covered by such plan and furnished during such first year; and

“(II) for each subsequent year such group health plan or health insurance coverage, respectively, is offered in such region, the median contracted rate determined under this clause for such items and services furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

“(iii) INSUFFICIENT INFORMATION; NEWLY COVERED ITEMS AND SERVICES.—In the case of a sponsor of a group health plan or health insurance issuer offering health insurance coverage in the group or individual market that does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019 (or, in the case of a newly covered item or service (as defined in clause (iv)(III)), in the first coverage year (as defined in clause (iv)(I)) for such item or service with respect to such plan or coverage) for an item or service (including with respect to provider type, or amount, of claims for items or services (as determined by the Secretary) provided in a particular geographic region (other than in a case with respect to which clause (ii) applies)) the term ‘median contracted rate’—

“(I) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or service with respect to such plan or coverage), means such rate for such item or service determined by the sponsor or issuer, respectively, through use of any database that is determined, in accordance with rulemaking described in paragraph (2)(B), to not have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region (such as a State all-payer claims database);

“(II) for an item or service furnished in a subsequent year (before the first sufficient information year (as defined in clause (iv)(II)) for such item or service with respect to such plan or coverage), means the rate determined under subclause (I) or this subclause, as applicable, for such item or service for the year previous to such subsequent year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

“(III) for an item or service furnished in the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given the term median contracted rate in clause (i)(I), except that in applying such clause to such item or service, the reference to ‘furnished during 2022’ shall be treated as a reference to furnished during such first sufficient information year, the reference to ‘in 2019’ shall be treated as a reference to such sufficient information year, and the increase described in such clause shall not be applied; and

“(IV) for an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given such term in clause (i)(II), except that in applying such clause to such item or service, the reference to ‘furnished during 2023 or a subsequent year’ shall be treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

“(iv) DEFINITIONS.—For purposes of this subparagraph:

“(I) FIRST COVERAGE YEAR.—The term ‘first coverage year’ means, with respect to a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual

market and an item or service for which coverage is not offered in 2019 under such plan or coverage, the first year after 2019 for which coverage for such item or service is offered under such plan or health insurance coverage.

“(II) FIRST SUFFICIENT INFORMATION YEAR.—The term ‘first sufficient information year’ means, with respect to a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market—

“(aa) in the case of an item or service for which the plan or coverage does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019, the first year subsequent to 2022 for which the sponsor or issuer has such sufficient information to calculate the median of such contracted rates in the year previous to such first subsequent year; and

“(bb) in the case of a newly covered item or service, the first year subsequent to the first coverage year for such item or service with respect to such plan or coverage for which the sponsor or issuer has sufficient information to calculate the median of the contracted rates described in clause (i)(I) in the year previous to such first subsequent year.

“(III) NEWLY COVERED ITEM OR SERVICE.—The term ‘newly covered item or service’ means, with respect to a group health plan or health insurance issuer offering health insurance coverage in the group or individual market, an item or service for which coverage was not offered in 2019 under such plan or coverage, but is offered under such plan or coverage in a year after 2019.

“(F) NONPARTICIPATING EMERGENCY FACILITY; PARTICIPATING EMERGENCY FACILITY.—

“(i) NONPARTICIPATING EMERGENCY FACILITY.—The term ‘nonparticipating emergency facility’ means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship directly or indirectly with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

“(ii) PARTICIPATING EMERGENCY FACILITY.—The term ‘participating emergency facility’ means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship directly or indirectly with the plan or issuer, respectively, with respect to the furnishing of such an item or service at such facility.

“(G) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

“(i) NONPARTICIPATING PROVIDER.—The term ‘nonparticipating provider’ means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, a physician or other health care provider who is acting within the scope of practice of that provider’s license or certification under applicable State law and who does not have a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

“(ii) PARTICIPATING PROVIDER.—The term ‘participating provider’ means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, a physician or other health care provider who is acting within the scope of practice of that provider’s license or certification under applicable State law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

“(H) RECOGNIZED AMOUNT.—The term ‘recognized amount’ means, with respect to an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market—

“(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such

plan, coverage, or issuer, respectively, such a nonparticipating provider or emergency facility, and such an item or service, the amount determined in accordance with such law;

“(ii) subject to clause (iii), in the case of such item or service furnished in a State that does not have in effect a specified State law, with respect to such plan, coverage, or issuer, respectively, such a nonparticipating provider or emergency facility, and such an item or service, an amount that is the median contracted rate (as defined in subparagraph (E)) for such year and determined in accordance with rule-making described in paragraph (2)(B)) for such item or service; or

“(iii) in the case of such item or service furnished in a State with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the State approves under such system for such item or service so furnished.

“(I) SPECIFIED STATE LAW.—The term ‘specified State law’ means, with respect to a State, an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, a State law that provides for a method for determining the amount of payment that is required to be covered by such a plan, coverage, or issuer, respectively (to the extent such State law applies to such plan, coverage, or issuer, subject to section 514 of the Employee Retirement Income Security Act of 1974) in the case of a participant, beneficiary, or enrollee covered under such plan or coverage and receiving such item or service from such a nonparticipating provider or emergency facility.

“(J) STABILIZE.—The term ‘to stabilize’, with respect to an emergency medical condition (as defined in subparagraph (B)), has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).”; and

(2) by adding at the end the following new subsections:

“(e) COVERAGE OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

“(1) IN GENERAL.—In the case of items or services (other than emergency services to which subsection (b) applies) for which any benefits are provided or covered by a group health plan or health insurance issuer offering health insurance coverage in the group or individual market furnished to a participant, beneficiary, or enrollee of such plan or coverage by a nonparticipating provider (as defined in subsection (b)(3)(G)(i)) (and who, with respect to such items and services, has not satisfied the notice and consent criteria of section 2799A–2(d)) with respect to a visit (as defined by the Secretary in accordance with paragraph (2)(B)) at a participating health care facility (as defined in paragraph (2)(A)), with respect to such plan or coverage, respectively, the plan or coverage, respectively—

“(A) shall not impose on such participant, beneficiary, or enrollee a cost-sharing amount (expressed as a copayment amount or coinsurance rate) for such items and services so furnished that is greater than the cost-sharing amount that would apply under such plan or coverage, respectively, had such items or services been furnished by a participating provider (as defined in subsection (b)(3)(G)(ii));

“(B) shall calculate such cost-sharing amount as if the total amount that would have been charged for such items and services by such participating provider were equal to the recognized amount (as defined in subsection (b)(3)(H)) for such items and services, plan or coverage, and year;

“(C) shall pay to such provider furnishing such items and services to such participant, beneficiary, or enrollee the amount by which the recognized amount (as defined in subsection (b)(3)(H)) for such items and services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such items and services (as determined in accordance with subparagraphs (A) and (B)); and

“(D) shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the plan or coverage, respectively, any cost-sharing payments made by the participant, beneficiary, or enrollee (and such in-network deductible and out-of-pocket maximums shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

“(2) DEFINITIONS.—In this section:

“(A) PARTICIPATING HEALTH CARE FACILITY.—

“(i) IN GENERAL.—The term ‘participating health care facility’ means, with respect to an item or service and a group health plan or health insurance issuer offering health insurance coverage in the group or individual market, a health care facility described in clause (ii) that has a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such an item or service at the facility.

“(ii) HEALTH CARE FACILITY DESCRIBED.—A health care facility described in this clause, with respect to a group health plan or health insurance coverage offered in the group or individual market, is each of the following:

“(I) A hospital (as defined in 1861(e) of the Social Security Act).

“(II) A hospital outpatient department.

“(III) A critical access hospital (as defined in section 1861(mm) of such Act).

“(IV) An ambulatory surgical center (as defined in section 1833(i)(1)(A) of such Act).

“(V) Any other facility that provides items or services for which coverage is provided under the plan or coverage, respectively.

“(B) VISIT.—The term ‘visit’ shall, with respect to items and services furnished to an individual at a participating health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility.

“(f) AIR AMBULANCE SERVICES.—

“(1) IN GENERAL.—In the case of a participant, beneficiary, or enrollee in a group health plan or health insurance coverage offered in the group or individual market who receives air ambulance services from a nonparticipating provider (as defined in subsection (b)(3)(G)) with respect to such plan or coverage, if such services would be covered if provided by a participating provider (as defined in such section) with respect to such plan or coverage—

“(A) the cost-sharing requirement (expressed as a copayment amount, co-insurance rate, or deductible) with respect to such services shall be the same requirement that would apply if such services were provided by such a participating provider, and any coinsurance or deductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

“(B) such cost-sharing amounts shall be counted toward the in-network deductible and in-network out-of-pocket maximum amount under the plan or coverage for the plan year (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider; and

“(C) the plan or coverage shall pay to such provider furnishing such services to such participant, beneficiary, or enrollee the amount by which the recognized amount (as defined in and determined pursuant to subsection (b)(3)(H)(ii)) for such services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such services (as determined in accordance with subparagraphs (A) and (B)).

“(2) AIR AMBULANCE SERVICE DEFINED.—For purposes of this section, the term ‘air ambulance service’ means medical transport by helicopter or airplane for patients.

“(g) CERTAIN ACCESS FEES TO CERTAIN DATABASES.—In the case of a sponsor of a group health plan or health insurance issuer offering health insurance coverage in the group or individual market that, pursuant to subsection (b)(3)(E)(iii), uses a database described in such subsection to determine a rate to apply under such subsection for an item or service by reason of having insufficient information described in such subsection with respect to such item or service, such sponsor or issuer shall cover the cost for access to such database.”.

(b) ERISA AMENDMENTS.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following:

“SEC. 716. CONSUMER PROTECTIONS.

“(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If a group health plan or health insurance issuer offering group health insurance coverage requires or provides for designation by a participant or beneficiary of a participating primary care provider,

then the plan or issuer shall permit each participant or beneficiary to designate any participating primary care provider who is available to accept such individual.

“(b) COVERAGE OF EMERGENCY SERVICES.—

“(1) IN GENERAL.—If a group health plan, or a health insurance issuer offering group health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)), the plan or issuer shall cover emergency services (as defined in paragraph (3)(C))—

“(A) without the need for any prior authorization determination;

“(B) whether the health care provider furnishing such services is a participating provider or a participating emergency facility, as applicable, with respect to such services;

“(C) in a manner so that, if such services are provided to a participant or beneficiary by a nonparticipating provider or a nonparticipating emergency facility—

“(i) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities with respect to such plan or coverage, respectively;

“(ii) the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;

“(iii) such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to the recognized amount (as defined in paragraph (3)(H)) for such services, plan or coverage, and year;

“(iv) the group health plan or health insurance issuer, respectively, pays to such provider or facility, respectively, the amount by which the recognized amount for such services and year involved exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)) and year; and

“(v) any cost-sharing payments made by the participant or beneficiary with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage, respectively (and such in-network deductible and out-of-pocket maximums shall be applied) in the same manner as if such cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility; and

“(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2704 of the Public Health Service Act, including as incorporated pursuant to section 715 of this Act and section 9815 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

“(2) AUDIT PROCESS AND REGULATIONS FOR MEDIAN CONTRACTED RATES.—

“(A) AUDIT PROCESS.—

“(i) IN GENERAL.—Not later than July 1, 2021, the Secretary, in consultation with appropriate State agencies and the Secretary of Health and Human Services and the Secretary of the Treasury, shall establish through rulemaking a process, in accordance with clause (ii), under which group health plans and health insurance issuers offering health insurance coverage in the group market are audited by the Secretary or applicable State authority to ensure that—

“(I) such plans and coverage are in compliance with the requirement of applying a median contracted rate under this section; and

“(II) such median contracted rate so applied satisfies the definition under paragraph (3)(E) with respect to the year involved, including with respect to a group health plan or health insurance issuer described in clause (ii) of such paragraph (3)(E).

“(ii) AUDIT SAMPLES.—Under the process established pursuant to clause (i), the Secretary—

“(I) shall conduct audits described in such clause, with respect to a year (beginning with 2022), of a sample with respect to such year of claims data from not more than 25 group health plans and

health insurance issuers offering health insurance coverage in the group market; and

“(II) may audit any group health plan or health insurance issuer offering health insurance coverage in the group market if the Secretary has received any complaint about such plan or coverage, respectively, that involves the compliance of the plan or coverage, respectively, with either of the requirements described in subclauses (I) and (II) of such clause.

“(iii) REPORTS.—Beginning for 2022, the Secretary shall annually submit to Congress information on the number of plans and issuers with respect to which audits were conducted during such year pursuant to this subparagraph.

“(B) RULEMAKING.—Not later than July 1, 2021, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Health and Human Services, shall establish through rulemaking—

“(i) the methodology the group health plan or health insurance issuer offering health insurance coverage in the group market shall use to determine the median contracted rate, differentiating by line of business;

“(ii) the information such plan or issuer, respectively, shall share with the nonparticipating provider or nonparticipating facility, as applicable, when making such a determination;

“(iii) the geographic regions applied for purposes of this subparagraph, taking into account access to items and services in rural and underserved areas, including health professional shortage areas, as defined in section 332 of the Public Health Service Act; and

“(iv) a process to receive complaints of violations of the requirements described in subclauses (I) and (II) of paragraph (2)(A)(i) by group health plans and health insurance issuers offering health insurance coverage in the group market.

Such rulemaking shall take into account payments that are made by such plan or issuer, respectively, that are not on a fee-for-service basis. Such methodology may account for relevant payment adjustments that take into account quality or facility type (including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities. In carrying out clause (iii), the Secretary shall consult with the National Association of Insurance Commissioners to establish the geographic regions under such clause and shall periodically update such regions, as appropriate.

“(3) DEFINITIONS.—In this section:

“(A) EMERGENCY DEPARTMENT OF A HOSPITAL.—The term ‘emergency department of a hospital’ includes a hospital outpatient department that provides emergency services.

“(B) EMERGENCY MEDICAL CONDITION.—The term ‘emergency medical condition’ means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

“(C) EMERGENCY SERVICES.—

“(i) IN GENERAL.—The term ‘emergency services’, with respect to an emergency medical condition, means—

“(I) a medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

“(II) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of such Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient.

“(ii) INCLUSION OF CERTAIN SERVICES OUTSIDE OF EMERGENCY DEPARTMENT.—

“(I) IN GENERAL.—For purposes of this subsection and section 2799A–1, in the case of an individual enrolled in a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market who is furnished services described in clause (i) by a participating or nonparticipating provider or a participating or nonparticipating emergency facility to stabilize such individual with respect to an emergency medical condition, the term ‘emergency services’ shall include, unless each of the conditions described in subclause (II) are met, in addition to the items and services described in clause (i), items and services for which benefits are provided or covered under the plan or coverage, respectively, furnished by a nonparticipating provider or nonparticipating facility, regardless of the department of the hospital in which such individual is furnished such items or services, if, after such stabilization but during such visit in which such individual is so stabilized, the provider or facility determines that such items or services are needed.

“(II) CONDITIONS.—For purposes of subclause (I), the conditions described in this subclause, with respect to an individual who is stabilized and furnished additional items and services described in subclause (I) after such stabilization by a provider or facility described in subclause (I), are the following:

“(aa) Such a provider or facility determines such individual is able to travel using nonmedical transportation or non-emergency medical transportation.

“(bb) Such provider furnishing such additional items and services satisfies the notice and consent criteria of section 2799A–2(d) of the Public Health Service Act with respect to such items and services.

“(cc) Such an individual is in a condition to receive (as determined in accordance with guidance issued by the Secretary) the information described in section 2799A–2 of the Public Health Service Act and to provide informed consent under such section, in accordance with applicable State law.

“(D) INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT.—The term ‘independent freestanding emergency department’ means a facility that—

“(i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

“(ii) provides any emergency services (as defined in subparagraph (C)).

“(E) MEDIAN CONTRACTED RATE.—

“(i) IN GENERAL.—The term ‘median contracted rate’ means, subject to clauses (ii) and (iii), with respect to a sponsor of a group health plan and health insurance issuer offering health insurance coverage in the group market—

“(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan or issuer, respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same line of business as the plan or coverage) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by such plan or such issuer, respectively) under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2)(B), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

“(II) for an item or service furnished during 2023 or a subsequent year, the median contracted rate determined under this clause for such an item or service furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

“(ii) NEW PLANS AND COVERAGE.—The term ‘median contracted rate’ means, with respect to a sponsor of a group health plan or health insurance issuer offering health insurance coverage in the group market in a geographic region in which such sponsor or issuer, respectively, did not offer any group health plan or health insurance coverage during 2019—

“(I) for the first year in which such group health plan or health insurance coverage, respectively, is offered in such region, a rate (determined in accordance with a methodology established by the Secretary) for items and services that are covered by such plan and furnished during such first year; and

“(II) for each subsequent year such group health plan or health insurance coverage, respectively, is offered in such region, the median contracted rate determined under this clause for such items and services furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

“(iii) INSUFFICIENT INFORMATION; NEWLY COVERED ITEMS AND SERVICES.—In the case of a sponsor of a group health plan or health insurance issuer offering health insurance coverage in the group market that does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019 (or, in the case of a newly covered item or service (as defined in clause (iv)(III)), in the first coverage year (as defined in clause (iv)(I)) for such item or service with respect to such plan or coverage) for an item or service (including with respect to provider type, or amount, of claims for items or services (as determined by the Secretary) provided in a particular geographic region (other than in a case with respect to which clause (ii) applies)) the term ‘median contracted rate’—

“(I) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or service with respect to such plan or coverage), means such rate for such item or service determined by the sponsor or issuer, respectively, through use of any database that is determined, in accordance with rulemaking described in paragraph (2)(B), to not have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region (such as a State all-payer claims database);

“(II) for an item or service furnished in a subsequent year (before the first sufficient information year (as defined in clause (iv)(II)) for such item or service with respect to such plan or coverage), means the rate determined under subclause (I) or this subclause, as applicable, for such item or service for the year previous to such subsequent year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

“(III) for an item or service furnished in the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given the term median contracted rate in clause (i)(I), except that in applying such clause to such item or service, the reference to ‘furnished during 2022’ shall be treated as a reference to furnished during such first sufficient information year, the reference to ‘in 2019’ shall be treated as a reference to such sufficient information year, and the increase described in such clause shall not be applied; and

“(IV) for an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given such term in clause (i)(II), except that in applying such clause to such item or service, the reference to ‘furnished during 2023 or a subsequent year’ shall be treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

“(iv) DEFINITIONS.—For purposes of this subparagraph:

“(I) FIRST COVERAGE YEAR.—The term ‘first coverage year’ means, with respect to a group health plan or health insurance coverage offered by a health insurance issuer in the group market and an item or service for which coverage is not offered in 2019 under such plan or coverage, the first year after 2019 for which coverage for

such item or service is offered under such plan or health insurance coverage.

“(II) FIRST SUFFICIENT INFORMATION YEAR.—The term ‘first sufficient information year’ means, with respect to a group health plan or health insurance coverage offered by a health insurance issuer in the group market—

“(aa) in the case of an item or service for which the plan or coverage does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019, the first year subsequent to 2022 for which such sponsor or issuer has such sufficient information to calculate the median of such contracted rates in the year previous to such first subsequent year; and

“(bb) in the case of a newly covered item or service, the first year subsequent to the first coverage year for such item or service with respect to such plan or coverage for which the sponsor or issuer has sufficient information to calculate the median of the contracted rates described in clause (i)(I) in the year previous to such first subsequent year.

“(III) NEWLY COVERED ITEM OR SERVICE.—The term ‘newly covered item or service’ means, with respect to a group health plan or health insurance issuer offering health insurance coverage in the group market, an item or service for which coverage was not offered in 2019 under such plan or coverage, but is offered under such plan or coverage in a year after 2019.

“(F) NONPARTICIPATING EMERGENCY FACILITY; PARTICIPATING EMERGENCY FACILITY.—

“(i) NONPARTICIPATING EMERGENCY FACILITY.—The term ‘nonparticipating emergency facility’ means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group market, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship directly or indirectly with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

“(ii) PARTICIPATING EMERGENCY FACILITY.—The term ‘participating emergency facility’ means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group market, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship directly or indirectly with the plan or issuer, respectively, with respect to the furnishing of such an item or service at such facility.

“(G) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

“(i) NONPARTICIPATING PROVIDER.—The term ‘nonparticipating provider’ means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group market, a physician or other health care provider who is acting within the scope of practice of that provider’s license or certification under applicable State law and who does not have a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

“(ii) PARTICIPATING PROVIDER.—The term ‘participating provider’ means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group market, a physician or other health care provider who is acting within the scope of practice of that provider’s license or certification under applicable State law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

“(H) RECOGNIZED AMOUNT.—The term ‘recognized amount’ means, with respect to an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan or health insurance coverage offered by a health insurance issuer in the group market—

“(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan, coverage, or issuer, respectively, such a nonparticipating provider or emergency facility, and such an item or service, the amount determined in accordance with such law;

“(ii) subject to clause (iii), in the case of such item or service furnished in a State that does not have in effect a specified State law, with respect to such plan, coverage, or issuer, respectively, such a nonparticipating provider or emergency facility, and such an item or service, an amount that is the median contracted rate (as defined in subparagraph (E)) for such year and determined in accordance with rule-making described in paragraph (2)(B)) for such item or service; or

“(iii) in the case of such item or service furnished in a State with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the State approves under such system for such item or service so furnished.

“(I) SPECIFIED STATE LAW.—The term ‘specified State law’ means, with respect to a State, an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan or health insurance coverage offered by a health insurance issuer in the group market, a State law that provides for a method for determining the amount of payment that is required to be covered by such a plan, coverage, or issuer, respectively (to the extent such State law applies to such plan, coverage, or issuer, subject to section 514) in the case of a participant or beneficiary covered under such plan or coverage and receiving such item or service from such a nonparticipating provider or emergency facility.

“(J) STABILIZE.—The term ‘to stabilize’, with respect to an emergency medical condition (as defined in subparagraph (B)), has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

“(c) ACCESS TO PEDIATRIC CARE.—

“(1) PEDIATRIC CARE.—In the case of a person who has a child who is a participant or beneficiary under a group health plan, or health insurance coverage offered by a health insurance issuer in the group market, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child’s primary care provider if such provider participates in the network of the plan or issuer.

“(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

“(d) PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.—

“(1) GENERAL RIGHTS.—

“(A) DIRECT ACCESS.—A group health plan, or health insurance issuer offering group health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant or beneficiary who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan’s or issuer’s policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

“(B) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan or health insurance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

“(2) APPLICATION OF PARAGRAPH.—A group health plan, or health insurance issuer offering group health insurance coverage, described in this paragraph is a group health plan or coverage that—

“(A) provides coverage for obstetric or gynecologic care; and

“(B) requires the designation by a participant or beneficiary of a participating primary care provider.

“(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to—

“(A) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

“(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the pri-

mary care health care professional or the plan or issuer of treatment decisions.

“(e) COVERAGE OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

“(1) IN GENERAL.—In the case of items or services (other than emergency services to which subsection (b) applies) for which any benefits are provided or covered by a group health plan or health insurance issuer offering health insurance coverage in the group market furnished to a participant or beneficiary of such plan or coverage by a nonparticipating provider (as defined in subsection (b)(3)(G)(i)) (and who, with respect to such items and services, has not satisfied the notice and consent criteria of section 2799A–2(d) of the Public Health Service Act) with respect to a visit (as defined by the Secretary in accordance with paragraph (2)(B)) at a participating health care facility (as defined in paragraph (2)(A)), with respect to such plan or coverage, respectively, the plan or coverage, respectively—

“(A) shall not impose on such participant or beneficiary a cost-sharing amount (expressed as a copayment amount or coinsurance rate) for such items and services so furnished that is greater than the cost-sharing amount that would apply under such plan or coverage, respectively, had such items or services been furnished by a participating provider (as defined in subsection (b)(3)(G)(ii));

“(B) shall calculate such cost-sharing amount as if the total amount that would have been charged for such items and services by such participating provider were equal to the recognized amount (as defined in subsection (b)(3)(H)) for such items and services, plan or coverage, and year;

“(C) shall pay to such provider furnishing such items and services to such participant or beneficiary the amount by which the recognized amount (as defined in subsection (b)(3)(H)) for such items and services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such items and services (as determined in accordance with subparagraphs (A) and (B)); and

“(D) shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the plan or coverage, respectively, any cost-sharing payments made by the participant or beneficiary (and such in-network deductible and out-of-pocket maximums shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

“(2) DEFINITIONS.—In this section:

“(A) PARTICIPATING HEALTH CARE FACILITY.—

“(i) IN GENERAL.—The term ‘participating health care facility’ means, with respect to an item or service and a group health plan or health insurance issuer offering health insurance coverage in the group market, a health care facility described in clause (ii) that has a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such an item or service at the facility.

“(ii) HEALTH CARE FACILITY DESCRIBED.—A health care facility described in this clause, with respect to a group health plan or health insurance coverage offered in the group market, is each of the following:

“(I) A hospital (as defined in 1861(e) of the Social Security Act).

“(II) A hospital outpatient department.

“(III) A critical access hospital (as defined in section 1861(mm) of such Act).

“(IV) An ambulatory surgical center (as defined in section 1833(i)(1)(A) of such Act).

“(V) Any other facility that provides items or services for which coverage is provided under the plan or coverage, respectively.

“(B) VISIT.—The term ‘visit’ shall, with respect to items and services furnished to an individual at a participating health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility.

“(f) AIR AMBULANCE SERVICES.—

“(1) IN GENERAL.—In the case of a participant or beneficiary in a group health plan or health insurance coverage offered in the group market who receives air ambulance services from a nonparticipating provider (as defined in subsection (b)(3)(G)) with respect to such plan or coverage, if such services would be cov-

ered if provided by a participating provider (as defined in such subsection) with respect to such plan or coverage—

“(A) the cost-sharing requirement (expressed as a copayment amount, coinsurance rate, or deductible) with respect to such services shall be the same requirement that would apply if such services were provided by such a participating provider, and any coinsurance or deductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

“(B) such cost-sharing amounts shall be counted toward the in-network deductible and in-network out-of-pocket maximum amount under the plan or coverage for the plan year (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider; and

“(C) the plan or coverage shall pay to such provider furnishing such services to such participant or beneficiary the amount by which the recognized amount (as defined in and determined pursuant to subsection (b)(3)(H)(ii)) for such services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such services (as determined in accordance with subparagraphs (A) and (B)).

“(2) AIR AMBULANCE SERVICE DEFINED.—For purposes of this section, the term ‘air ambulance service’ means medical transport by helicopter or airplane for patients.

“(g) CERTAIN ACCESS FEES TO CERTAIN DATABASES.—In the case of a sponsor of a group health plan or health insurance issuer offering health insurance coverage in the group market that, pursuant to subsection (b)(3)(E)(iii), uses a database described in such subsection to determine a rate to apply under such subsection for an item or service by reason of having insufficient information described in such subsection with respect to such item or service, such sponsor or issuer shall cover the cost for access to such database.”.

(2) CLERICAL AMENDMENT.—The table of contents of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 714 the following:

“Sec. 715. Additional market reforms.
“Sec. 716. Consumer protections.”.

(c) IRC AMENDMENTS.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

“SEC. 9816. CONSUMER PROTECTIONS.

“(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If a group health plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, then the plan shall permit each participant or beneficiary to designate any participating primary care provider who is available to accept such individual.

“(b) COVERAGE OF EMERGENCY SERVICES.—

“(1) IN GENERAL.—If a group health plan provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)), the plan shall cover emergency services (as defined in paragraph (3)(C))—

“(A) without the need for any prior authorization determination;

“(B) whether the health care provider furnishing such services is a participating provider or a participating emergency facility, as applicable, with respect to such services;

“(C) in a manner so that, if such services are provided to a participant or beneficiary by a nonparticipating provider or a nonparticipating emergency facility—

“(i) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities with respect to such plan;

“(ii) the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;

“(iii) such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such partici-

participating provider or participating emergency facility were equal to the recognized amount (as defined in paragraph (3)(H)) for such services, plan, and year;

“(iv) the group health plan pays to such provider or facility, respectively, the amount by which the recognized amount for such services and year involved exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)) and year; and

“(v) any cost-sharing payments made by the participant or beneficiary with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan (and such in-network deductible and out-of-pocket maximums shall be applied) in the same manner as if such cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility; and

“(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2704 of this Act, including as incorporated pursuant to section 715 of the Employee Retirement Income Security Act of 1974 and section 9815 of this Act, and other than applicable cost-sharing).

“(2) AUDIT PROCESS AND REGULATIONS FOR MEDIAN CONTRACTED RATES.—

“(A) AUDIT PROCESS.—

“(i) IN GENERAL.—Not later than July 1, 2021, the Secretary, in consultation with appropriate State agencies and the Secretary of Health and Human Services and the Secretary of Labor, shall establish through rulemaking a process, in accordance with clause (ii), under which group health plans are audited by the Secretary or applicable State authority to ensure that—

“(I) such plans are in compliance with the requirement of applying a median contracted rate under this section; and

“(II) such median contracted rate so applied satisfies the definition under paragraph (3)(E) with respect to the year involved, including with respect to a group health plan described in clause (ii) of such paragraph (3)(E).

“(ii) AUDIT SAMPLES.—Under the process established pursuant to clause (i), the Secretary—

“(I) shall conduct audits described in such clause, with respect to a year (beginning with 2022), of a sample with respect to such year of claims data from not more than 25 group health plans; and

“(II) may audit any group health plan if the Secretary has received any complaint about such plan or coverage, respectively, that involves the compliance of the plan with either of the requirements described in subclauses (I) and (II) of such clause.

“(iii) REPORTS.—Beginning for 2022, the Secretary shall annually submit to Congress a report on the number of plans and issuers with respect to which audits were conducted during such year pursuant to this subparagraph.

“(B) RULEMAKING.—Not later than July 1, 2021, the Secretary, in consultation with the Secretary of Labor and the Secretary of Health and Human Services, shall establish through rulemaking—

“(i) the methodology the group health plan shall use to determine the median contracted rate, differentiating by line of business;

“(ii) the information such plan or issuer, respectively, shall share with the nonparticipating provider or nonparticipating facility, as applicable, when making such a determination;

“(iii) the geographic regions applied for purposes of this subparagraph, taking into account access to items and services in rural and underserved areas, including health professional shortage areas, as defined in section 332 of the Public Health Service Act; and

“(iv) a process to receive complaints of violations of the requirements described in subclauses (I) and (II) of paragraph (2)(A)(i) by group health plans.

Such rulemaking shall take into account payments that are made by such plan that are not on a fee-for-service basis. Such methodology may account for relevant payment adjustments that take into account quality or facility type (including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities. In carrying out

clause (iii), the Secretary shall consult with the National Association of Insurance Commissioners to establish the geographic regions under such clause and shall periodically update such regions, as appropriate.

“(3) DEFINITIONS.—In this section:

“(A) EMERGENCY DEPARTMENT OF A HOSPITAL.—The term ‘emergency department of a hospital’ includes a hospital outpatient department that provides emergency services.

“(B) EMERGENCY MEDICAL CONDITION.—The term ‘emergency medical condition’ means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

“(C) EMERGENCY SERVICES.—

“(i) IN GENERAL.—The term ‘emergency services’, with respect to an emergency medical condition, means—

“(I) a medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

“(II) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of such Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient.

“(ii) INCLUSION OF CERTAIN SERVICES OUTSIDE OF EMERGENCY DEPARTMENT.—

“(I) IN GENERAL.—For purposes of this subsection and section 2799A–1, in the case of an individual enrolled in a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market who is furnished services described in clause (i) by a participating or nonparticipating provider or a participating or nonparticipating emergency facility to stabilize such individual with respect to an emergency medical condition, the term ‘emergency services’ shall include, unless each of the conditions described in subclause (II) are met, in addition to the items and services described in clause (i), items and services for which benefits are provided or covered under the plan or coverage, respectively, furnished by a nonparticipating provider or nonparticipating facility, regardless of the department of the hospital in which such individual is furnished such items or services, if, after such stabilization but during such visit in which such individual is so stabilized, the provider or facility determines that such items or services are needed.

“(II) CONDITIONS.—For purposes of subclause (I), the conditions described in this subclause, with respect to an individual who is stabilized and furnished additional items and services described in subclause (I) after such stabilization by a provider or facility described in subclause (I), are the following:

“(aa) Such a provider or facility determines such individual is able to travel using nonmedical transportation or non-emergency medical transportation.

“(bb) Such provider furnishing such additional items and services satisfies the notice and consent criteria of section 2799A–2(d) of the Public Health Service Act with respect to such items and services.

“(cc) Such an individual is in a condition to receive (as determined in accordance with guidance issued by the Secretary) the information described in section 2799A–2 of the Public Health Service Act and to provide informed consent under such section, in accordance with applicable State law.

“(D) INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT.—The term ‘independent freestanding emergency department’ means a facility that—

“(i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

“(ii) provides any emergency services (as defined in subparagraph (C)).

“(E) MEDIAN CONTRACTED RATE.—

“(i) IN GENERAL.—The term ‘median contracted rate’ means, subject to clauses (ii) and (iii), with respect to a sponsor of a group health plan—

“(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan (determined with respect to all such plans of such sponsor that are offered within the same line of business as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan) under such plans on January 31, 2019 for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2)(B), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

“(II) for an item or service furnished during 2023 or a subsequent year, the median contracted rate determined under this clause for such an item or service furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

“(ii) NEW PLANS AND COVERAGE.—The term ‘median contracted rate’ means, with respect to a sponsor of a group health plan in a geographic region in which such sponsor, respectively, did not offer any group health plan or health insurance coverage during 2019—

“(I) for the first year in which such group health plan is offered in such region, a rate (determined in accordance with a methodology established by the Secretary) for items and services that are covered by such plan and furnished during such first year; and

“(II) for each subsequent year such group health plan is offered in such region, the median contracted rate determined under this clause for such items and services furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

“(iii) INSUFFICIENT INFORMATION; NEWLY COVERED ITEMS AND SERVICES.—In the case of a sponsor of a group health plan that does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019 (or, in the case of a newly covered item or service (as defined in clause (iv)(III)), in the first coverage year (as defined in clause (iv)(I)) for such item or service with respect to such plan) for an item or service (including with respect to provider type, or amount, of claims for items or services (as determined by the Secretary) provided in a particular geographic region (other than in a case with respect to which clause (ii) applies)) the term ‘median contracted rate’—

“(I) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or service with respect to such plan), means such rate for such item or service determined by the sponsor through use of any database that is determined, in accordance with rulemaking described in paragraph (2)(B), to not have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region (such as a State all-payer claims database);

“(II) for an item or service furnished in a subsequent year (before the first sufficient information year (as defined in clause (iv)(II)) for such item or service with respect to such plan), means the rate determined under subclause (I) or this subclause, as applicable, for

such item or service for the year previous to such subsequent year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

“(III) for an item or service furnished in the first sufficient information year for such item or service with respect to such plan, has the meaning given the term median contracted rate in clause (i)(I), except that in applying such clause to such item or service, the reference to ‘furnished during 2022’ shall be treated as a reference to furnished during such first sufficient information year, the reference to ‘on January 31, 2019’ shall be treated as a reference to in such sufficient information year, and the increase described in such clause shall not be applied; and

“(IV) for an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan, has the meaning given such term in clause (i)(II), except that in applying such clause to such item or service, the reference to ‘furnished during 2023 or a subsequent year’ shall be treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

“(iv) DEFINITIONS.—For purposes of this subparagraph:

“(I) FIRST COVERAGE YEAR.—The term ‘first coverage year’ means, with respect to a group health plan and an item or service for which coverage is not offered in 2019 under such plan or coverage, the first year after 2019 for which coverage for such item or service is offered under such plan.

“(II) FIRST SUFFICIENT INFORMATION YEAR.—The term ‘first sufficient information year’ means, with respect to a group health plan—

“(aa) in the case of an item or service for which the plan does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019, the first year subsequent to 2022 for which such sponsor has such sufficient information to calculate the median of such contracted rates in the year previous to such first subsequent year; and

“(bb) in the case of a newly covered item or service, the first year subsequent to the first coverage year for such item or service with respect to such plan for which the sponsor has sufficient information to calculate the median of the contracted rates described in clause (i)(I) in the year previous to such first subsequent year.

“(III) NEWLY COVERED ITEM OR SERVICE.—The term ‘newly covered item or service’ means, with respect to a group health plan, an item or service for which coverage was not offered in 2019 under such plan or coverage, but is offered under such plan or coverage in a year after 2019.

“(F) NONPARTICIPATING EMERGENCY FACILITY; PARTICIPATING EMERGENCY FACILITY.—

“(i) NONPARTICIPATING EMERGENCY FACILITY.—The term ‘nonparticipating emergency facility’ means, with respect to an item or service and a group health plan, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship directly or indirectly with the plan for furnishing such item or service under the plan.

“(ii) PARTICIPATING EMERGENCY FACILITY.—The term ‘participating emergency facility’ means, with respect to an item or service and a group health plan, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship directly or indirectly with the plan, with respect to the furnishing of such an item or service at such facility.

“(G) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

“(i) NONPARTICIPATING PROVIDER.—The term ‘nonparticipating provider’ means, with respect to an item or service and a group health plan, a physician or other health care provider who is acting within the scope of practice of that provider’s license or certification under applicable State law and who does not have a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan.

“(ii) PARTICIPATING PROVIDER.—The term ‘participating provider’ means, with respect to an item or service and a group health plan, a physician or other health care provider who is acting within the scope of practice of that provider’s license or certification under applicable State law and who has a contractual relationship with the plan for furnishing such item or service under the plan.

“(H) RECOGNIZED AMOUNT.—The term ‘recognized amount’ means, with respect to an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan—

“(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan; such a nonparticipating provider or emergency facility; and such an item or service, the amount determined in accordance with such law;

“(ii) subject to clause (iii), in the case of such item or service furnished in a State that does not have in effect a specified State law, with respect to such plan; such a nonparticipating provider or emergency facility; and such an item or service, an amount that is the median contracted rate (as defined in subparagraph (E)) for such year and determined in accordance with rulemaking described in paragraph (2)(B)) for such item or service; or

“(iii) in the case of such item or service furnished in a State with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the State approves under such system for such item or service so furnished.

“(I) SPECIFIED STATE LAW.—The term ‘specified State law’ means, with respect to a State, an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan, a State law that provides for a method for determining the amount of payment that is required to be covered by such a plan (to the extent such State law applies to such plan, subject to section 514 of the Employee Retirement Income Security Act of 1974) in the case of a participant or beneficiary covered under such plan and receiving such item or service from such a nonparticipating provider or emergency facility.

“(J) STABILIZE.—The term ‘to stabilize’, with respect to an emergency medical condition (as defined in subparagraph (B)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

“(c) ACCESS TO PEDIATRIC CARE.—

“(1) PEDIATRIC CARE.—In the case of a person who has a child who is a participant or beneficiary under a group health plan, if the plan requires or provides for the designation of a participating primary care provider for the child, the plan shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child’s primary care provider if such provider participates in the network of the plan or issuer.

“(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan with respect to coverage of pediatric care.

“(d) PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.—

“(1) GENERAL RIGHTS.—

“(A) DIRECT ACCESS.—A group health plan described in paragraph (2) may not require authorization or referral by the plan or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant or beneficiary who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan’s policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan.

“(B) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

“(2) APPLICATION OF PARAGRAPH.—A group health plan described in this paragraph is a group health plan that—

“(A) provides coverage for obstetric or gynecologic care; and

“(B) requires the designation by a participant or beneficiary of a participating primary care provider.

“(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to—

“(A) waive any exclusions of coverage under the terms and conditions of the plan with respect to coverage of obstetrical or gynecological care; or

“(B) preclude the group health plan involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan of treatment decisions.

“(e) COVERAGE OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

“(1) IN GENERAL.—In the case of items or services (other than emergency services to which subsection (b) applies) for which any benefits are provided or covered by a group health plan furnished to a participant or beneficiary of such plan by a nonparticipating provider (as defined in subsection (b)(3)(G)(i)) (and who, with respect to such items and services, has not satisfied the notice and consent criteria of section 2799A–2(d) of the Public Health Service Act) with respect to a visit (as defined by the Secretary in accordance with paragraph (2)(B)) at a participating health care facility (as defined in paragraph (2)(A)), with respect to such plan, the plan—

“(A) shall not impose on such participant or beneficiary a cost-sharing amount (expressed as a copayment amount or coinsurance rate) for such items and services so furnished that is greater than the cost-sharing amount that would apply under such plan had such items or services been furnished by a participating provider (as defined in subsection (b)(3)(G)(ii));

“(B) shall calculate such cost-sharing amount as if the total amount that would have been charged for such items and services by such participating provider were equal to the recognized amount (as defined in subsection (b)(3)(H)) for such items and services, plan, and year;

“(C) shall pay to such provider furnishing such items and services to such participant or beneficiary the amount by which the recognized amount (as defined in subsection (b)(3)(H)) for such items and services and year involved exceeds the cost-sharing amount imposed under the plan for such items and services (as determined in accordance with subparagraphs (A) and (B)); and

“(D) shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the plan, any cost-sharing payments made by the participant or beneficiary (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

“(2) DEFINITIONS.—In this section:

“(A) PARTICIPATING HEALTH CARE FACILITY.—

“(i) IN GENERAL.—The term ‘participating health care facility’ means, with respect to an item or service and a group health plan, a health care facility described in clause (ii) that has a contractual relationship with the plan, with respect to the furnishing of such an item or service at the facility.

“(ii) HEALTH CARE FACILITY DESCRIBED.—A health care facility described in this clause, with respect to a group health plan, is each of the following:

“(I) A hospital (as defined in 1861(e) of the Social Security Act).

“(II) A hospital outpatient department.

“(III) A critical access hospital (as defined in section 1861(mm) of such Act).

“(IV) An ambulatory surgical center (as defined in section 1833(i)(1)(A) of such Act).

“(V) Any other facility that provides items or services for which coverage is provided under the plan or coverage, respectively.

“(B) VISIT.—The term ‘visit’ shall, with respect to items and services furnished to an individual at a participating health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility.

“(f) AIR AMBULANCE SERVICES.—

“(1) IN GENERAL.—In the case of a participant or beneficiary in a group health plan who receives air ambulance services from a nonparticipating provider (as defined in subsection (b)(3)(G)) with respect to such plan or coverage, if such services would be covered if provided by a participating provider (as defined in such subsection) with respect to such plan—

“(A) the cost-sharing requirement (expressed as a copayment amount, co-insurance rate, or deductible) with respect to such services shall be the same requirement that would apply if such services were provided by such a participating provider, and any coinsurance or deductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

“(B) such cost-sharing amounts shall be counted toward the in-network deductible and in-network out-of-pocket maximum amount under the plan for the plan year (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider; and

“(C) the plan or coverage shall pay to such provider furnishing such services to such participant or beneficiary the amount by which the recognized amount (as defined in and determined pursuant to subsection (b)(3)(H)(ii)) for such services and year involved exceeds the cost-sharing amount imposed under the plan for such services (as determined in accordance with subparagraphs (A) and (B)).

“(2) AIR AMBULANCE SERVICE DEFINED.—For purposes of this section, the term ‘air ambulance service’ means medical transport by helicopter or airplane for patients.

“(g) CERTAIN ACCESS FEES TO CERTAIN DATABASES.—In the case of a sponsor of a group health plan that, pursuant to subsection (b)(3)(E)(iii), uses a database described in such subsection to determine a rate to apply under such subsection for an item or service by reason of having insufficient information described in such subsection with respect to such item or service, such sponsor shall cover the cost for access to such database.”.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

“Sec. 9815. Additional market reforms.

“Sec. 9816. Consumer protections.”.

(d) ADDITIONAL APPLICATION PROVISIONS.—

(1) APPLICATION TO FEHB.—

(A) IN GENERAL.—Section 8902 of title 5, United States Code, is amended by adding at the end the following new subsection:

“(p) Each contract under this chapter shall require the carrier to comply with requirements described in the provisions of section 2719A of the Public Health Service Act and sections 2730 and 2731 of such Act, sections 716, 717, and 718 of the Employee Retirement Income Security Act of 1974, sections 9816, 9817, and 9818 of the Internal Revenue Code of 1986 (as applicable), and section 2(d) of the Ban Surprise Billing Act in the same manner as such provisions apply to a group health plan or health insurance issuer offering health insurance coverage, as described in such sections. The provisions of sections 2799A–1, 2799A–2, 2799A–3, and 2799A–4 of the Public Health Service Act shall apply to a health care provider and facility and an air ambulance provider described in such respective sections with respect to a participant, beneficiary, or enrollee in a health benefits plan under this chapter in the same manner as such provisions apply to such a provider and facility with respect to an enrollee in a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, as described in such sections.”.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall apply with respect to contracts entered into or renewed for contract years beginning on or after January 1, 2022.

(2) APPLICATION TO GRANDFATHERED PLANS.—Section 1251(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18011(a)) is amended by adding at the end the following:

“(5) APPLICATION OF ADDITIONAL PROVISIONS.—Subsections (b), (e), (f), (g), and (h) of section 2719A of the Public Health Service Act shall apply to grandfathered health plans for plan years beginning on or after January 1, 2022.”.

(3) COORDINATION.—The Secretary of the Treasury, the Secretary of Health and Human Services, and the Secretary of Labor shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(A) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which 2 or more such Secretaries have responsibility under this title (and the amendments made by this title) are administered so as to have the same effect at all times; and

(B) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

(4) **RULE OF CONSTRUCTION.**—Nothing in this title, including the amendments made by this title may be construed as modifying, reducing, or eliminating—

(A) the protections under section 222 of the Indian Health Care Improvement Act (25 U.S.C. 1621u) and under subpart I of part 136 of title 42, Code of Federal Regulations (or any successor regulation), against payment liability for a patient who receives contract health services that are authorized by the Indian Health Service; or

(B) the requirements under section 1866(a)(1)(U) of the Social Security Act (42 U.S.C. 1395cc(a)(1)(U)).

(e) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2022.

SEC. 3. PREVENTING CERTAIN CASES OF BALANCE BILLING.

(a) **IN GENERAL.**—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended by adding at the end the following new part:

“PART D—HEALTH CARE PROVIDER REQUIREMENTS

“SEC. 2799A-1. BALANCE BILLING IN CASES OF EMERGENCY SERVICES.

“(a) **IN GENERAL.**—In the case of a participant, beneficiary, or enrollee with benefits under a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market who is furnished during a plan year beginning on or after January 1, 2022, emergency services for which any benefit is provided under such plan or coverage with respect to an emergency medical condition with respect to a visit at an emergency department of a hospital or an independent freestanding emergency department—

“(1) in the case that the hospital or independent freestanding emergency department is a nonparticipating emergency facility, the emergency department of a hospital or independent freestanding emergency department shall not hold the participant, beneficiary, or enrollee liable for a payment amount for such emergency services so furnished that is more than the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii) of section 2719A(b)(1)(C), section 716(b)(1)(C) of the Employee Retirement Income Security Act of 1974, and section 9816(b)(1)(C) of the Internal Revenue Code of 1986, as applicable); and

“(2) in the case that such services are furnished by a nonparticipating provider, the health care provider shall not hold such participant, beneficiary, or enrollee liable for a payment amount for an emergency service furnished to such individual by such provider with respect to such emergency medical condition and visit for which the individual receives emergency services at the hospital or emergency department that is more than the cost-sharing amount for such services furnished by the provider (as determined in accordance with clauses (ii) and (iii) of section 2719A(b)(1)(C), section 716(b)(1)(C) of the Employee Retirement Income Security Act of 1974, and section 9816(b)(1)(C) of the Internal Revenue Code of 1986, as applicable).

“(b) **DEFINITION.**—In this section, the term ‘visit’ shall have such meaning as applied to such term for purposes of section 2719A(e).

“SEC. 2799A-2. BALANCE BILLING IN CASES OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.

“(a) **IN GENERAL.**—Subject to subsection (b), in the case of a participant, beneficiary, or enrollee with benefits under a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market who is furnished during a plan year beginning on or after January 1, 2022, items or services (other than emergency services to which section 2799A-1 applies) for which any benefit is provided under such plan or coverage at a participating health care facility by a nonparticipating provider, such provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for such an item or service furnished by such provider with respect to a visit at such facility that is more than the cost-sharing amount for such item or service (as determined in accordance with subparagraphs (A) and (B) of section 2719A(e)(1), section 716(e)(1) of the Employee Retirement Income Security Act of 1974, and section 9816(e)(1) of the Internal Revenue Code of 1986, as applicable).

“(b) **EXCEPTION.**—

“(1) IN GENERAL.—Subsection (a) shall not apply with respect to items or services (other than ancillary services described in paragraph (2)) furnished by a nonparticipating provider to a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, if the provider satisfies the notice and consent criteria of subsection (d).

“(2) ANCILLARY SERVICES DESCRIBED.—For purposes of paragraph (1), ancillary services described in this paragraph are, with respect to a participating health care facility—

“(A) subject to paragraph (3), items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a physician or non-physician practitioner, and items and services provided by assistant surgeons, hospitalists, and intensivists;

“(B) subject to paragraph (3), diagnostic services (including radiology and laboratory services);

“(C) items and services provided by such other specialty practitioners, as the Secretary specifies through rulemaking; and

“(D) items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

“(3) EXCEPTION.—The Secretary may, through rulemaking, establish a list (and update such list) of advanced diagnostic laboratory tests, which shall not be included as an ancillary service described in paragraph (2) and with respect to which subsection (a) would apply.

“(c) CLARIFICATION.—In the case of a nonparticipating provider that satisfies the notice and consent criteria of subsection (d) with respect to an item or service (referred to in this subsection as a ‘covered item or service’), such notice and consent criteria may not be construed as applying with respect to any item or service that is furnished as a result of unforeseen, urgent medical needs that arise at the time such covered item or service is furnished. For purposes of the previous sentence, a covered item or service shall not include an ancillary service described in subsection (b)(2).

“(d) NOTICE AND CONSENT TO BE TREATED BY A NONPARTICIPATING PROVIDER OR NONPARTICIPATING FACILITY.—

“(1) IN GENERAL.—A nonparticipating provider or nonparticipating facility satisfies the notice and consent criteria of this subsection, with respect to items or services furnished by the provider or facility to a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, if the provider (or, if applicable, the participating health care facility on behalf of such provider) or nonparticipating facility—

“(A) provides to the participant, beneficiary, or enrollee (or to an authorized representative of the participant, beneficiary, or enrollee) on the date on which the individual is furnished such items or services and, in the case that the participant, beneficiary, or enrollee makes an appointment to be furnished such items or services, on such date the appointment is made—

“(i) an oral explanation of the written notice described in clause (ii); and

“(ii) a written notice in paper or electronic form (and including electronic notification, as practicable) specified by the Secretary, not later than July 1, 2021, through guidance (which shall be updated as determined necessary by the Secretary) that—

“(I) contains the information required under paragraph (2);

“(II) clearly states that consent to receive such items and services from such nonparticipating provider or nonparticipating facility is optional and that the participant, beneficiary, or enrollee may instead seek care from a participating provider or at a participating facility, with respect to such plan or coverage, as applicable, in which case the cost-sharing responsibility of the participant, beneficiary, or enrollee would not exceed such responsibility that would apply with respect to such an item or service that is furnished by a participating provider or participating facility, as applicable with respect to such plan;

“(III) is available in the 15 most common languages in the geographic region of the applicable facility and, in the case the primary language of the beneficiary, participant, or enrollee, respectively, is not one of such 15 language, makes a good faith effort to also provide such notice orally in such primary language of the beneficiary, participant, or enrollee; and

“(IV) is signed and dated by the participant, beneficiary, or enrollee (or by an authorized representative of the participant, beneficiary, or enrollee) and, with respect to items or services to be furnished by such a provider that are not poststabilization services described in section 2719A(b)(3)(C)(ii), is so signed and dated not less than 72 hours prior to the participant, beneficiary, or enrollee being furnished such items or services by such provider; and

“(B) obtains from the participant, beneficiary, or enrollee (or from such an authorized representative) the consent described in paragraph (3) to be treated by a nonparticipating provider or nonparticipating facility.

“(2) INFORMATION REQUIRED UNDER WRITTEN NOTICE.—For purposes of paragraph (1)(A)(ii)(I), the information described in this paragraph, with respect to a nonparticipating provider or nonparticipating facility and a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, is each of the following:

“(A) Notification, as applicable, that the health care provider is a nonparticipating provider with respect to the health plan or the health care facility is a nonparticipating facility with respect to the health plan.

“(B) Notification of the good faith estimated amount that such provider or facility may charge the participant, beneficiary, or enrollee for such items and services involved, including a notification that the provision of such estimate or consent to be treated under paragraph (3) does not constitute a contract with respect to the charges estimated for such items and services.

“(C) In the case of a participating facility and a nonparticipating provider, a list of any participating providers at the facility who are able to furnish such items and services involved and notification that the participant, beneficiary, or enrollee may be referred, at their option, to such a participating provider.

“(D) Information about whether prior authorization or other care management limitations may be required in advance of receiving such items or services at the facility.

“(3) CONSENT DESCRIBED TO BE TREATED BY A NONPARTICIPATING PROVIDER OR NONPARTICIPATING FACILITY.—For purposes of paragraph (1)(B), the consent described in this paragraph, with respect to a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market who is to be furnished items or services by a nonparticipating provider or nonparticipating facility, is a document specified by the Secretary through rulemaking, in consultation with the Secretary of Labor, that—

“(A) acknowledges that the participant, beneficiary, or enrollee has been—

“(i) provided with a written good faith estimate and an oral explanation of the charge that may be applied for the items or services anticipated to be furnished by such provider or facility; and

“(ii) informed that the payment of such charge by the participant, beneficiary, or enrollee may not accrue toward meeting any limitation that the plan or coverage places on cost-sharing, including an explanation that such payment may not apply to an in-network deductible applied under the plan or coverage; and

“(B) documents the consent of the participant, beneficiary, or enrollee to be furnished such item or services by such provider or facility.

“(4) RULE OF CONSTRUCTION.—The consent described in paragraph (3), with respect to a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, shall constitute only consent to the receipt of the information provided pursuant to this subsection and shall not constitute a contractual agreement of the participant, beneficiary, or enrollee to any estimated charge or amount included in such information.

“(e) RETENTION OF CERTAIN DOCUMENTS.—A nonparticipating facility (with respect to such facility or any nonparticipating provider at such facility) or a participating facility (with respect to nonparticipating providers at such facility) that obtains from a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market (or an authorized representative of such participant, beneficiary, or enrollee) a written notice in accordance with subsection (d)(1)(A)(ii), with respect to furnishing an item or service to such participant, beneficiary, or enrollee, shall retain

such notice for at least a 2-year period after the date on which such item or service is so furnished.

“(f) DEFINITIONS.—In this section:

“(1) The terms ‘nonparticipating provider’ and ‘participating provider’ have the meanings given such terms, respectively, in subsection (b)(3) of section 2719A.

“(2) The term ‘participating health care facility’ has the meaning given such term in subsection (e)(2) of section 2719A.

“(3) The term ‘nonparticipating facility’ means—

“(A) with respect to emergency services (as defined in section 2719A(b)(3)(C)(i)) and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively; and

“(B) with respect to services described in section 2719A(b)(3)(C)(ii) and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, a hospital or an independent freestanding emergency department, that does not have a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively.

“(4) The term ‘participating facility’ means—

“(A) with respect to emergency services (as defined in clause (i) of section 2719A(b)(3)(C)) that are not described in clause (ii) of such section and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively; and

“(B) with respect to services that pursuant to clause (ii) of section 2719A(b)(3)(C) are included as emergency services (as defined in clause (i) of such section) and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, a hospital or an independent freestanding emergency department, that has a contractual relationship with the plan or coverage, respectively, with respect to the furnishing of such services under the plan or coverage, respectively.

“SEC. 2799A-3. PROVIDER REQUIREMENT WITH RESPECT TO PUBLIC PROVISION OF INFORMATION.

“(a) IN GENERAL.—Each health care provider and health care facility shall make publicly available, and (if applicable) post on a public website of such provider or facility and provide to individuals who are participants, beneficiaries, or enrollees of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market a one-page notice in plain language containing information on—

“(1) the requirements and prohibitions of such provider or facility under sections 2799A-1, 2799A-2, and 2799A-4 (relating to prohibitions on balance billing in certain circumstances);

“(2) if provided for under applicable State law, any other requirements on such provider or facility regarding the amounts such provider or facility may, with respect to an item or service, charge a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market with respect to which such provider or facility does not have a contractual relationship for furnishing such item or service under the plan or coverage, respectively, after receiving payment from the plan or coverage, respectively, for such item or service and any applicable cost-sharing payment from such participant, beneficiary, or enrollee; and

“(3) information on contacting appropriate State and Federal agencies in the case that an individual believes that such provider or facility has violated any requirement described in paragraph (1) or (2) with respect to such individual.

“(b) GUIDANCE.—Not later than 6 months after the date of the enactment of this section, the Secretary, in consultation with the Secretary of Labor, shall issue guidance on the requirements for the notice under this section.

“SEC. 2799A-4. AIR AMBULANCE SERVICES.

“In the case of a participant, beneficiary, or enrollee with benefits under a group health plan or health insurance coverage offered by a health insurance issuer in the

group or individual market who is furnished on or after January 1, 2022, air ambulance services from a nonparticipating provider (as defined in section 2719A(b)(3)(G)) with respect to such plan or coverage, such provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for such service furnished by such provider that is more than the cost-sharing amount for such service (as determined in accordance with paragraphs (1) and (2) of section 2719A(f), section 716(f) of the Employee Retirement Income Security Act of 1974, or section 9816(f) of the Internal Revenue Code of 1986, as applicable).

“SEC. 2799A-5. ENFORCEMENT.

“(a) STATE ENFORCEMENT.—

“(1) STATE AUTHORITY.—Each State may require a provider or health care facility (including a provider of air ambulance services) subject to the requirements of this part (except section 2799A-5) to satisfy such requirements applicable to the provider or facility.

“(2) FAILURE TO IMPLEMENT REQUIREMENTS.—In the case of a determination by the Secretary that a State has failed to substantially enforce the requirements specified in paragraph (1) with respect to applicable providers and facilities in the State, the Secretary shall enforce such requirements under subsection (b) insofar as they relate to violations of such requirements occurring in such State.

“(3) NOTIFICATION OF SECRETARY OF LABOR.—A State may notify the Secretary of Labor of instances of violations of sections 2799A-1, 2799A-2, or 2799A-4 with respect to participants or beneficiaries under a group health plan or health insurance coverage offered by a health insurance issuer in the group market and any enforcement actions taken against providers or facilities as a result of such violations, including the disposition of any such enforcement actions.

“(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

“(1) IN GENERAL.—If a provider or facility is found to be in violation of a requirement specified in subsection (a)(1) by the Secretary, the Secretary may apply a civil monetary penalty with respect to such provider or facility (including, as applicable, a provider of air ambulance services) in an amount not to exceed \$10,000 per violation. The provisions of subsections (c) (with the exception of the first sentence of paragraph (1) of such subsection), (d), (e), (g), (h), (k), and (l) of section 1128A of the Social Security Act shall apply to a civil monetary penalty or assessment under this subsection in the same manner as such provisions apply to a penalty, assessment, or proceeding under subsection (a) of such section.

“(2) LIMITATION.—The provisions of paragraph (1) shall apply to enforcement of a provision (or provisions) specified in subsection (a)(1) only as provided under subsection (a)(2).

“(3) COMPLAINT PROCESS.—The Secretary shall, through rulemaking conducted in consultation with the Secretary of Labor, establish a process to receive consumer complaints of violations of such provisions and resolve such complaints within 60 days of receipt of such complaints. Such process shall provide that the Secretary of Labor be informed of complaints by participants or beneficiaries under a group health plan or health insurance coverage offered by a health insurance issuer in the group market and any enforcement actions against providers resulting from such complaints, including the disposition of any such enforcement actions.

“(4) EXCEPTION.—The Secretary may waive the penalties described under paragraph (1) with respect to a facility or provider (including a provider of air ambulance services) who does not knowingly violate, and should not have reasonably known it violated, sections 2799A-1, 2799A-2, or 2799A-4 with respect to a participant, beneficiary, or enrollee, if such facility or provider, within 30 days of the violation, withdraws the bill that was in violation of such provision and reimburses the health plan or participant, beneficiary, or enrollee, as applicable, in an amount equal to the difference between the amount billed and the amount allowed to be billed under the provision, plus interest, at an interest rate determined by the Secretary.

“(5) HARDSHIP EXEMPTION.—The Secretary may establish a hardship exemption to the penalties under this subsection.

“(c) CONTINUED APPLICABILITY OF STATE LAW.—The sections specified in subsection (a)(1) shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any requirement or prohibition except to the extent that such requirement or prohibition prevents the application of a requirement or prohibition of such a section.”

(b) SECRETARY OF LABOR INVESTIGATIVE AUTHORITY.—

(1) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.) is amended by adding at the end the following new section:

“SEC. 522. INVESTIGATIVE AUTHORITY REGARDING VIOLATIONS OF CERTAIN HEALTH CARE PROVIDER REQUIREMENTS; COMPLAINT PROCESS.

“(a) INVESTIGATIVE AUTHORITY.—Upon receiving a notice from a State or the Secretary of Health and Human Services of violations of sections 2799A–1, 2799A–2, or 2799A–4 of the Public Health Service Act, the Secretary of Labor shall have the power to conduct an investigation to identify patterns of such violations with respect to participants or beneficiaries under a group health plan or health insurance coverage offered in connection with a group health plan by a health insurance issuer in the group market. The Secretary may assist States, the Secretary of Health and Human Services, plans, or issuers to ensure that appropriate measures have been taken to correct such violations retrospectively and prospectively with respect to participants or beneficiaries under a group health plan or health insurance coverage offered in connection with a group health plan by a health insurance issuer in the group market.

“(b) COMPLAINT PROCESS.—Not later than January 1, 2022, the Secretary shall establish a process under which the Secretary—

“(1) may receive complaints from participants and beneficiaries of group health plans or health insurance coverage offered in connection with such plans relating to alleged violations of the sections specified in subsection (a); and

“(2) transmits such complaints to States or the Secretary of Health and Human Services (as determined appropriate by the Secretary) for potential enforcement actions.”.

(2) TECHNICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) is amended by inserting after the item relating to section 521 the following new item:

“Sec. 522. Investigative authority regarding violations of certain health care provider requirements; complaint process.”.

(c) DISCLOSURE OF CERTAIN PROTECTIONS AGAINST BALANCE BILLING.—Section 716 of the Employee Retirement Income Security Act of 1974, as added by section 2, is further amended by adding at the end the following new subsection:

“(h) DISCLOSURE OF CERTAIN PROTECTIONS AGAINST BALANCE BILLING.—Each group health plan and health insurance issuer offering group health insurance coverage shall make publicly available, and (if applicable) post on a public website of such plan or issuer—

“(1) information in plain language on—

“(A) the requirements and prohibitions applied under sections 2799A–1, 2799A–2 and 2799A–4 of the Public Health Service Act (relating to prohibitions on balance billing in certain circumstances);

“(B) if provided for under applicable State law, any other requirements on providers and facilities regarding the amounts such providers and facilities may, with respect to an item or service, charge a participant, beneficiary, or enrollee of such plan or coverage with respect to which such a provider or facility does not have a contractual relationship for furnishing such item or service under the plan or coverage after receiving payment from the plan or coverage for such item or service and any applicable cost-sharing payment from such participant, beneficiary, or enrollee; and

“(C) the requirements applied under subsections (b), (e), and (f); and

“(2) information on contacting appropriate State and Federal agencies in the case that an individual believes that such a provider or facility has violated any requirement described in paragraph (1) with respect to such individual.”.

SEC. 4. INDEPENDENT DISPUTE RESOLUTION PROCESS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this section, the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury (in this section referred to as the “Secretaries”) shall jointly establish by regulation an independent dispute resolution process (in this section referred to as the “IDR process”) under which, with respect to a payment made by a group health plan or health insurance issuer offering health insurance coverage in the group or individual market pursuant to subsection (b)(1), (e)(1), or (f)(1) of section 2719A of the Public Health Service Act, section 716 of the Employee Retirement Income Security Act of 1974, or section 9816 of the Internal Revenue Code of 1986 (as applicable) using the recognized amount (as defined in and determined pursuant to section

2719A(b)(3)(H)(ii) of the Public Health Service Act or subsection (b)(3)(H)(ii) of section 716 of the Employee Retirement Income Security Act of 1974 or section 9816 of the Internal Revenue Code of 1986, as applicable) to a nonparticipating provider (as defined in subparagraph (G) of section 2719A(b)(3) of the Public Health Service Act or subparagraph (G) of subsection (b)(3) of section 716 of the Employee Retirement Income Security Act of 1974 or section 9816 of the Internal Revenue Code of 1986, as applicable) or a nonparticipating emergency facility (as defined in subparagraph (F) of such section 2719A(b)(3) or such subsection (b)(3) of such section 716 or such section 9816, as applicable) with respect to an item or service (or, in the case of payment made under section 2719A(f)(1) of the Public Health Service Act or subsection (f)(1) of section 716 of the Employee Retirement Income Security Act of 1974 or section 9816 of the Internal Revenue Code of 1986, as applicable, with respect to air ambulance services) furnished by such provider or facility—

(A) subject to subparagraph (B), the nonparticipating provider, nonparticipating emergency facility, or group health plan or health insurance issuer, respectively, may, not later than the date specified in paragraph (2), submit a request that such payment should be increased or decreased; and

(B) in the case a settlement described in subsection (d)(2) is not reached with respect to such request, an entity certified and selected under subsection (c) shall determine in accordance with such paragraph an alternative payment to be applied, with respect to such request.

(2) DATE SPECIFIED.—For purposes of paragraph (1)(A), the date specified in this paragraph is—

(A) in the case of a request described in such paragraph (1)(A) being submitted by a nonparticipating provider or nonparticipating emergency facility, with respect to items and services (or air ambulance services) described in paragraph (1), the date that is 30 days after the applicable date described in subsection (b)(2)(A)(ii); or

(B) in the case of such a request filed by a group health plan or health insurance issuer, the date that is 30 days after the date of the submission of the notice described in subsection (b)(1)(B)(ii).

(3) CLARIFICATION.—A nonparticipating provider may not, with respect to an item or service (or air ambulance service) furnished by such provider, submit a request under the IDR process if such provider is exempt from the requirement under subsection (a) of section 2799A–2 of the Public Health Service Act with respect to such item or service pursuant to subsection (e) of such section.

(b) REQUIREMENTS FOR REQUESTS TO BE ELIGIBLE FOR SUBMISSION UNDER IDR PROCESS.—

(1) TIMING REQUIREMENTS.—A request may not be submitted under the IDR process, with respect to items and services (or air ambulance services) furnished by a nonparticipating provider or nonparticipating emergency facility for which a group health plan or health insurance issuer offering health insurance coverage in the group or individual market made a payment pursuant to subsection (b)(1), (e)(1), or (f)(1) of section 2719A of the Public Health Service Act or subsection (b)(1), (e)(1), or (f)(1) of section 716 of the Employee Retirement Income Security Act of 1974 or section 9816 of the Internal Revenue Code of 1986 (as applicable) unless—

(A) in the case such request is being submitted by the nonparticipating provider or nonparticipating emergency facility—

(i) the provider or facility, respectively, filed, not later than 30 days after the date such payment is received by the provider or facility, respectively, an appeal under the appeals process of the group health plan or health insurance issuer, the subject of which includes the payment for such items and services (or air ambulance services); and

(ii) such request is not submitted before the sooner of the date on which such appeal has been resolved or the date that is 30 days after the date on which such appeal is so filed; or

(B) in the case such request is being submitted by the group health plan or health insurance issuer—

(i) the group health plan or health insurance issuer, respectively, not later than 30 days after such provider or facility, respectively, receives such payment, submits to such provider or facility, respectively, a notice that such plan or issuer, respectively, disputes the amount of such payment with respect to such items and services (or air ambulance services); and

(ii) such request is not submitted before the date that is 30 days after the date of the submission of such notice.

(2) **MINIMUM MEDIAN CONTRACTED RATE.**—A request may not be submitted under the IDR process, with respect to items and services (or air ambulance services) furnished in a geographic area by a nonparticipating provider or nonparticipating emergency facility for which a group health plan or health insurance issuer offering health insurance coverage in the group or individual market made a payment pursuant to subsection (b)(1), (e)(1), or (f)(1) of section 2719A of the Public Health Service Act or subsection (b)(1), (e)(1), or (f)(1) of section 716 of the Employee Retirement Income Security Act of 1974 or section 9816 of the Internal Revenue Code of 1986 (as applicable) unless—

(A) in the case such item or service is furnished during 2022, the median contracted rate (as defined in subsection (b)(3)(E) of section 2719A of the Public Health Service Act or subsection (b)(3)(E) of section 716 of the Employee Retirement Income Security Act of 1974 or section 9816 of the Internal Revenue Code of 1986 (as applicable)) for such year under such plan or such coverage with respect to each such item or service furnished by such a provider or such a facility in such area is at least \$750 (or, in the case of air ambulance services, is at least \$25,000); or

(B) in the case such item or service (or air ambulance services) is furnished during a subsequent year, the median contracted rate (as so defined) for such year under such plan or such coverage with respect to each such item or service furnished by such a provider or such a facility in such area is at least the amount applied under this paragraph for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(3) **LIMITATION ON BATCHING OF ITEMS AND SERVICES IN A REQUEST.**—A request may not be submitted under the IDR process by a nonparticipating provider, nonparticipating emergency facility, or a group health plan or health insurance issuer offering health insurance coverage in the group or individual market, with respect to multiple items and services (or multiple air ambulance services), unless—

(A) all such items and services (or air ambulance services) included in such request are furnished by the same provider or facility;

(B) payment for all such items and services (or air ambulance services) made pursuant to subsection (b)(1), (e)(1), or (f)(1) of section 2719A of the Public Health Service Act or subsection (b)(1), (e)(1), or (f)(1) of section 716 of the Employee Retirement Income Security Act of 1974 or section 9816 of the Internal Revenue Code of 1986 (as applicable) was made by a single group health plan or health insurance coverage;

(C) all such items and services (or air ambulance services) are related to the treatment of the same condition; and

(D) all such items and services were furnished during the 30-day period following the date on which the first item or service (or air ambulance service) included in such request was furnished.

(c) **IDR ENTITIES.**—

(1) **PROCESS OF CERTIFICATION.**—The process described in subsection (a) shall include a certification process under which eligible entities may be certified to carry out the IDR process.

(2) **CERTIFICATION.**—

(A) **IN GENERAL.**—An entity wishing to participate in the IDR process under this section shall request certification from the Secretaries. The Secretaries shall determine whether or not to certify applicant entities, taking into consideration whether the entity is unbiased and unaffiliated with health insurance issuers, group health plans, health care facilities, and health care providers and free of conflicts of interest, in accordance with the Secretaries' rulemaking on determining criteria for conflicts of interest.

(B) **ELIGIBLE ENTITIES.**—For purposes of this section, an eligible entity is an entity that is a nongovernmental entity and that agrees to comply with the fee limitations described in subparagraph (C).

(C) **FEE LIMITATIONS.**—For purposes of subparagraph (B), the fee limitations described in this subparagraph are limitations established by the Secretaries for the amount a certified IDR entity may charge a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering health insurance coverage in the group or individual market for services furnished by such entity with respect to the resolution of a specified request of such provider, facility, plan, or issuer under the process described in subsection (a).

(3) **SELECTION OF CERTIFIED IDR ENTITY.**—The group health plan or health insurance issuer offering health insurance coverage in the group or individual market and the nonparticipating provider or the nonparticipating emergency fa-

cility (as applicable) involved in a request submitted under the IDR process shall agree on a certified IDR entity to resolve such request. In the case that such plan or issuer (as applicable) and such provider or facility (as applicable) cannot so agree, such an entity shall be selected by the Secretaries at random, in accordance with a manner and timeline specified by the Secretaries.

(d) PAYMENT DETERMINATION.—

(1) TIMING.—A certified IDR entity selected under subsection (c)(3) with respect to a request under the IDR process shall, subject to paragraph (2), not later than 30 days after being so selected, determine the alternative payment that should be made for items and services (or air ambulance services) included in such request in accordance with paragraph (3).

(2) SETTLEMENT.—

(A) IN GENERAL.—If such entity determines that a settlement between the group health plan or issuer, as applicable, and the provider or facility, as applicable, is likely with respect to a request under the IDR process, the entity may direct the parties to attempt, for a period not to exceed 10 days, a good faith negotiation for a settlement of such request.

(B) TIMING.—The period for a settlement described in subparagraph (A) shall accrue toward the 30-day period described in paragraph (1).

(3) DETERMINATION OF ALTERNATIVE PAYMENT.—

(A) IN GENERAL.—The group health plan or health insurance issuer offering health insurance coverage in the group or individual market (as applicable) and the nonparticipating provider or nonparticipating emergency facility (as applicable) involved shall, with respect to a request under the IDR process, each submit to the certified IDR entity selected under subsection (c)(3) for such request a final offer to be considered for the alternative payment to be applied with respect to items and services (or air ambulance services) which are the subject of the request. Such entity shall determine, in accordance with subparagraph (B), which such offer is the most reasonable and will be applied as the alternative payment.

(B) CONSIDERATIONS IN DETERMINATION.—

(i) IN GENERAL.—In determining which final offer is the alternative payment to be applied, the certified IDR entity selected under subsection (c)(3) for such request shall consider—

(I) the median contracted rates (as defined in subsection (b)(3)(E) of section 2719A of the Public Health Service Act or subsection (b)(3)(E) of section 716 of the Employee Retirement Income Security Act of 1974 or section 9816 of the Internal Revenue Code of 1986 (as applicable)) for the applicable year for items or services (or air ambulance services) that are comparable to the items and services (or air ambulance services) included in the request and that are furnished in the same geographic area (as defined by the Secretaries for purposes of such subsection) as such items and services (or air ambulance services) (not including any facility fees with respect to such rates); and

(II) in the case of items and services (other than air ambulances services), each circumstance described in clause (ii) with respect to which information is submitted by either party or, in the case of air ambulance services, each circumstance described in clause (iii) with respect to which information is submitted by either party.

(ii) ADDITIONAL CIRCUMSTANCES FOR CERTAIN ITEMS AND SERVICES.—For purposes of clause (i)(II), the circumstances described in this clause are, with respect to items and services (other than air ambulance services) included in the request under the IDR process of a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer the following:

(I) The level of training, education, experience, and quality and outcomes measurements of the provider or facility that furnished such items and services (such as those endorsed by the consensus-based entity authorized under section 1890 of the Social Security Act).

(II) The market share held by the provider or facility, or the plan or issuer, in the geographic area in which the item or service was provided.

(III) Any other extenuating circumstances with respect to the furnishing of such items and services that relate to the acuity of the individual receiving such items and services or the complexity of furnishing such items and services to such individual.

(IV) A demonstration of good faith efforts (or lack of good faith efforts) made by the provider or facility (as applicable) or the plan or issuer (as applicable).

(iii) ADDITIONAL CIRCUMSTANCES FOR AIR AMBULANCE SERVICES.—For purposes of clause (i)(II), the circumstances described in this clause are, with respect to air ambulance services included in the request under the IDR process of a nonparticipating provider, group health plan, or health insurance issuer the following:

(I) The quality and outcomes measurements of the provider that furnished such services.

(II) Any other extenuating circumstances with respect to the furnishing of such services that relate to the acuity of the individual receiving such services or the complexity of furnishing such services to such individual.

(III) The training, education, experience, and quality of the medical personnel that furnished such services.

(IV) Ambulance vehicle type, including the clinical capability level of such vehicle.

(V) Population density of the pick up location (such as urban, suburban, rural, or frontier).

(iv) PROHIBITION ON CONSIDERATION OF BILLED CHARGES.—In determining which final offer is the alternative payment amount to be applied with respect to items and services (or air ambulance services) furnished by a provider or facility and included in the request under the IDR process, the certified IDR entity selected under subsection (c)(3) with respect to such request shall not consider the amount that would have been billed by such provider or facility with respect to such items and services had the provisions of section 2799A–1, 2799A–2, or 2799A–4 of the Public Health Service Act (as applicable) not applied.

(C) EFFECTS OF DETERMINATION.—

(i) IN GENERAL.—A determination of a certified IDR entity under subparagraph (A) shall be binding.

(ii) LIMITATION ON CERTAIN SUBSEQUENT IDR CLAIMS.—In the case of a determination of a certified IDR entity under subparagraph (A), with respect to a request submitted under subsection (a)(1)(A) and the two parties involved with such request, the party that submitted such initial request may not submit during the 90-day period following such determination a subsequent request under such subsection involving the same other party to such request with respect to such an item or service (or air ambulance service) that was the subject of such initial request.

(D) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—In the case of a request made by a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering health insurance coverage in the group or individual market and submitted to a certified IDR entity—

(i) if such entity makes a determination with respect to such request under subparagraph (A), the party whose offer is not chosen under such clause shall be responsible for paying all fees charged by such entity; and

(ii) if the parties reach a settlement with respect to such request prior to such a determination, each party shall pay half of all fees charged by such entity, unless the parties otherwise agree.

(E) PAYMENT.—Not later than 30 days after the date on which a determination described in subparagraph (B) is made with respect to a request under the IDR process of a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering health insurance coverage in the group or individual market—

(i) in the case that the alternative payment determined to be applied is greater than the amount paid with respect to such request, such plan or issuer (as applicable) shall pay directly to the provider or facility (as applicable) the difference between such alternative payment and the amount so paid; and

(ii) in the case that the alternative payment determined to be applied is less than the amount paid with respect to such request, such provider or facility (as applicable) shall pay directly to the plan or issuer (as applicable) the difference between the amount so paid and such alternative payment.

(e) PUBLICATION OF INFORMATION RELATING TO DISPUTES.—

(1) PUBLICATION OF INFORMATION.—For 2022 and each subsequent year, the Secretaries shall make available on the public website of the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury—

(A) the number of requests submitted under the IDR process during such year;

(B) the practice size of the providers and facilities submitting requests under the IDR process during such year;

(C) the number of such requests with respect to which a final determination was made under subsection (d)(3)(A);

(D) the average response time under the process, after the first sign of billing discrepancies between the providers, facilities, group health plans, and health insurance issuers involved in the process during such year;

(E) information comparing the average period for resolving such a billing discrepancy between such a provider, facility, plan, or issuer during such year and the average period for resolving such a discrepancy between such parties during the most recent year before the date of the enactment of this Act; and

(F) the information described in paragraph (2) for each request with respect to which such a determination was so made.

(2) INFORMATION WITH RESPECT TO REQUESTS.—For purposes of paragraph (1), the information described in this paragraph is, with respect to a request under the IDR process of a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering health insurance coverage in the group or individual market—

(A) a description of each item and service (or air ambulance service) included in such request;

(B) the geography in which the items and services (or air ambulance services) included in such request were provided;

(C) the amount of the offer submitted under subsection (d)(3)(A) by the group health plan or health insurance issuer (as applicable) and by the nonparticipating provider or nonparticipating emergency facility (as applicable) expressed as a percentage of the median contracted rate;

(D) whether the offer selected by the certified IDR entity under such subsection to be the alternative payment applied was the offer submitted by such plan or issuer (as applicable) or by such provider or facility (as applicable) and the amount of such offer so selected expressed as a percentage of the median contracted rate;

(E) the category and practice specialty of each such provider or facility involved in furnishing such items and services (or, in the case of air ambulance services, the ambulance vehicle type, including the clinical capability level of such vehicle); and

(F) the identity of the group health plan or health insurance issuer, provider, or facility, with respect to the request.

(3) IDR ENTITY REQUIREMENTS.—For 2022 and each subsequent year, an IDR entity, as a condition of certification as an IDR entity, shall submit to the Secretaries such information as the Secretaries determine necessary for the Secretaries to carry out the provisions of this subsection.

(f) ENFORCEMENT.—

(1) IN GENERAL.—Any health care provider, health care facility, group health plan, or health insurance issuer offering group or individual health insurance coverage that violates a provision of this section shall be subject to a civil monetary penalty in an amount not to exceed \$10,000 for each such violation.

(2) APPLICATION.—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b) and the first sentence of subsection (c)(1)) shall apply with respect to a civil monetary penalty imposed under this subsection in the same manner as such provisions apply with respect to a penalty or proceeding under subsection (a) of such section, except that any reference to “the Secretary” in such provisions shall be treated as a reference to “the Secretaries”.

(g) DEFINITIONS.—In this subsection, the terms “group health plan”, “group market”, “health insurance issuer”, “health insurance coverage”, “individual health insurance coverage”, “group health insurance coverage”, and “individual market” have the meanings given such terms, respectively, in section 2791 of the Public Health Service Act.

(h) REPORT.—Not later than December 31, 2023, the Comptroller General of the United States shall conduct a study and submit to Congress a report on the IDR process established under this section. Such study and report shall include an anal-

ysis of potential financial relationships between providers and facilities that utilize the IDR process and private equity investment firms.

SEC. 5. ADVISORY COMMITTEE ON GROUND AMBULANCE AND PATIENT BILLING.

(a) **IN GENERAL.**—Not later than 60 days after the date of enactment of this Act, the Secretary of Labor, Secretary of Health and Human Services, and the Secretary of the Treasury (the Secretaries) shall jointly establish an advisory committee for the purpose of reviewing options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for such services, and protect consumers from balance billing.

(b) **COMPOSITION OF THE ADVISORY COMMITTEE.**—The advisory committee shall be composed of the following members:

- (1) The Secretary of Labor, or the Secretary's designee.
- (2) The Secretary of Health and Human Services, or the Secretary's designee.
- (3) The Secretary of the Treasury, or the Secretary's designee.
- (4) One representative, to be appointed jointly by the Secretaries, for each of the following:
 - (A) Each relevant Federal agency, as determined by the Secretaries.
 - (B) State insurance regulators.
 - (C) Health insurance providers.
 - (D) Patient advocacy groups.
 - (E) Consumer advocacy groups.
 - (F) State and local governments.
 - (G) Physician specializing in emergency, trauma, cardiac, or stroke.

(5) Three representatives, to be appointed jointly by the Secretaries, to represent the various segments of the ground ambulance industry.

(6) Up to an additional 2 representatives otherwise not described in paragraphs (1) through (5), as determined necessary and appropriate by the Secretaries.

(c) **CONSULTATION.**—The advisory committee shall, as appropriate, consult with relevant experts and stakeholders, including those not otherwise included under subsection (b), while conducting the review described in subsection (a).

(d) **RECOMMENDATIONS.**—The advisory committee shall make recommendations with respect to disclosure of charges and fees for ground ambulance services and insurance coverage, consumer protection and enforcement authorities of the Departments of Labor, Health and Human Services, and the Treasury and State authorities, and the prevention of balance billing to consumers. The recommendations shall address, at a minimum—

- (1) options, best practices, and identified standards to prevent instances of balance billing;
- (2) steps that can be taken by State legislatures, State insurance regulators, State attorneys general, and other State officials as appropriate, consistent with current legal authorities regarding consumer protection; and
- (3) legislative options for Congress to prevent balance billing.

(e) **REPORT.**—Not later than 180 days after the date of the first meeting of the advisory committee, the advisory committee shall submit to the Secretaries, and the Committees on Education and Labor, Energy and Commerce, and Ways and Means of the House of Representatives and the Committees on Finance and Health, Education, Labor, and Pensions a report containing the recommendations made under subsection (d).

SEC. 6. IMPROVING PROVIDER DIRECTORIES.

(a) **PHSA.**—Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended by adding at the end the following new section:

“SEC. 2730. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

“(a) NETWORK STATUS OF PROVIDERS.—

“(1) IN GENERAL.—Beginning on the date that is one year after the date of enactment of this section, a group health plan or a health insurance issuer of offering group or individual health insurance coverage shall—

“(A) establish business processes to ensure that all enrollees in such plan or coverage receive proof of a health care provider's network status, based on what a plan or issuer knows or should know—

“(i) upon a telephone inquiry by an enrollee—

“(I) through a written electronic communication from the plan or issuer to the enrollee, as soon as practicable and not later than 1 business day after such inquiry is made by such participant, beneficiary, or enrollee for such information;

“(II) through an oral communication from the plan or issuer to the enrollee, as soon as practicable and not later than 1 business day after such inquiry is made by such enrollee for such information, which communication shall be documented by such plan or issuer, and such documentation shall be kept in the enrollee’s file for a minimum of 2 years; and

“(ii) in real-time through an online health care provider directory search tool maintained by the plan or issuer; and

“(B) include in any print directory—

“(i) a disclosure that the information included in the directory is accurate as of the date of the last data update and that enrollees or prospective enrollees should consult the group health plan’s or issuer’s electronic provider directory on its website or call a specified customer service telephone number to obtain the most current provider directory information; and

“(ii) a list of the categories of providers of ancillary services for which the plan or coverage has no in-network providers.

“(2) GROUP HEALTH PLAN AND HEALTH INSURANCE ISSUER BUSINESS PROCESSES.—Beginning on the date that is one year after the date of the enactment of this section, a group health plan or a health insurance issuer offering group or individual health insurance coverage shall establish business processes to—

“(A) verify and update, at least once every 90 days, the provider directory information for all providers included in the online health care provider directory search tool described in paragraph (1)(A)(ii); and

“(B) remove any provider from such online directory search tool if such provider has not verified the directory information within the previous 6 months or the plan or issuer has been unable to verify the provider’s network participation.

“(b) COST-SHARING LIMITATIONS.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall not apply, and shall ensure that no provider applies, cost-sharing to an enrollee for treatment or services provided by a health care provider in excess of the normal cost-sharing applied for such treatment or services provided in-network (including any balance bill issued by the health care provider involved), if such enrollee, or health care provider referring such enrollee, demonstrates (based on the electronic, written information described in subsection (a)(1)(A)(i)(I), the oral confirmation described in subsection (a)(1)(A)(i)(II) received by the enrollee not more than 30 days before the date the treatment or services were received, or a copy of the online provider directory described in subsection (a)(1)(A)(ii) on a date not more than 30 days before the date the treatment or services were received), that the enrollee relied on the information described in subsection (a)(1) for which such enrollee provides such documentation, that indicated that the provider is an in-network provider, if the provider was out-of-network at the time the treatment or service involved was received.

“(c) DEFINITION.—For purposes of this section, the term ‘provider directory information’ includes the names, addresses, specialty, and telephone numbers of individual health care providers, and the names, addresses, and telephone numbers of each medical group, clinic, or facility contracted to participate in any of the networks of the group health plan or health insurance coverage involved.

“(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories.”

(b) ERISA.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by section 2, is further amended by adding at the end the following:

“SEC. 717. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

“(a) NETWORK STATUS OF PROVIDERS.—

“(1) IN GENERAL.—Beginning on the date that is one year after the date of enactment of this section, a group health plan (or health insurance coverage offered in connection with such a plan) shall—

“(A) establish business processes to ensure that all participants and beneficiaries in such plan or coverage receive proof of a health care provider’s network status, based on what a plan or issuer of such coverage knows or should know—

“(i) upon a telephone inquiry by a participant or beneficiary—

“(I) through a written electronic communication from the plan or issuer to the participant or beneficiary, as soon as practicable and not later than 1 business day after such inquiry is made by such participant or beneficiary for such information;

“(II) through an oral communication from the plan or issuer to the participant or beneficiary, as soon as practicable and not later than 1 business day after such inquiry is made by such participant or beneficiary for such information, which communication shall be documented by such plan or issuer, and such documentation shall be kept in the participant’s or beneficiary’s file for a minimum of 5 years; and

“(ii) in real-time through an online health care provider directory search tool maintained by the plan or issuer; and

“(B) include in any print directory—

“(i) a disclosure that the information included in the directory is accurate as of the date of the last data update and that participants or beneficiaries or prospective participants or beneficiaries should consult the group health plan’s or issuer’s electronic provider directory on its website or call a specified customer service telephone number to obtain the most current provider directory information; and

“(ii) a list of the categories of providers of ancillary services for which the plan or coverage has no in-network providers.

“(2) GROUP HEALTH PLAN AND HEALTH INSURANCE ISSUER BUSINESS PROCESSES.—Beginning on the date that is one year after the date of enactment of this section, a group health plan (or health insurance coverage offered in connection with such a plan) shall establish business processes to—

“(A) verify and update, at least once every 90 days, the provider directory information for all providers included in the online health care provider directory search tool described in paragraph (1)(A)(ii); and

“(B) remove any provider from such online directory search tool if such provider has not verified the directory information within the previous 6 months or the plan or issuer has been unable to verify the provider’s network participation.

“(b) COST-SHARING LIMITATIONS.—A group health plan (or health insurance coverage offered in connection with such a plan) shall not apply, and shall ensure that no provider applies, cost-sharing to a participant or beneficiary for treatment or services provided by a health care provider in excess of the normal cost-sharing applied for such treatment or services provided in-network (including any balance bill issued by the health care provider involved), if such participant or beneficiary, or health care provider referring such participant or beneficiary, demonstrates (based on the electronic, written information described in subsection (a)(1)(A)(i)(I), the oral confirmation described in subsection (a)(1)(A)(i)(II) received by the participant or beneficiary not more than 30 days before the date the treatment or services were received, or a copy of the online provider directory described in subsection (a)(1)(A)(ii) on a date not more than 30 days before the date the treatment or services were received), that the participant or beneficiary relied on the information described in subsection (a)(1) for which such participant or beneficiary provides such documentation, that indicated that the provider is an in-network provider, if the provider was out-of-network at the time the treatment or service involved was received.

“(c) DEFINITION.—For purposes of this section, the term ‘provider directory information’ includes the names, addresses, specialty, and telephone numbers of individual health care providers, and the names, addresses, and telephone numbers of each medical group, clinic, or facility contracted to participate in any of the networks of the group health plan or health insurance coverage involved.”

(c) IRC.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 2, is further amended by adding at the end the following:

“SEC. 9817. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

“(a) NETWORK STATUS OF PROVIDERS.—

“(1) IN GENERAL.—Beginning on the date that is one year after the date of enactment of this section, a group health plan shall—

“(A) establish business processes to ensure that all participants or beneficiaries in such plan receive proof of a health care provider’s network status, based on what a plan or issuer knows or should know—

“(i) upon a telephone inquiry by a participant or beneficiary—

“(I) through a written electronic communication from the plan to the participant or beneficiary, as soon as practicable and not later than 1 business day after such inquiry is made by such participant or beneficiary for such information;

“(II) through an oral communication from the plan to the participant or beneficiary, as soon as practicable and not later than 1 business day after such inquiry is made by such participant or ben-

eficiary for such information, which communication shall be documented by such plan, and such documentation shall be kept in the participant's or beneficiary's file for a minimum of 2 years; and

“(ii) in real-time through an online health care provider directory search tool maintained by the plan; and

“(B) include in any print directory—

“(i) a disclosure that the information included in the directory is accurate as of the date of the last data update and that participants or beneficiaries or prospective participants or beneficiaries should consult the group health plan's electronic provider directory on its website or call a specified customer service telephone number to obtain the most current provider directory information; and

“(ii) a list of the categories of providers of ancillary services for which the plan or coverage has no in-network providers.

“(2) GROUP HEALTH PLAN BUSINESS PROCESSES.—Beginning on the date that is one year after the date of enactment of this section, a group health plan shall establish business processes to—

“(A) verify and update, at least once every 90 days, the provider directory information for all providers included in the online health care provider directory search tool described in paragraph (1)(A)(ii); and

“(B) remove any provider from such online directory search tool if such provider has not verified the directory information within the previous 6 months or the plan or issuer has been unable to verify the provider's network participation.

“(b) COST-SHARING LIMITATIONS.—A group health plan shall not apply, and shall ensure that no provider applies, cost-sharing to a participant or beneficiary for treatment or services provided by a health care provider in excess of the normal cost-sharing applied for such treatment or services provided in-network (including any balance bill issued by the health care provider involved), if such participant or beneficiary, or health care provider referring such participant or beneficiary, demonstrates (based on the electronic, written information described in subsection (a)(1)(A)(i)(I), the oral confirmation described in subsection (a)(1)(A)(i)(II) received by the participant or beneficiary not more than 30 days before the date the treatment or services were received, or a copy of the online provider directory described in subsection (a)(1)(A)(ii) on a date not more than 30 days before the date the treatment or services were received), that the participant or beneficiary relied on the information described in subsection (a)(1) for which such participant or beneficiary provides such documentation, that indicated that the provider is an in-network provider, if the provider was out-of-network at the time the treatment or service involved was received.

“(c) DEFINITION.—For purposes of this section, the term ‘provider directory information’ includes the names, addresses, specialty, and telephone numbers of individual health care providers, and the names, addresses, and telephone numbers of each medical group, clinic, or facility contracted to participate in any of the networks of the group health plan involved.

“(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories.”.

(d) CLERICAL AMENDMENTS.—

(1) ERISA.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), as amended by section 2, is further amended by inserting after the item relating to section 716 the following new item:

“Sec. 717. Protecting patients and improving the accuracy of provider directory information.”.

(2) IRC.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 2, is further amended by adding at the end the following new item:

“Sec. 9817. Protecting patients and improving the accuracy of provider directory information.”.

(e) PROVIDER REQUIREMENTS.—Part D of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as added by section 3, is amended—

(1) by redesignating section 2799A–5 as section 2799A–7; and

(2) by inserting after section 2799A–4 the following new section:

“SEC. 2799A–5. PROVIDER REQUIREMENTS TO PROTECT PATIENTS AND IMPROVE THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

“(a) PROVIDER BUSINESS PROCESSES.—A health care provider shall have in place business processes to ensure the timely provision of provider directory information to a group health plan or a health insurance issuer offering group or individual health insurance coverage to support compliance by such plans or issuers with sec-

tion 2730(a)(1), section 717(a)(1) of the Employee Retirement Income Security Act of 1974, or section 9817(a)(1) of the Internal Revenue Code of 1986 (as applicable). Such providers shall submit provider directory information to a plan or issuers, at a minimum—

“(1) when the provider begins a network agreement with a plan or with an issuer with respect to certain coverage;

“(2) when the provider terminates a network agreement with a plan or with an issuer with respect to certain coverage;

“(3) when there are material changes to the content of provider directory information described in section 2730(a)(1), section 717(a)(1) of the Employee Retirement Income Security Act of 1974, or section 9817(a)(1) of the Internal Revenue Code of 1986 (as applicable); and

“(4) every 90 days throughout the duration of the network agreement with a plan or issuer.

“(b) ENFORCEMENT.—

“(1) CIVIL PENALTIES.—

“(A) IN GENERAL.—Subject to paragraph (2), a health care provider that violates a requirement under subsection (a) or takes actions that prevent a group health plan or health insurance issuer from complying with subsection (a)(1) or (b) of sections 2730, 717 of the Employee Retirement Income Security Act of 1974, or 9817 of the Internal Revenue Code of 1986 (as applicable) shall be subject to a civil monetary penalty of not more than \$10,000 for each act constituting such violation.

“(B) SAFE HARBOR.—The Secretary may waive the penalty described under paragraph (1) with respect to a health care provider that unknowingly violates section 2730(b)(1), section 717(b)(1) of the Employee Retirement Income Security Act of 1974, or section 9817(b)(1) of the Internal Revenue Code of 1986 (as applicable) with respect to an enrollee if such provider rescinds the bill involved and, if applicable, reimburses the enrollee within 30 days of the date on which the provider billed the enrollee in violation of such subsection.

“(C) PROCEDURE.—The provisions of section 1128A of the Social Security Act, other than subsections (a) and (b) and the first sentence of subsection (c)(1) of such section, shall apply to civil money penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A of the Social Security Act.

“(2) REFUNDS TO ENROLLEES.—If a health care provider submits a bill to an enrollee based on cost-sharing for treatment or services provided by the health care provider that is in excess of the normal cost-sharing applied for such treatment or services provided in-network, as prohibited under section 2730(b), section 717(b) of the Employee Retirement Income Security Act of 1974, or section 9817(b) of the Internal Revenue Code of 1986 (as applicable) and the enrollee pays such bill, the provider shall reimburse the enrollee for the full amount paid by the enrollee in excess of the in-network cost-sharing amount for the treatment or services involved, plus interest, at an interest rate determined by the Secretary.

“(c) LIMITATION.—Nothing in this section shall prohibit a provider from requiring in the terms of a contract, or contract termination, with a group health plan or health insurance issuer—

“(1) that the plan or issuer remove, at the time of termination of such contract, the provider from a directory of the plan or issuer described in section 2730(a)(1), section 717(a)(1) of the Employee Retirement Income Security Act of 1974, or section 9817(a)(1) of the Internal Revenue Code of 1986 (as applicable); or

“(2) that the plan or issuer bear financial responsibility, including under section 2730(b), section 717(b) of the Employee Retirement Income Security Act of 1974, or section 9817(b) of the Internal Revenue Code of 1986 (as applicable) for providing inaccurate network status information to an enrollee.

“(d) DEFINITION.—For purposes of this section, the term ‘provider directory information’ includes the names, addresses, specialty, and telephone numbers of individual health care providers, and the names, addresses, and telephone numbers of each medical group, clinic, or facility contracted to participate in any of the networks of the group health plan or health insurance coverage involved.

“(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories.”

SEC. 7. INCREASING TRANSPARENCY IN HEALTH COVERAGE.

(a) DISCLOSURE OF DIRECT AND INDIRECT COMPENSATION FOR BROKERS AND CONSULTANTS TO EMPLOYER-SPONSORED HEALTH PLANS AND ENROLLEES IN PLANS ON THE INDIVIDUAL MARKET.—

(1) GROUP HEALTH PLANS.—Section 408(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1108(b)(2)) is amended—

(A) by striking “(2) Contracting or making” and inserting “(2)(A) Contracting or making”; and

(B) by adding at the end the following:

“(B)(i) No contract or arrangement for services between a covered plan and a covered service provider, and no extension or renewal of such a contract or arrangement, is reasonable within the meaning of this paragraph unless the requirements of this subparagraph are met.

“(ii)(I) For purposes of this subparagraph:

“(aa) The term ‘covered plan’ means a group health plan as defined section 733(a).

“(bb) The term ‘covered service provider’ means a service provider that enters into a contract or arrangement with the covered plan and reasonably expects \$1,000 (or such amount as the Secretary may establish in regulations to account for inflation since the date of the enactment of the Ban Surprise Billing Act, as appropriate) or more in compensation, direct or indirect, to be received in connection with providing one or more of the following services, pursuant to the contract or arrangement, regardless of whether such services will be performed, or such compensation received, by the covered service provider, an affiliate, or a subcontractor:

“(AA) Brokerage services, for which the covered service provider, an affiliate, or a subcontractor reasonably expects to receive indirect compensation or direct compensation described in item (dd), provided to a covered plan with respect to selection of insurance products (including vision and dental), recordkeeping services, medical management vendor, benefits administration (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness services, transparency tools and vendors, group purchasing organization preferred vendor panels, disease management vendors and products, compliance services, employee assistance programs, or third party administration services.

“(BB) Consulting, for which the covered service provider, an affiliate, or a subcontractor reasonably expects to receive indirect compensation or direct compensation described in item (dd), related to the development or implementation of plan design, insurance or insurance product selection (including vision and dental), recordkeeping, medical management, benefits administration selection (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness design and management services, transparency tools, group purchasing organization agreements and services, participation in and services from preferred vendor panels, disease management, compliance services, employee assistance programs, or third party administration services.

“(cc) The term ‘affiliate’, with respect to a covered service provider, means an entity that directly or indirectly (through one or more intermediaries) controls, is controlled by, or is under common control with, such provider, or is an officer, director, or employee of, or partner in, such provider.

“(dd)(AA) The term ‘compensation’ means anything of monetary value, but does not include non-monetary compensation valued at \$250 (or such amount as the Secretary may establish in regulations to account for inflation since the date of enactment of the Ban Surprise Billing Act, as appropriate) or less, in the aggregate, during the term of the contract or arrangement.

“(BB) The term ‘direct compensation’ means compensation received directly from a covered plan.

“(CC) The term ‘indirect compensation’ means compensation received from any source other than the covered plan, the plan sponsor, the covered service provider, or an affiliate. Compensation received from a subcontractor is indirect compensation, unless it is received in connection with services performed under a contract or arrangement with a subcontractor.

“(ee) The term ‘responsible plan fiduciary’ means a fiduciary with authority to cause the covered plan to enter into, or extend or renew, the contract or arrangement.

“(ff) The term ‘subcontractor’ means any person or entity (or an affiliate of such person or entity) that is not an affiliate of the covered service provider and that, pursuant to a contract or arrangement with the covered service provider or an affiliate, reasonably expects to receive \$1,000 (or such amount as the Secretary may establish in regulations to account for inflation since the date of enactment of the Ban Surprise Billing Act, as appropriate) or more in compensation for performing one or more services described in item (bb) under a contract or arrangement with the covered plan.

“(II) For purposes of this subparagraph, a description of compensation or cost may be expressed as a monetary amount, formula, or a per capita charge for each enrollee or, if the compensation or cost cannot reasonably be expressed in such terms, by any other reasonable method, including a disclosure that additional compensation may be earned but may not be calculated at the time of contract if such a disclosure includes a description of the circumstances under which the additional compensation may be earned and a reasonable and good faith estimate if the covered service provider cannot otherwise readily describe compensation or cost and explains the methodology and assumptions used to prepare such estimate. Any such description shall contain sufficient information to permit evaluation of the reasonableness of the compensation or cost.

“(III) No person or entity is a ‘covered service provider’ within the meaning of subclause (I)(bb) solely on the basis of providing services as an affiliate or a subcontractor that is performing one or more of the services described in subitem (AA) or (BB) of such subclause under the contract or arrangement with the covered plan.

“(iii) A covered service provider shall disclose to a responsible plan fiduciary, in writing, the following:

“(I) A description of the services to be provided to the covered plan pursuant to the contract or arrangement.

“(II) If applicable, a statement that the covered service provider, an affiliate, or a subcontractor will provide, or reasonably expects to provide, services pursuant to the contract or arrangement directly to the covered plan as a fiduciary (within the meaning of section 3(21)).

“(III) A description of all direct compensation, either in the aggregate or by service, that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with the services described in subclause (I).

“(IV)(aa) A description of all indirect compensation that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with the services described in subclause (I)—

“(AA) including compensation from a vendor to a brokerage firm based on a structure of incentives not solely related to the contract with the covered plan; and

“(BB) not including compensation received by an employee from an employer on account of work performed by the employee.

“(bb) A description of the arrangement between the payer and the covered service provider, an affiliate, or a subcontractor, as applicable, pursuant to which such indirect compensation is paid.

“(cc) Identification of the services for which the indirect compensation will be received, if applicable.

“(dd) Identification of the payer of the indirect compensation.

“(V) A description of any compensation that will be paid among the covered service provider, an affiliate, or a subcontractor, in connection with the services described in subclause (I) if such compensation is set on a transaction basis (such as commissions, finder’s fees, or other similar incentive compensation based on business placed or retained), including identification of the services for which such compensation will be paid and identification of the payers and recipients of such compensation (including the status of a payer or recipient as an affiliate or a subcontractor), regardless of whether such compensation also is disclosed pursuant to subclause (III) or (IV).

“(VI) A description of any compensation that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with termination of the contract or arrangement, and how any prepaid amounts will be calculated and refunded upon such termination.

“(iv) A covered service provider shall disclose to a responsible plan fiduciary, in writing a description of the manner in which the compensation described in clause (iii), as applicable, will be received.

“(v)(I) A covered service provider shall disclose the information required under clauses (iii) and (iv) to the responsible plan fiduciary not later than the

date that is reasonably in advance of the date on which the contract or arrangement is entered into, and extended or renewed.

“(II) A covered service provider shall disclose any change to the information required under clause (iii) and (iv) as soon as practicable, but not later than 60 days from the date on which the covered service provider is informed of such change, unless such disclosure is precluded due to extraordinary circumstances beyond the covered service provider’s control, in which case the information shall be disclosed as soon as practicable.

“(vi)(I) Upon the written request of the responsible plan fiduciary or covered plan administrator, a covered service provider shall furnish any other information relating to the compensation received in connection with the contract or arrangement that is required for the covered plan to comply with the reporting and disclosure requirements under this Act.

“(II) The covered service provider shall disclose the information required under clause (iii)(I) reasonably in advance of the date upon which such responsible plan fiduciary or covered plan administrator states that it is required to comply with the applicable reporting or disclosure requirement, unless such disclosure is precluded due to extraordinary circumstances beyond the covered service provider’s control, in which case the information shall be disclosed as soon as practicable.

“(vii) No contract or arrangement will fail to be reasonable under this subparagraph solely because the covered service provider, acting in good faith and with reasonable diligence, makes an error or omission in disclosing the information required pursuant to clause (iii) (or a change to such information disclosed pursuant to clause (v)(II)) or clause (vi), provided that the covered service provider discloses the correct information to the responsible plan fiduciary as soon as practicable, but not later than 30 days from the date on which the covered service provider knows of such error or omission.

“(viii)(I) Pursuant to subsection (a), subparagraphs (C) and (D) of section 406(a)(1) shall not apply to a responsible plan fiduciary, notwithstanding any failure by a covered service provider to disclose information required under clause (iii), if the following conditions are met:

“(aa) The responsible plan fiduciary did not know that the covered service provider failed or would fail to make required disclosures and reasonably believed that the covered service provider disclosed the information required to be disclosed.

“(bb) The responsible plan fiduciary, upon discovering that the covered service provider failed to disclose the required information, requests in writing that the covered service provider furnish such information.

“(cc) If the covered service provider fails to comply with a written request described in subclause (II) within 90 days of the request, the responsible plan fiduciary notifies the Secretary of the covered service provider’s failure, in accordance with subclauses (II) and (III).

“(II) A notice described in subclause (I)(cc) shall contain—

“(aa) the name of the covered plan;

“(bb) the plan number used for the annual report on the covered plan;

“(cc) the plan sponsor’s name, address, and employer identification number;

“(dd) the name, address, and telephone number of the responsible plan fiduciary;

“(ee) the name, address, phone number, and, if known, employer identification number of the covered service provider;

“(ff) a description of the services provided to the covered plan;

“(gg) a description of the information that the covered service provider failed to disclose;

“(hh) the date on which such information was requested in writing from the covered service provider; and

“(ii) a statement as to whether the covered service provider continues to provide services to the plan.

“(III) A notice described in subclause (I)(cc) shall be filed with the Department not later than 30 days following the earlier of—

“(aa) The covered service provider’s refusal to furnish the information requested by the written request described in subclause (I)(bb); or

“(bb) 90 days after the written request referred to in subclause (I)(cc) is made.

“(IV) If the covered service provider fails to comply with the written request under subclause (I)(bb) within 90 days of such request, the responsible plan fiduciary shall determine whether to terminate or continue the contract or arrangement under section 404. If the requested information relates to future

services and is not disclosed promptly after the end of the 90-day period, the responsible plan fiduciary shall terminate the contract or arrangement as expeditiously as possible, consistent with such duty of prudence.

“(ix) Nothing in this subparagraph shall be construed to supersede any provision of State law that governs disclosures by parties that provide the services described in this section, except to the extent that such law prevents the application of a requirement of this section.”.

(2) APPLICABILITY OF EXISTING REGULATIONS.—Nothing in the amendments made by paragraph (1) shall be construed to affect the applicability of section 2550.408b–2 of title 29, Code of Federal Regulations (or any successor regulations), with respect to any applicable entity other than a covered plan or a covered service provider (as defined in section 408(b)(2)(B)(ii) of the Employee Retirement Income Security Act of 1974, as amended by paragraph (1)).

(3) INDIVIDUAL MARKET COVERAGE.—Subpart 1 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–41 et seq.) is amended by adding at the end the following:

“SEC. 2746. DISCLOSURE TO ENROLLEES OF INDIVIDUAL MARKET COVERAGE.

“(a) IN GENERAL.—A health insurance issuer offering individual health insurance coverage shall make disclosures to enrollees in such coverage, as described in subsection (b), and reports to the Secretary, as described in subsection (c), regarding direct or indirect compensation provided to an agent or broker associated with enrolling individuals in such coverage.

“(b) DISCLOSURE.—A health insurance issuer described in subsection (a) shall disclose to an enrollee the amount of direct or indirect compensation provided to an agent or broker for services provided by such agent or broker associated with plan selection and enrollment. Such disclosure shall be—

“(1) made prior to the individual finalizing plan selection; and

“(2) included on any documentation confirming the individual’s enrollment.

“(c) REPORTING.—A health insurance issuer described in subsection (a) shall annually report to the Secretary, prior to the beginning of open enrollment, any direct or indirect compensation provided to an agent or broker associated with enrolling individuals in such coverage.

“(d) RULEMAKING.—Not later than 1 year after the date of enactment of the Ban Surprise Billing Act, the Secretary shall finalize, through notice-and-comment rulemaking, the form and manner in which issuers described in subsection (a) are required to make the disclosures described in subsection (b) and the reports described in subsection (c). Such rulemaking may also include adjustments to notice requirements to reflect the different processes for plan renewals, in order to provide enrollees with full, timely information.”.

(4) TRANSITION RULE.—No contract executed prior to the effective date described in paragraph (5) by a group health plan subject to the requirements of section 408(b)(2)(B) of the Employee Retirement Income Security Act of 1974 (as amended by paragraph (1)) or by a health insurance issuer subject to the requirements of section 2746 of the Public Health Service Act (as added by paragraph (3)) shall be subject to the requirements of such section 408(b)(2)(B) or such section 2746, as applicable.

(5) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (3) shall apply beginning one year after the date of enactment of this Act.

(b) STANDARDIZED REPORTING FORMAT.—Section 716 of the Employee Retirement Income Security Act of 1974, as added by section 2 and amended by section 3(c), is further amended by adding at the end the following new subsection:

“(i) STANDARDIZED REPORTING FORMAT.—

“(1) IN GENERAL.—Not later than 1 year after the date of enactment of this subsection, the Secretary shall establish a standardized reporting format for the reporting, by group health plans (or health insurance coverage offered in connection with such a plan) to State All Payer Claims Databases, of medical claims, pharmacy claims, dental claims, and eligibility and provider files that are collected from private and public payers, and shall provide guidance to States on the process by which States may collect such data from such plans or coverage in the standardized reporting format.

“(2) DEFINITION.—In this subsection, the term ‘State All Payer Claims Database’ means, with respect to a State, a database that may include medical claims, pharmacy claims, dental claims, and eligibility and provider files, which are collected from private and public payers.”.

SEC. 8. ACCESS TO COST-SHARING INFORMATION.

(a) INSURER AND PLAN REQUIREMENTS.—

(1) PHSA.—Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–11 et seq.), as amended by section 6(a), is further amended by inserting after section 2730 the following:

“SEC. 2731. PROVISION OF COST-SHARING INFORMATION.

“A group health plan or a health insurance issuer offering group or individual health insurance coverage shall provide a participant, beneficiary, or enrollee in the plan or coverage with a good faith estimate of the enrollee’s cost-sharing (including deductibles, copayments, and coinsurance) for which the participant, beneficiary, or enrollee may be responsible for paying with respect to a specific health care service (including any service that is reasonably expected to be provided in conjunction with such specific service), as soon as practicable and not later than 2 business days after a request for such information by a participant, beneficiary, or enrollee.”.

(2) ERISA.—

(A) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by section 6(b), is further amended by adding at the end the following:

“SEC. 718. PROVISION OF COST-SHARING INFORMATION.

“A group health plan (or health insurance coverage offered in connection with such a plan) shall provide a participant or beneficiary in the plan or coverage with a good faith estimate of the participant’s or beneficiary’s cost-sharing (including deductibles, copayments, and coinsurance) for which the participant or beneficiary may be responsible for paying with respect to a specific health care service (including any service that is reasonably expected to be provided in conjunction with such specific service), as soon as practicable and not later than 2 business days after a request for such information by a participant or beneficiary. For purposes of the previous sentence, the Secretary shall develop and make available in multiple languages (as specified by the Secretary) a model form that is in easily understandable language and format.”.

(B) APPLICATION.—The amendment made by subparagraph (A) shall apply regardless of whether the model form described in the section 718 proposed to be added by such subparagraph has been developed or made available.

(3) IRC.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 6(c), is further amended by adding at the end the following:

“SEC. 9818. PROVISION OF COST-SHARING INFORMATION.

“A group health plan shall provide a participant or beneficiary in the plan with a good faith estimate of the participant’s or beneficiary’s cost-sharing (including deductibles, copayments, and coinsurance) for which the participant or beneficiary may be responsible for paying with respect to a specific health care service (including any service that is reasonably expected to be provided in conjunction with such specific service), as soon as practicable and not later than 2 business days after a request for such information by a participant or beneficiary.”.

(4) CLERICAL AMENDMENTS.—

(A) ERISA.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), as amended by section 8(b)(4), is further amended by inserting after the item relating to section 717 the following new item:

“Sec. 718. Provision of cost-sharing information.”.

(B) IRC.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 8(b)(4), is further amended by adding at the end the following new item:

“Sec. 9818. Provision of cost-sharing information.”.

(b) PROVIDER REQUIREMENTS.—Part D of title XXVII of the Public Health Service Act, as added by section 3 and amended by section 6, is further amended by inserting before section 2799A–7 the following new section:

“SEC. 2799A–6. PROVISION OF COST-SHARING INFORMATION.

“A provider that is in-network with respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage shall, upon request by a participant, beneficiary, or enrollee, provide to a participant, beneficiary, or enrollee in the plan or coverage the following information, together with accurate and complete information about the participant’s, beneficiary’s, or enrollee’s coverage under the applicable plan or coverage:

“(1) As soon as practicable and not later than 2 business days after the participant, beneficiary, or enrollee requests such information, a good faith estimate of the expected participant, beneficiary, or enrollee cost-sharing for the provision of a particular health care service (including any service that is reasonably expected to be provided in conjunction with such specific service).

“(2) As soon as practicable and not later than 2 business days after a participant, beneficiary, or enrollee requests such information, the contact information for any ancillary providers for a scheduled health care service.”.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply with respect to plan years beginning on or after the date that is 18 months after the date of enactment of this Act.

SEC. 9. TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS.

(a) PHSA.—Section 2719A of the Public Health Service Act, as amended by section 2, is further amended by adding at the end the following new subsection:

“(g) TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS.—

“(1) IN GENERAL.—A group health plan or a health insurance issuer offering group or individual health insurance coverage and providing or covering any benefit with respect to items or services shall include, in clear writing, on any plan or insurance identification card issued to enrollees in the plan or coverage the amount of the in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket maximum limitation that apply to such plan or coverage.

“(2) GUIDANCE.—The Secretary, in consultation with the Secretary of Labor and Secretary of the Treasury, shall issue guidance to implement paragraph (1).”.

(b) ERISA.—Section 716 of the Employee Retirement Income Security Act of 1974, as added by section 2 and as amended by sections 3(c) and 7(b), is further amended by adding at the end the following new subsection:

“(j) TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS.—

“(1) IN GENERAL.—A group health plan or a health insurance issuer offering group health insurance coverage and providing or covering any benefit with respect to items or services shall include, in clear writing, on any plan or insurance identification card issued to participants or beneficiaries in the plan or coverage the amount of the in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket maximum limitation that apply to such plan or coverage.

“(2) GUIDANCE.—The Secretary, in consultation with the Secretary of Health and Human Services and Secretary of the Treasury, shall issue guidance to implement paragraph (1).”.

(c) IRC.—Section 9816 of the Internal Revenue Code of 1986, as added by section 2, is further amended by adding at the end the following new subsection:

“(h) TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS.—

“(1) IN GENERAL.—A group health plan providing or covering any benefit with respect to items or services shall include, in clear writing, on any plan or insurance identification card issued to participants or beneficiaries in the plan the amount of the in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket maximum limitation that apply to such plan.

“(2) GUIDANCE.—The Secretary, in consultation with the Secretary of Health and Human Services and Secretary of Labor, shall issue guidance to implement paragraph (1).”.

(d) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to plan years beginning on or after January 1, 2022.

SEC. 10. CONTINUITY OF CARE.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by sections 2, 6, and 8, is further amended by adding at the end the following:

“SEC. 719. CONTINUITY OF CARE.

“(a) ENSURING CONTINUITY OF CARE WITH RESPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER NETWORK STATUS.—

“(1) IN GENERAL.—In the case of an individual with benefits under a group health plan or health insurance coverage offered by a health insurance issuer in connection with a group health plan and with respect to a health care pro-

vider or facility that has a contractual relationship with such plan or such issuer (as applicable) for furnishing items and services under such plan or such coverage, if, while such individual is a continuing care patient (as defined in subsection (b)) with respect to such provider or facility—

“(A) such contractual relationship is terminated (as defined in paragraph (b));

“(B) benefits provided under such plan or such health insurance coverage with respect to such provider or facility are terminated because of a change in the terms of the participation of the provider or facility in such plan or coverage; or

“(C) a contract between such group health plan and a health insurance issuer offering health insurance coverage in connection with such plan is terminated, resulting in a loss of benefits provided under such plan with respect to such provider or facility;

the plan or issuer, respectively, shall meet the requirements of paragraph (2) with respect to such individual.

“(2) REQUIREMENTS.—The requirements of this paragraph are that the plan or issuer—

“(A) notify each individual enrolled under such plan or coverage who is a continuing care patient with respect to a provider or facility at the time of a termination described in paragraph (1) affecting such provider or facility on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility under this section;

“(B) provide such individual with an opportunity to notify the plan or issuer of the individual's need for transitional care; and

“(C) permit the patient to elect to continue to have benefits provided under such plan or such coverage, under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan or coverage had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a continuing care patient during the period beginning on the date on which the notice under subparagraph (A) is provided and ending on the earlier of—

“(i) the 90-day period beginning on such date; or

“(ii) the date on which such individual is no longer a continuing care patient with respect to such provider or facility.

“(b) DEFINITIONS.—In this section:

“(1) CONTINUING CARE PATIENT.—The term ‘continuing care patient’ means an individual who, with respect to a provider or facility—

“(A) is undergoing a course of treatment for a serious and complex condition from the provider or facility;

“(B) is undergoing a course of institutional or inpatient care from the provider or facility;

“(C) is scheduled to undergo nonelective surgery from the provider or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery;

“(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

“(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

“(2) SERIOUS AND COMPLEX CONDITION.—The term ‘serious and complex condition’ means, with respect to a participant, beneficiary, or enrollee under a group health plan or health insurance coverage—

“(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

“(B) in the case of a chronic illness or condition, a condition that—

“(i) is life-threatening, degenerative, potentially disabling, or congenital; and

“(ii) requires specialized medical care over a prolonged period of time.

“(3) TERMINATED.—The term ‘terminated’ includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.”.

(b) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001), as amended by sections 2, 6, and 8, is further amended by inserting after the item relating to section 718 the following new item:

“Sec. 719. Continuity of care.”.

(c) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply with respect to plan years beginning on or after January 1, 2021.

SEC. 11. REPORT BY COMPTROLLER GENERAL ON ACCESS TO HEALTH CARE PROVIDERS.

Not later than January 1, 2023, the Comptroller General of the United States shall submit to Congress, and make publicly available, a report—

(1) on the effect of the provisions of, including amendments made by, this Act on access to health care providers, including in rural and underserved communities and health professional shortage areas (as defined in section 332 of the Public Health Service Act (42 U.S.C. 254e)); and

(2) including—

(A) an analysis of access to health care in the communities and areas described in paragraph (1) and the extent of provider shortages in such communities and areas; and

(B) legislative and regulatory recommendations to address any such shortage.

SEC. 12. REPORT BY COMPTROLLER GENERAL ON ADEQUACY OF PROVIDER NETWORKS.

Not later than January 1, 2023, the Comptroller General of the United States shall submit to Congress, and make publicly available, a report on the adequacy of provider networks in group health plans and group and individual health insurance coverage, including legislative recommendations to improve the adequacy of such networks.

SEC. 13. IMPLEMENTING PROTECTIONS AGAINST PROVIDER NONDISCRIMINATION.

Not later than 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury shall issue interim final rules implementing the protections of section 2706(a) of the Public Health Service Act (42 U.S.C. 300gg–5(a)). The Secretaries shall accept and consider public comments on any interim final rule issued pursuant to this subsection for a period of 60 days after the date of such issuance.

PURPOSE AND SUMMARY

The Ban Surprise Billing Act is comprehensive, bipartisan legislation that makes several major reforms to protect consumers from surprise medical bills and improve transparency in health coverage. Surprise medical bills arise when a consumer covered by a health plan is unexpectedly treated by an out-of-network provider and is required to pay the difference between what the plan pays and the provider's charge. The issue of surprise bills, which can often expose a consumer to thousands of dollars of unforeseen medical costs, is widespread. In 2017, one in six Americans covered by an employer-sponsored plan received a surprise medical bill for out-of-network care despite having health insurance.¹ One in ten elective hospital admissions and one in five admissions from emergency departments result in surprise bills.²

First, the *Ban Surprise Billing Act* protects participants, beneficiaries, and enrollees in group health plans and coverage in the group or individual markets from surprise medical bills. To ensure that consumers are held harmless under the terms of their plan or coverage, it limits cost-sharing to the in-network rate: (1) in emergency situations, whenever a participant, beneficiary, or enrollee receives out-of-network emergency care without having a choice of provider; and (2) in non-emergency settings, when out-of-network care from certain ancillary providers is chosen without the individ-

¹ Rachel Bluth, *1 In 6 Insured Hospital Patients Get a Surprise Bill for Out-Of-Network Care*, Kaiser Health News (June 20, 2019), <https://khn.org/news/1-in-6-insured-hospital-patients-get-a-surprise-bill-for-out-of-network-care/>.

² Christopher Garmon & Benjamin Chartock, *One in Five Inpatient Emergency Department Cases May Lead To Surprise Bills*, 36 Health Affairs 177 (2017), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0970>.

ual's knowledge. It also extends these protections to patients who receive services from air ambulance providers.

Second, the *Ban Surprise Billing Act* includes strong prohibitions on balance billing by providers. Balance billing occurs when a patient is held financially liable for the difference between a provider's billed charge and the allowed amount under a health plan. The legislation prohibits out-of-network providers or facilities from balance billing patients in all emergency situations and in non-emergency situations by ancillary providers. It limits balance billing for elective out-of-network care at in-network facilities to situations in which a patient has a choice of an in-network provider at the facility and if the out-of-network provider complies with strong notice-and-consent requirements. Violations of these prohibitions on balance billing by providers will be enforced primarily by the states, who retain authority to regulate insurance coverage, and secondarily by the Secretary of Health and Human Services, subject to oversight by the Secretary of Labor regarding violations impacting participants and beneficiaries under group health plans or coverage.

Third, in order to resolve payment disputes between providers and health plans, the *Ban Surprise Billing Act* employs a hybrid approach that relies upon both a market-based benchmark payment and an Independent Dispute Resolution (IDR) process. For claims under \$750 (under \$25,000 for air ambulance claims), payment for out-of-network care will be based on the median contracted rate for similar services in the geographic area. For claims of at least \$750 (\$25,000 for air ambulance claims), the benchmark rate may serve as the payment amount or, alternatively, either the provider or plan may elect to utilize the binding IDR process to determine a fair payment amount. Importantly, guardrails—including a prohibition on consideration of provider billed charges by IDR entities—are put into effect to reduce costs for patients and prevent inflationary effects on health care costs.

Fourth, the *Ban Surprise Billing Act* takes additional steps to improve transparency in health coverage. For example, it requires group health plans and issuers offering coverage in the group or individual markets to establish business processes to verify and update provider directories and protect consumers from using inaccurate or out-of-date directory information. It improves the availability of information regarding cost-sharing on insurance cards. It requires brokers and consultants to disclose to group health plan sponsors and individual market consumers whether they have received any direct or indirect compensation for referrals. The *Ban Surprise Billing Act* also requires the Secretary of Labor to develop a standardized form to facilitate group health plans' information reporting to state All-Payer Claims Databases. These and other reforms will meaningfully improve the quality and affordability of care while increasing transparency in coverage and empowering patients to make informed decisions about their care.

Finally, the bill is drafted in a legally sound manner that will ensure its requirements are enforceable and fully protect participants, beneficiaries, and enrollees in group health plans and coverage in the group and individual markets from surprise medical bills. All provisions of the *Ban Surprise Billing Act* that are intended to apply to plans covered by the *Employee Retirement In-*

come Security Act of 1974 (ERISA) are drafted as explicit amendments to ERISA, resolving any question as to their applicability and enforceability by the Secretary of Labor.

COMMITTEE ACTION

116TH CONGRESS

On April 2, 2019, the Committee on Education and Labor's (the Committee) Subcommittee on Health, Employment, Labor, and Pensions held the first ever Congressional hearing on surprise billing entitled "Examining Surprise Billing: Protecting Patients from Financial Pain" (April 2nd Subcommittee Hearing). The hearing explored the causes of surprise billing, the impact of surprise medical bills on consumers, and the policies needed to both protect consumers and improve transparency in health coverage. The Committee heard testimony from Ms. Christen Linke Young, Fellow, USC Brookings Schaeffer Initiative on Health Policy, Washington, DC; Ms. Ilyse Schuman, Senior Vice President, Health Policy, American Benefits Council, Washington, DC; Mr. Frederick Isasi, Executive Director, Families USA, Washington, DC; and Dr. Jack Hoadley, Research Professor Emeritus, Georgetown University Health Policy Institute, McCourt School of Public Policy, McLean, VA.

On February 7, 2020, Congressman Robert C. "Bobby" Scott (D-VA-3), Chairman of the Committee on Education and Labor, introduced H.R. 5800, the *Ban Surprise Billing Act*, with Congresswoman Virginia Foxx (R-NC-5), Ranking Member of the Committee on Education and Labor, as an original cosponsor.

On February 11, 2020, the Committee marked up H.R. 5800 and ordered it to be reported favorably, as amended, to the House of Representatives by a vote of 32 Yeas and 13 Nays.

At the markup, the Committee considered the following amendments to H.R. 5800:

- Congressman Scott offered an Amendment in the Nature of a Substitute (ANS) that made minor technical corrections to the bill. The ANS also requires the Comptroller General to conduct a study of the IDR process established by the bill and analyze potential financial relationships between providers or facilities that utilize the IDR process and private equity firms. The ANS, as amended with further amendments described below, was adopted by voice vote.

- Congresswoman Donna Shalala (D-FL-27) offered an amendment allowing for care begun with an in-network provider to continue at the in-network rate for 90 days if the provider leaves the network. The amendment was adopted by voice vote.

- Congressman Greg Murphy (R-NC-3) offered an amendment requiring certain provider directory documents to be retained by health plans for five years. The amendment was adopted by voice vote.

- Congresswoman Shalala offered an amendment requiring a rulemaking on provider nondiscrimination requirements. The amendment was adopted by voice vote.

- Congressman Murphy offered an amendment providing that the IDR process established under the bill must require public disclosure of the average response time following a billing discrepancy

and the average time to resolve a billing discrepancy. The amendment was adopted by voice vote.

- Congresswoman Ilhan Omar (D–MN–5) offered an amendment requiring the Secretary of Labor to submit a template for disseminating cost-sharing information. The amendment was adopted by voice vote.

- Congressman Phil Roe (R–TN–1) offered an amendment striking the air ambulance provisions of the bill. The amendment was defeated by a vote of 8 Yeas and 37 Nays.

- Congresswoman Kim Schrier (D–WA–8) offered an amendment requiring the Comptroller General to conduct a study of network adequacy in health plans and coverage. The amendment was adopted by voice vote.

- Congressman Roe offered an amendment striking the median contracted rate benchmark and substituting “commercially reasonable” rates. The amendment was defeated by a vote of 15 Yeas and 30 Nays.

- Congresswoman Susie Lee (D–NV–3) offered an amendment requiring the Comptroller General to conduct a study of provider access in underserved areas. The amendment was adopted by voice vote.

- Congressman Roe offered an amendment striking the median contracted rate benchmark and substituting “previously contracted” rates. The amendment was defeated by a vote of 16 Yeas and 29 Nays.

- Congresswoman Schrier offered an amendment adding good faith efforts to contract as a consideration for IDR entities. The amendment was adopted by voice vote.

- Congressman Lloyd Smucker (R–PA–11) offered an amendment allowing for the continuation of certain contracting practices, notwithstanding the enactment of the *Ban Surprise Billing Act*. The amendment was withdrawn.

- Congressman Joe Morelle (D–NY–25) offered an ANS substituting the text of H.R. 5826, the *Consumer Protections Against Surprise Medical Bills Act of 2020*, in place of the text of H.R. 5800. The amendment was withdrawn.

- Congressman Morelle offered an amendment to strike the threshold for claims to be eligible for the IDR process. The amendment was defeated by a vote of 15 Yeas and 30 Nays.

COMMITTEE VIEWS

INTRODUCTION

As the Committee of jurisdiction over employer-sponsored health coverage, a central goal in developing and advancing the Ban Surprise Billing Act is to ensure that reforms apply throughout the health care system—not only in the individual market, but also to the approximately 157 million Americans who are covered through a workplace health plan.³ In addition, while meaningfully improving the affordability of care for millions, the bill was carefully crafted to strike a balance between the various concerns of stakeholders—including providers, hospitals, labor unions, health insur-

³Kaiser Family Foundation, *Health Insurance Coverage of the Total Population*, <https://www.kff.org/other/state-indicator/total-population/> (last visited Feb. 23, 2020) (Covering the 2018 timeframe.).

ers, and employers—many of whom have divergent views on how to effectively address the issue of surprise billing.

While striking a careful balance between the concerns of stakeholders, the *Ban Surprise Billing Act* puts consumers and patients first, and has been commended by dozens of advocacy groups. A coalition of twenty-three patient organizations, including the American Heart Association, American Lung Association, and American Cancer Society, applauded the bill for its “robust protections for all patients in all health settings. . . . Importantly, these protections extend to patients covered by employer-sponsored plans.”⁴ Similarly, the No Surprises coalition, a group of thirteen consumer organizations, including Families USA, National Consumers League, and Consumer Reports, highlighted the bill’s strong protections against growth in health care premiums: “With health care costs a primary concern for America’s families, we strongly prefer the benchmark approach taken by the Education and Labor [Committee] as the most effective cost control mechanism available.”⁵

BACKGROUND ON SURPRISE MEDICAL BILLS

Surprise medical bills occur when consumers covered by health insurance are subject to higher-than-expected out-of-pocket costs when they receive care from a provider who is outside their plan’s network. These costs can include cost-sharing at out-of-network rates under their health plan as well as balance bills from a provider requiring the consumer to pay the difference between the provider’s out-of-network charge and the amount, if any, that the plan will pay for the item or service. The rise of managed care plans, such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Point of Service (POS) plans, in which the insurer contracts with a network of doctors, hospitals, or other health care providers, has placed an increasing number of consumers at risk of receiving surprise bills.⁶

Situations in which patients have little or no control over whether a provider is in- or out-of-network can arise in both emergency and non-emergency situations. Patients in emergency settings often receive care at a hospital that is not in their plan’s network or are transported by an out-of-network ambulance. Non-emergency situations can also lead to surprise bills when patients receive care at a facility that is in-network but unknowingly receive services by out-of-network providers. Among the most common non-emergency services that result in surprise out-of-network bills are pathology, radiology, anesthesiology, and other ancillary health services for

⁴ Press Release, ALS Association, et al. (Feb. 11, 2020), <https://rarediseases.org/wp-content/uploads/2020/02/NORD-2020-EdLabor-SMB-Markup-STMT-FINAL.pdf>.

⁵ Letter from No Surprises: People Against Surprise Medical Bills to the Honorable Robert C. “Bobby” Scott, Chairman, Committee on Education and Labor, et al. (Feb. 11, 2020) (on file with Committee).

⁶ Over the past three decades, the number of individuals enrolled in a conventional health insurance arrangement through their employer has declined from 73 percent of workers to approximately ten percent. By 2018, approximately 49 percent of individuals with employer-sponsored coverage were enrolled in a PPO, 16 percent in an HMO, and six percent in a POS plan. Kaiser Family Foundation, *2018 Employer Health Benefits Survey*, <https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-5-market-shares-of-health-plans/> (last visited May 20, 2020).

which the patient did not have an opportunity to choose the provider or was unaware the care was being provided at all.⁷

THE PREVALENCE AND FINANCIAL IMPACT OF SURPRISE MEDICAL BILLS

Surprise medical bills are widespread in private health coverage, impacting consumers in both the group and individual markets. In 2017, one in six Americans covered by an employer-sponsored plan received a surprise medical bill for out-of-network care despite having health insurance.⁸ One in ten elective hospital admissions and one in five admissions to emergency departments result in surprise bills.⁹ Services particularly likely to be out-of-network include ambulance transportation, including more than half of all emergency ground ambulance transports¹⁰ and nearly 70 percent of air ambulance transports.¹¹

The financial liability imposed on patients by surprise medical bills can be staggering. A series of articles published by Vox in 2019 drew substantial public attention to the devastating stories of patients who have received surprise bills; among the most shocking was a spinal surgery patient who received a bill of \$101,000 despite having confirmed that her surgeon was in-network.¹² These unexpected medical bills can result in financial ruin, as nearly four in ten American adults are unable to cover a \$400 emergency expense,¹³ yet the average surprise balance bill by emergency physicians in 2014 and 2015 was an estimated \$620 greater than the Medicare rate for the same service.¹⁴ The ever-present threat of out-of-pocket medical expenses contributes to the fact that approximately two-thirds of consumers have expressed a fear that they will not be able to afford an unanticipated medical expense for themselves or a family member.¹⁵ These costs have further negative impacts on when and how patients receive needed care, often resulting in care delays and negatively affecting patient choices.¹⁶

Surprise medical bills have devastating financial impacts on Americans and on their ability to afford needed health care. Consumers, who are subject to these bills through no fault of their own, should not be liable for unexpected and unreasonable out-of-

⁷ Loren Adler et al., *Stopping Surprise Medical Bills: Federal Action Is Needed*, Health Affairs (Feb. 1, 2017), <https://www.healthaffairs.org/doi/10.1377/hlthaff.20170201.058570/full/>.

⁸ Rachel Bluth, *supra* note 1.

⁹ Christopher Garmon & Benjamin Chartock, *supra* note 2.

¹⁰ *Id.*

¹¹ U.S. Gov't Accountability Off., GAO-19-292, Air Ambulances: Available Data Show Privately-Insured Patients Are at Financial Risk 16 (2019), <https://www.gao.gov/assets/700/697684.pdf>.

¹² Sarah Kliff, *A Spinal Surgery, a \$101,000 Bill, and a New Law to Prevent More Surprises*, Vox (Mar. 19, 2019 8:00AM), <https://www.vox.com/health-care/2019/3/19/18233051/surprise-medical-bills-arbitration-new-york>.

¹³ Board of Governors of the Federal Reserve System, Economic Well-Being of U.S. Households in 2018 21 (2019), <https://www.federalreserve.gov/publications/files/2018-report-economic-well-being-us-households-201905.pdf>.

¹⁴ Zack Cooper & Fiona Scott Morton, *Out-of-Network Emergency-Physician Bills—An Unwelcome Surprise*, 375 New England Journal of Medicine 1915 (2016), http://zackcooper.com/sites/default/files/paper-files/NEJM_surprise_billing.pdf.

¹⁵ Jordan Rau, *Surprise Medical Bills Are What Americans Fear Most in Paying for Health Care*, Kaiser Health News (Sept. 5, 2018), <https://khn.org/news/surprise-medical-bills-are-what-americans-fear-most-in-paying-for-health-care/>.

¹⁶ According to one survey, 45 percent of individuals, the majority of whom are covered by health insurance, report that they have delayed or avoided receiving health care due to high out-of-pocket costs. Kyle T. Smith et al., *Access Is Necessary but Not Sufficient: Factors Influencing Delay and Avoidance of Health Care Services*, 3 Medical Decision Making Policy & Practice 1 (2018). See also Benjamin Chartock et al., *Consumers' Responses To Surprise Medical Bills In Elective Situations*, 38 Health Affairs 425 (2019).

pocket costs. There is substantial bipartisan interest in reducing the burden of surprise medical bills on consumers. In addition, there has been a growing sentiment among health care stakeholders that surprise billing must be addressed at the federal level, although opinions differ regarding the appropriate approach to do so.

SURPRISE BILLING REPRESENTS A MARKET FAILURE

Economists generally regard the practice of surprise medical billing as arising from a failure in the health care market, which causes providers—particularly in certain specialties—to have little or no incentive to contract to join a health plan’s network due to a number of unique circumstances. These providers face highly inelastic demands for their services because patients lack the ability to meaningfully choose or refuse care, such as during an emergency or when ancillary services are provided of which a patient may not even be aware. They also often hold substantial market power, resulting in one or only very few providers available to provide critical items or services in a geographic area. These circumstances enable some providers to charge amounts for their services that exceed the marginal cost of producing those services and resulting in compensation far above what is needed to sustain their practice.

The presence of this market failure in certain provider specialties is strongly supported by evidence reflecting the highly inflated payment rates for these services. For example, in comparison to the amount paid by Medicare for similar items or services, the median billed charge for emergency medicine is 465 percent of the Medicare rate; similar disparities are present for pathology (343 percent), diagnostic radiology (402 percent), and anesthesiology (551 percent).¹⁷ These inflated payment rates are, in turn, reflected in the cost of in-network care. While the average in-network physician is paid at 128 percent of Medicare rates, in-network payments for emergency medicine (306 percent), radiology (200 percent), and anesthesiology (344 percent) far exceed Medicare rates.¹⁸ These costs are directly felt through higher out-of-pocket expenses and exorbitant surprise bills for out-of-network care, as well as by all consumers who share in rising overall health care costs through higher premiums.

The financial opportunity from inflated out-of-network prices has made health care an attractive market for private equity firms, hedge funds, and venture capital firms.¹⁹ For example, private equity deals related to health care more than doubled between 2008 and 2018,²⁰ and private equity firms now own the two largest physician staffing companies, which together account for 30 percent of

¹⁷ *Examining Surprise Billing: Protecting Patients from Financial Pain Before the Subcomm. on Health, Employment, Labor, and Pensions of the H. Comm. on Educ. & Labor*, 116th Cong. (2019) (written testimony of Christen Linke Young, Fellow, USC–Brookings Schaeffer Initiative on Health Policy at 17) [hereinafter Young Testimony].

¹⁸ Young Testimony at 9.

¹⁹ Rachel Bluth & Emmarie Huettelman, *Investors’ Deep-Pocket Push to Defend Surprise Medical Bills*, Kaiser Health News (Sept. 11, 2019), <https://khn.org/news/investors-deep-pocket-push-to-defend-surprise-medical-bills/>.

²⁰ Samantha Liss, *Private Equity Sees Ripe Opportunity in Healthcare this Year*, Health Care Dive (Mar. 25, 2019), <https://www.healthcaredive.com/news/private-equity-sees-ripe-opportunity-in-healthcare-this-year/548831/>.

the physician-staffing market.²¹ Research on one large private equity-owned firm showed that when it entered a hospital network, out-of-network billing rates increased by more than 81 percentage points.²²

EXISTING STATE LAWS AND THE NEED FOR FEDERAL ACTION

A number of states have taken significant steps to address surprise medical bills through consumer protection laws that shield patients from surprise billing in the individual, small group, and fully-insured group markets. In total, about half of the states in the U.S. have enacted at least some form of surprise billing legislation; however, most Americans live in states that have not enacted laws that are considered comprehensive by experts.²³ Federal action is necessary to ensure that patients throughout the country are protected from unexpected costs arising from surprise billing practices.

Moreover, states are unable to protect consumers fully in employer-sponsored plans from surprise bills because ERISA prohibits states from regulating self-insured group health plans, which cover more than 60 percent of people enrolled in employer-sponsored health plans.²⁴ ERISA contains a broad preemption clause providing that federal law “shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”²⁵ States are therefore unable to apply their surprise medical bill laws to millions of their residents, and as a result, a federal legislative response is necessary.

THE CENTRAL ROLE OF ERISA IN ENSURING SURPRISE BILLING PROTECTIONS APPLY

The *Patient Protection and Affordable Care Act* (ACA)²⁶ made a number of major changes to the private health insurance market through amendments to Part A of title XXVII of the *Public Health Service Act* (PHSA).²⁷ These provisions, insofar as they impact group health plans and health insurance issuers providing health insurance coverage in connection with group health plans, are incorporated by reference into ERISA through Section 715 of ERISA.²⁸

However, serious questions exist as to whether amendments to Part A of title XXVII of the PHSA enacted subsequent to the ACA are automatically incorporated into ERISA. A recent decision by the Supreme Court of the United States, *Jam v. International Finance Corp.*,²⁹ articulated an approach to statutory interpretation that would suggest that subsequent amendments are not automati-

²¹ *Id.*

²² Zack Cooper et al., National Bureau of Economic Research, Surprise! Out-of-Network Billing for Emergency Care in the United States 2018–23 (2019) <https://www.nber.org/papers/w23623.pdf>.

²³ Jack Hoadley et al., *State Efforts to Protect Consumers from Balance Billing*, Commonwealth Fund (Jan. 18, 2019), <https://www.commonwealthfund.org/blog/2019/state-efforts-protect-consumers-balance-billing>.

²⁴ 2018 *Employer Health Benefits Survey, Section 10: Plan Funding*, Kaiser Family Foundation (Oct. 3, 2018), <https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-10-plan-funding/> (last visited June 5, 2020).

²⁵ 29 U.S.C. § 1144.

²⁶ 42 U.S.C. § 18001 et seq.

²⁷ 42 U.S.C. §§ 300gg et seq.

²⁸ 29 U.S.C. § 1185d. Note that a similar provision incorporates Part A of title XXVII of the *Public Health Service Act* into the Internal Revenue Code. 26 U.S.C. § 9815.

²⁹ 139 S. Ct. 759 (2019).

cally incorporated. In that decision, Chief Justice Roberts distinguished between two scenarios in which a statute incorporates external law by reference. In situations in which “a statute refers to a general subject, the statute adopts the law on that subject as it exists whenever a question under the statute arises.”³⁰ However, the Court drew a clear distinction “when a statute [] refers to another statute by specific title or section number.”³¹ In such situations, the referring statute “in effect cuts and pastes the referenced statute as it existed when the referring statute was enacted, without any subsequent amendments.”³²

Although the statute at issue in *Jam* was the *International Organizations Immunities Act*, the principle of statutory interpretation articulated by the Court is directly applicable to title XXVII of the PHSA and the incorporation by reference provision of ERISA. Because Section 715 of ERISA *specifically* references “the provisions of part A of title XXVII of the Public Health Service Act,” the Court’s reasoning in *Jam* suggests that ERISA only incorporates the law in Part A of title XXVII of the PHSA as it stood on the date of enactment of the ACA on March 23, 2010. Therefore, in order for subsequent amendments to Part A of title XXVII of the PHSA to apply to ERISA, the amendments must be drafted directly to ERISA. Therefore, the *Ban Surprise Billing Act* is drafted in this manner in order to protect consumers comprehensively and unequivocally from surprise bills.

COMPREHENSIVE PROTECTIONS ARE NEEDED TO PROTECT CONSUMERS FULLY

There is widespread agreement that any surprise billing solution must comprehensively protect consumers by “taking the consumer out of the middle” of surprise billing disputes. Since a large share of American consumers have very little financial cushion—as noted above, about 40 percent could not afford an unexpected \$400 emergency expense in 2018—surprise medical bills can lead to financial stress, debt, damaged credit, and bankruptcy.³³ The fact that individual consumers are ill-equipped to bear the risk of large, unpredictable costs underpins the notion of insurance in the market for health care. Consumers do not need to receive an exorbitant bill themselves to be negatively affected by surprise billing practices; when plans pay high out-of-network bills, these costs are passed on to all consumers in the form of higher premiums.³⁴

At the April 2nd Subcommittee Hearing, witnesses discussed several critical issues Congress must address to provide comprehensive protections for consumers from surprise medical billing. First, in order to hold a consumer truly harmless from the financial devastation of surprise bills, health plans must provide that cost-sharing be limited to in-network amounts in surprise billing situations to ensure that the patient is treated as if they were seeing an in-network provider.³⁵ Second, a surprise billing solution must pro-

³⁰ *Id.* at 769.

³¹ *Id.*

³² *Id.*

³³ Federal Reserve Board, *supra* note 13.

³⁴ Young Testimony at 2.

³⁵ *Examining Surprise Billing: Protecting Patients from Financial Pain*, Hearing Before the Subcomm. on Health, Employment, Labor, and Pensions of the H. Comm. on Educ. & Labor, Continued

hibit providers from sending balance bills to patients for amounts in excess of their in-network cost-sharing under the plan.³⁶ Third, in order to resolve disputes between providers and plans over payments, legislation must establish a fair payment amount.³⁷

In addition, witnesses and Members noted that measures to improve transparency in health coverage could serve as important complements to surprise billing legislation. Specifically, improvements to provider directories—described as “notoriously inaccurate” by Dr. Jack Hoadley during his testimony—were mentioned as potentially beneficial for consumers.³⁸ Further measures to improve transparency, such as including additional information regarding coverage on insurance cards, were also raised by Members such as Congressman Roe in his written questions for the hearing record.³⁹ However, witnesses emphasized that improvements to transparency, though helpful, are not substitutes for a comprehensive solution to the underlying issue of surprise medical billing.⁴⁰

RESOLVING PAYMENT DISPUTES BETWEEN PROVIDERS AND HEALTH PLANS

A key element of any solution to address surprise billing comprehensively is the payment rate, which is the amount that payers must remit to providers for out-of-network items and services. Two payment rate options have emerged as the predominant contenders to correct the market failure associated with surprise billing: (1) the benchmark rate model, and (2) the IDR process, also referred to as arbitration. Under a benchmark rate model, payments to providers for out-of-network items and services default to a pre-determined amount, such as a percentage of the Medicare rate (typically 125 percent of Medicare) or the median contracted (in-network) rate in the geographic area where the service took place.⁴¹ In contrast, the IDR process is mediated by a third-party arbitrator, and legislation typically specifies guidance or criteria for the arbitrator to consider. A common approach is to use “baseball-style” arbitra-

116th Cong. (2019) (written testimony of Frederick Isasi, Executive Director, Families USA, Washington, DC at 6).

³⁶ *Id.*

³⁷ *Id.*

³⁸ H. Comm. on Educ. & Labor, *Examining Surprise Billing: Protecting Patients from Financial Pain*, YouTube (Apr. 7, 2019), <https://www.youtube.com/watch?v=HyUd2-YPN0> (see 46:33).

³⁹ *Examining Surprise Billing: Protecting Patients from Financial Pain, Hearing Before the Subcomm. on Health, Employment, Labor, and Pensions of the H. Comm. on Educ. & Labor*, 116th Cong 194–95 (response to Committee Member questions by Ilyse Schuman, Senior Vice President, Health Policy, American Benefits Council).

⁴⁰ *Examining Surprise Billing: Protecting Patients from Financial Pain, Hearing Before the Subcomm. on Health, Employment, Labor, and Pensions of the H. Comm. on Educ. & Labor*, 116th Cong. (2019) 202 (response to Committee Member questions by Christen Linke Young, Fellow, USC-Brookings Schaeffer Initiative on Health Policy) (“Enhanced transparency about cost-sharing can be useful, but I do not believe it will provide a meaningful tool to address surprise out-of-network billing.”).

⁴¹ When the benchmark is set at a negotiated rate such as the median in-network rate, it is typically linked to previously agreed-upon rates (such as 2019 rates) and linked to inflation thereafter, which prevents providers from influencing their own pay. Examples of recent federal legislation that rely exclusively on benchmark rates are the *Lower Health Care Costs Act* (S. 1895), which passed the Senate Health, Education, Labor, and Pensions (HELP) Committee on June 26, 2019, by a vote of 20–3, and the *No Surprises Act* (H.R. 3630), as introduced in the U.S. House of Representatives on June 9, 2019. Both bills set benchmark rates at the median contracted (in-network) rate, although H.R. 3630 was amended in the Committee on Energy and Commerce to allow for limited arbitration for disputed bills for which the median in-network rate is at least \$1,250.

tion, under which each side submits a price, and the arbitrator chooses one, with both sides bound by the decision.⁴²

Both approaches “take the consumer out of the middle” of surprise billing disputes. Both also offer the opportunity to tether payment rates for surprise out-of-network bills directly to market-based prices, curbing cost growth relative to the status quo. For example, the commonly considered median in-network benchmark rate is a market-based price; it reflects negotiations between providers and insurers in a local health care market. An IDR process may also partially reflect market-based prices if the arbitrator is instructed under the legislation to consider a market-derived price such as the median in-network rate, although the IDR process entails some additional administrative costs. However, some IDR process proposals would have the arbitrator consider non-market-based rates such as providers’ billed charges,⁴³ which may drive up consumer costs.⁴⁴

Of the two options, evidence indicates that benchmark rates will generally slow the rapid growth of health care costs, both by lowering costs in the near term relative to the status quo and by slowing the rate of health care cost inflation in future years.⁴⁵ Benchmark rates achieve this primarily by removing providers’ incentives and ability to charge very high out-of-network prices,⁴⁶ thus reducing providers’ bargaining power to negotiate or demand higher prices of health plans,⁴⁷ the costs of which insurers typically pass on to consumers.⁴⁸ Slower growth in health care costs will, in turn,

⁴² An example of federal legislation that relies on the arbitration approach is the *Consumer Protections Against Surprise Medical Bills Act of 2020* (H.R. 5826) which was reported by the House Ways and Means Committee on February 12, 2020, by voice vote. The bill allows arbitration to take place if the payer and provider fail to negotiate a solution within 30 days; it instructs the arbitrator to consider the median in-network rate for the item or service, among other criteria.

⁴³ For example, under New York’s surprise billing law, arbitration entities are instructed to consider several factors in baseball-style arbitration, including the 80th percentile of billed charges. Loren Adler, *Experience with New York’s Arbitration Process for Surprise Out-of-Network Bills*, Brookings Institution (Oct. 24, 2019), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/10/24/experience-with-new-yorks-arbitration-process-for-surprise-out-of-network-bills/>.

⁴⁴ Loren Adler et al., *Rep. Ruiz’s Arbitration Proposal for Surprise Billing (H.R. 3502) Would Lead to Much Higher Costs And Deficits*, Health Affairs Blog (July 16, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190716.355260/full/>; see also David Hyman & Benedic Ippolito, *Arbitration not the Answer to Fix Surprise Medical Billing*, Real Clear Policy (Feb. 12, 2019), https://www.realclearpolicy.com/articles/2019/02/12/arbitration_not_the_answer_to_fix_surprise_medical_billing_111042.html.

⁴⁵ For example, the Congressional Budget Office (CBO) estimates that the surprise billing provisions of the Senate HELP Committee bill, which sets the benchmark rate at the relevant median in-network payment rate, would reduce commercial insurance premiums by an average of one percent nationwide and decrease deficits by \$25 billion over 10 years relative to the status quo. Of this \$25 billion, approximately \$24 billion stems from increased tax revenue due to lower premiums for tax-privileged employment-based insurance, while over \$1 billion stems from reduced federal spending. Congressional Budget Office, S.1895, *Lower Health Care Costs Act 3* (2019), https://www.cbo.gov/system/files/2019-07/s1895_0.pdf. By contrast, while CBO has not published a formal assessment of an IDR process model, CBO reportedly has stated that establishing a system similar to New York’s at the national level would increase the federal deficit by “double digit billions” over a ten-year period. Rachana Pradhan, *More States Crack Down on Vaping*, Politico (Sep. 25, 2019), <https://www.politico.com/newsletters/politico-pulse/2019/09/25/more-states-crack-down-on-vaping-757620>.

⁴⁶ Michelle Andrews, *California Surprise-Billing Law Protects Patients but Aggravates Many Doctors*, California Healthline (Dec. 4, 2019), <https://californiahealthline.org/news/california-surprise-billing-law-protects-patients-but-aggravates-many-doctors/>.

⁴⁷ Loren Adler et al., Brookings, *State Approaches to Mitigating Surprise Out-of-Network Billing* at 9 (2019), https://www.brookings.edu/wp-content/uploads/2019/02/Adler_et_al_State-Approaches-to-Mitigating-Surprise-Billing-2019.pdf.

⁴⁸ See Glenn Melnick, *Blame Emergency Rooms for the Out-of-Control Cost of Health Care*, New York Times (Sept. 5, 2018), <https://www.nytimes.com/2018/09/05/opinion/emergency-rooms-cost-insurance.html>. Furthermore, benchmarking obviates the additional administrative costs in-

Continued

reduce growth in consumers' premiums and government spending on health care.

The IDR process, on the other hand, has the potential advantage of allowing payment rates "to vary more for specific circumstances and potentially adjust more easily over time."⁴⁹ This added flexibility may be particularly merited in high-stakes and complex situations in which a market-based benchmark such as the median in-network rate is less likely to reflect or be monetarily close to the cost of furnishing the item or service.

There is a wide range of opinions among various stakeholders about which approach to payment rates is optimal. To bridge this divide, the *Ban Surprise Billing Act* incorporates a hybrid approach that will ensure that an efficient, market-based payment benchmark is employed, while providing for a noninflationary IDR mechanism for cases in which claims of at least \$750 (or \$25,000 for air ambulance services). This strikes an appropriate balance between the views of various stakeholders and is designed to reduce premiums and the deficit.

CONCLUSION

H.R. 5800, the *Ban Surprise Billing Act*, protects consumers from the financial devastation of surprise medical billing through a targeted and balanced approach that carefully weighs the needs of all stakeholders with divergent views on the issue. Most importantly, the legislation provides robust protections from surprise medical bills for workers and families across the country.

SECTION-BY-SECTION ANALYSIS

Sec. 1. Short title

This section states that the Act may be cited as the *Ban Surprise Billing Act*.

Sec. 2. Preventing surprise medical bills

This section establishes consumer protections in the group and individual markets to protect participants, beneficiaries, and enrollees from surprise medical bills. It limits cost-sharing owed under a health plan or coverage to the in-network rate whenever a participant, beneficiary, or enrollee receives out-of-network emergency care, including air ambulance services and non-emergency care provided by out-of-network ancillary providers. It also requires that the costs of out-of-network care received in a situation where a surprise bill would have occurred in either emergency or non-emergency settings be counted toward the in-network deductible or out-of-pocket limit under the plan or coverage.

This section provides that the recognized amount under the plan or coverage for certain out-of-network items or services will be determined based on a market-based benchmark of the median contracted rate for similar services in the geographic area. The methodology for determining the benchmark will be established by the

surers face under an arbitration model which, if high enough, could "undermine the effectiveness of the policy by leading insurers to simply accede to providers' demands rather than pursue arbitration," causing insurers to pass increased costs on to consumers, again leading to health care cost inflation. Loren Adler et al., *supra* note 47.

⁴⁹ Loren Adler et al., *supra* note 47.

Secretaries of Health and Human Services, Labor, and the Treasury (“Secretaries”) and the Secretaries shall establish a process whereby plans or providers may file complaints of violations of the requirements for determining the benchmark payment. Plans and issuers will be subject to audit by the Secretaries to ensure compliance with these requirements. The audit process specified in the bill is not intended to limit, restrict, or otherwise interfere with the Secretary of Labor’s existing investigative and enforcement authority under Part 5 of ERISA, including the Secretary’s authority to conduct additional audits regarding the median contracted rate and any other provisions of the bill.

This section also provides that in determining the allowed amount under the plan or coverage, state laws for determining the payment amount may remain in effect with respect to plans and coverage within the jurisdiction of states, including amounts determined under an All-Payer Model Agreement under Section 1115A of the *Social Security Act*. In cases in which no applicable state law is in effect, the allowed amount will be the median of the in-network rate recognized by the plan or issuer for a similar item or service provided in the same geographic region.

Sec. 3. Preventing certain cases of balance billing

This section prohibits out-of-network facilities and providers, including air ambulance providers, from engaging in balance billing of a participant, beneficiary, or enrollee in a group or individual health plan or coverage. In emergency situations, providers are prohibited from holding a participant, beneficiary, or enrollee liable for an amount greater than the cost-sharing owed under the plan or coverage. In non-emergency situations, ancillary providers are prohibited from holding a participant, beneficiary, or enrollee liable for an amount greater than the cost-sharing owed under the plan or coverage. This section further specifies that such ancillary services include emergency medicine, anesthesiology, pathology, radiology, neonatology, and certain diagnostic services. In addition, in cases in which no in-network provider can furnish the item or service at the facility, such out-of-network services will be treated as ancillary services.

In cases in which elective out-of-network care is sought, this section requires that out-of-network providers and facilities provide notice to a participant, beneficiary, or enrollee of their network status and a good faith estimate of charges that may be applied for the out-of-network care. In order for the item or service to be treated as out-of-network, this information must be provided at the time an appointment is scheduled and the consent of the patient must be obtained at least 72 hours in advance of when the items or services are furnished.

This section also provides for state enforcement under the Act of provider requirements and the prohibition on balance billing. In cases in which states fail to implement the requirements and do not substantially enforce the prohibitions, this section provides that the Secretary of Health and Human Services shall have the authority to apply, with respect to a facility or provider, a civil monetary penalty of up to \$10,000 per violation. In addition, this section requires states and the Secretary of Health and Human Services to inform the Secretary of Labor of violations of requirements impact-

ing individuals in group health plans or coverage and any enforcement actions, including the disposition of such actions.

Sec. 4. Independent dispute resolution

This section requires the Secretaries of Health and Human Services, the Treasury, and Labor to jointly establish an Independent Dispute Resolution (IDR) process to determine payment amounts. The Secretaries shall jointly certify such IDR entities, subject to standards to prevent conflicts of interest and financial relationships between certified entities and either providers or plans. This section permits providers and payers to elect to utilize the IDR process for any amounts for which the median contracted rate is at least \$750 (\$25,000 for air ambulance services).

This section authorizes certified IDR entities to consider several factors in determining payment amounts, including the median contracted rate for a similar item or service furnished in the same geographic area, the level of training and experience of the provider, and extenuating circumstances such as the complexity of the specific case or the acuity of the patient. It prohibits IDR entities from considering the billed charges of the provider for the item or service.

Sec. 5. Advisory committee on ground ambulance and patient billing

This section requires the Secretaries of Health and Human Services, Labor, and the Treasury to establish an advisory committee to develop recommendations to protect consumers from ground ambulance balance bills.

Sec. 6. Improving provider directories

This section requires group health plans and issuers offering coverage in the group or individual markets to establish business processes to verify and update provider directories and to respond to inquiries with respect to the network status of a provider within one business day of a request. It limits cost-sharing to the in-network rate when a participant, beneficiary, or enrollee relied in good faith on out-of-date provider directories under the plan or coverage.

Sec. 7. Improving transparency in health coverage

This section requires brokers and consultants to disclose to group health plan sponsors and consumers enrolled in coverage in the individual market whether they have received any direct or indirect compensation for referrals.

This section also requires the Secretary of Labor to develop a standardized form to allow group health plans and issuers to report information to state All-Payer Claims Databases.

Sec. 8. Access to cost-sharing information

This section requires providers, group health plans, and issuers offering coverage in the group or individual markets to provide to a participant, beneficiary, or enrollee a good faith estimate of cost-sharing owed for a health care service within two business days of a request.

Sec. 9. Transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations

This section requires group health plans and issuers offering coverage in the group or individual markets to include on insurance identification cards the amount of the in-network and out-of-network deductibles and out-of-pocket limitations under the plan or coverage.

EXPLANATION OF AMENDMENTS

The amendments, including the amendment in the nature of a substitute, are explained in the descriptive portions of this report.

APPLICATION OF LAW TO THE LEGISLATIVE BRANCH

Pursuant to section 102(b)(3) of the *Congressional Accountability Act*, Pub. L. No. 104–1, H.R. 5800, as amended, does not apply to terms and conditions of employment or to access to public services or accommodations within the legislative branch.

UNFUNDED MANDATE STATEMENT

Pursuant to Section 423 of the *Congressional Budget and Impoundment Control Act* (as amended by Section 101(a)(2) of the *Unfunded Mandates Reform Act*, Pub. L. No. 104 4), the Committee adopts as its own the estimate of and statement regarding federal mandates in H.R. 5800, as amended, prepared by the Director of the Congressional Budget Office.

EARMARK STATEMENT

In accordance with clause 9 of rule XXI of the Rules of the House of Representatives, H.R. 5800 does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as described in clauses 9(e), 9(f), and 9(g) of rule XXI.

ROLL CALL VOTES

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the Committee advises that the following roll call votes occurred during the Committee's consideration of H.R. 5800:

Date: 2/11/2020

COMMITTEE ON EDUCATION AND LABOR RECORD OF COMMITTEE VOTE

Roll Call: 1

Bill: H.R. 5800

Amendment Number: 7

Disposition: defeated by a vote of 8-37

Sponsor/Amendment: Roe/ Strikes air ambulance provision

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mr. SCOTT (VA) (Chairman)		X		Mrs. FOXX (NC) (Ranking)		X	
Mrs. DAVIS (CA)		X		Mr. ROE (TN)	X		
Mr. GRIJALVA (AZ)		X		Mr. THOMPSON (PA)		X	
Mr. COURNTEY (CT)		X		Mr. WALBERG (MI)		X	
Ms. FUDGE (OH)			X	Mr. GUTHRIE (KY)		X	
Mr. SABLAN (MP)		X		Mr. BYRNE (AL)			X
Ms. WILSON (FL)		X		Mr. GROTHMAN (WI)	X		
Ms. BONAMICI (OR)		X		Ms. STEFANIK (NY)		X	
Mr. TAKANO (CA)		X		Mr. ALLEN (GA)	X		
Ms. ADAMS (NC)			X	Mr. SMUCKER (PA)	X		
Mr. DESAULNIER (CA)		X		Mr. BANKS (IN)	X		
Mr. NORCROSS (NJ)		X		Mr. WALKER (NC)			X
Ms. JAYAPAL (WA)		X		Mr. COMER (KY)		X	
Mr. MORELLE (NY)		X		Mr. CLINE (VA)		X	
Ms. WILD (PA)		X		Mr. FULCHER (ID)		X	
Mr. HARDER (CA)		X		Mr. WATKINS (KS)	X		
Mrs. MCBATH (GA)		X		Mr. WRIGHT (TX)			X
Ms. SCHRIER (WA)		X		Mr. MEUSER (PA)		X	
Ms. UNDERWOOD (IL)		X		Mr. JOHNSON (SD)	X		
Mrs. HAYES (CT)		X		Mr. KELLER (PA)		X	
Ms. SHALALA (FL)		X		Mr. MURPHY (NC)	X		
Mr. LEVIN (MI)		X		Mr. VAN DREW (NJ)		X	
Ms. OMAR (MN)		X					
Mr. TRONE (MD)		X					
Ms. STEVENS (MI)		X					
Mrs. LEE (NV)		X					
Mrs. TRAHAN (MA)		X					
Mr. CASTRO (TX)		X					

TOTALS: Ayes: 8

Nos: 37

Not Voting: 5

Total: 50 / Quorum: / Report:

(28 D - 22 R)

*Although not present for the recorded vote, Member expressed he/she would have voted AYE if present at time of vote.

*Although not present for the recorded vote, Member expressed he/she would have voted NO if present at time of vote.

Date: 2/11/2020

COMMITTEE ON EDUCATION AND LABOR RECORD OF COMMITTEE VOTE

Roll Call: 2

Bill: H.R. 5800

Amendment Number: 9

Disposition: defeated by a vote of 15-30

Sponsor/Amendment: Roe /Changes median in-network to "commercially reasonable" rates

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mr. SCOTT (VA) (Chairman)		X		Mrs. FOXX (NC) (Ranking)		X	
Mrs. DAVIS (CA)		X		Mr. ROE (TN)	X		
Mr. GRIJALVA (AZ)		X		Mr. THOMPSON (PA)	X		
Mr. COURNTEY (CT)		X		Mr. WALBERG (MI)		X	
Ms. FUDGE (OH)			X	Mr. GUTHRIE (KY)		X	
Mr. SABLON (MP)		X		Mr. BYRNE (AL)			X
Ms. WILSON (FL)		X		Mr. GROTHMAN (WI)	X		
Ms. BONAMICI (OR)		X		Ms. STEFANIK (NY)		X	
Mr. TAKANO (CA)		X		Mr. ALLEN (GA)	X		
Ms. ADAMS (NC)			X	Mr. SMUCKER (PA)	X		
Mr. DESAULNIER (CA)		X		Mr. BANKS (IN)	X		
Mr. NORCROSS (NJ)		X		Mr. WALKER (NC)			X
Ms. JAYAPAL (WA)		X		Mr. COMER (KY)		X	
Mr. MORELLE (NY)	X			Mr. CLINE (VA)		X	
Ms. WILD (PA)	X			Mr. FULCHER (ID)	X		
Mr. HARDER (CA)		X		Mr. WATKINS (KS)	X		
Mrs. MCBATH (GA)		X		Mr. WRIGHT (TX)			X
Ms. SCHRIER (WA)	X			Mr. MEUSER (PA)		X	
Ms. UNDERWOOD (IL)		X		Mr. JOHNSON (SD)		X	
Mrs. HAYES (CT)		X		Mr. KELLER (PA)		X	
Ms. SHALALA (FL)	X			Mr. MURPHY (NC)	X		
Mr. LEVIN (MI)		X		Mr. VAN DREW (NJ)	X		
Ms. OMAR (MN)		X					
Mr. TRONE (MD)		X					
Ms. STEVENS (MI)		X					
Mrs. LEE (NV)	X						
Mrs. TRAHAN (MA)		X					
Mr. CASTRO (TX)		X					

TOTALS: Ayes: 15

Nos: 30

Not Voting: 5

Total: 50 / Quorum: / Report:

(28 D - 22 R)

*Although not present for the recorded vote, Member expressed he/she would have voted AYE if present at time of vote.

*Although not present for the recorded vote, Member expressed he/she would have voted NO if present at time of vote.

Date: 2/11/2020

COMMITTEE ON EDUCATION AND LABOR RECORD OF COMMITTEE VOTE

Roll Call: 3

Bill: H.R. 5800

Amendment Number: 11

Disposition: defeated by a vote of 16-29

Sponsor/Amendment: Roe /Changes median in-network to "previously contracted" rates

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mr. SCOTT (VA) (Chairman)		X		Mrs. FOXX (NC) (Ranking)		X	
Mrs. DAVIS (CA)		X		Mr. ROE (TN)	X		
Mr. GRUJALVA (AZ)		X		Mr. THOMPSON (PA)	X		
Mr. COURNTEY (CT)		X		Mr. WALBERG (MI)		X	
Ms. FUDGE (OH)			X	Mr. GUTHRIE (KY)		X	
Mr. SABLON (MP)		X		Mr. BYRNE (AL)			X
Ms. WILSON (FL)		X		Mr. GROTHMAN (WI)	X		
Ms. BONAMICI (OR)		X		Ms. STEFANIK (NY)		X	
Mr. TAKANO (CA)		X		Mr. ALLEN (GA)	X		
Ms. ADAMS (NC)			X	Mr. SMUCKER (PA)	X		
Mr. DESAULNIER (CA)		X		Mr. BANKS (IN)	X		
Mr. NORCROSS (NJ)		X		Mr. WALKER (NC)			X
Ms. JAYAPAL (WA)		X		Mr. COMER (KY)		X	
Mr. MORELLE (NY)	X			Mr. CLINE (VA)		X	
Ms. WILD (PA)	X			Mr. FULCHER (ID)	X		
Mr. HARDER (CA)		X		Mr. WATKINS (KS)	X		
Mrs. MCBATH (GA)		X		Mr. WRIGHT (TX)			X
Ms. SCHRIER (WA)	X			Mr. MEUSER (PA)		X	
Ms. UNDERWOOD (IL)		X		Mr. JOHNSON (SD)		X	
Mrs. HAYES (CT)		X		Mr. KELLER (PA)		X	
Ms. SHALALA (FL)	X			Mr. MURPHY (NC)	X		
Mr. LEVIN (MI)		X		Mr. VAN DREW (NJ)	X		
Ms. OMAR (MN)		X					
Mr. TRONE (MD)		X					
Ms. STEVENS (MI)	X						
Mrs. LEE (NV)	X						
Mrs. TRAHAN (MA)		X					
Mr. CASTRO (TX)		X					

TOTALS: Ayes: 16

Nos: 29

Not Voting: 5

Total: 50 / Quorum: / Report:

(28 D - 22 R)

*Although not present for the recorded vote, Member expressed he/she would have voted AYE if present at time of vote.

*Although not present for the recorded vote, Member expressed he/she would have voted NO if present at time of vote.

Date: 2/11/2020

COMMITTEE ON EDUCATION AND LABOR RECORD OF COMMITTEE VOTE

Roll Call: 4

Bill: H.R. 5800

Amendment Number: 15

Disposition: defeated by a vote of 15-30

Sponsor/Amendment: Morelle/ Deletes the threshold for arbitration

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mr. SCOTT (VA) (Chairman)		X		Mrs. FOXX (NC) (Ranking)		X	
Mrs. DAVIS (CA)		X		Mr. ROE (TN)	X		
Mr. GRIJALVA (AZ)		X		Mr. THOMPSON (PA)	X		
Mr. COURNTEY (CT)		X		Mr. WALBERG (MI)		X	
Ms. FUDGE (OH)			X	Mr. GUTHRIE (KY)		X	
Mr. SABLON (MP)		X		Mr. BYRNE (AL)			X
Ms. WILSON (FL)		X		Mr. GROTHMAN (WI)	X		
Ms. BONAMICI (OR)		X		Ms. STEFANIK (NY)	X		
Mr. TAKANO (CA)		X		Mr. ALLEN (GA)	X		
Ms. ADAMS (NC)			X	Mr. SMUCKER (PA)	X		
Mr. DESAULNIER (CA)		X		Mr. BANKS (IN)		X	
Mr. NORCROSS (NJ)		X		Mr. WALKER (NC)			X
Ms. JAYAPAL (WA)		X		Mr. COMER (KY)		X	
Mr. MORELLE (NY)	X			Mr. CLINE (VA)		X	
Ms. WILD (PA)		X		Mr. FULCHER (ID)	X		
Mr. HARDER (CA)		X		Mr. WATKINS (KS)	X		
Mrs. MCBATH (GA)		X		Mr. WRIGHT (TX)			X
Ms. SCHRIER (WA)	X			Mr. MEUSER (PA)		X	
Ms. UNDERWOOD (IL)		X		Mr. JOHNSON (SD)	X		
Mrs. HAYES (CT)		X		Mr. KELLER (PA)		X	
Ms. SHALALA (FL)	X			Mr. MURPHY (NC)	X		
Mr. LEVIN (MI)		X		Mr. VAN DREW (NJ)	X		
Ms. OMAR (MN)		X					
Mr. TRONE (MD)		X					
Ms. STEVENS (MI)		X					
Mrs. LEE (NV)	X						
Mrs. TRAHAN (MA)		X					
Mr. CASTRO (TX)		X					

TOTALS: Ayes: 15

Nos: 30

Not Voting: 5

Total: 50 / Quorum: / Report:

(28 D - 22 R)

*Although not present for the recorded vote, Member expressed he/she would have voted AYE if present at time of vote.

*Although not present for the recorded vote, Member expressed he/she would have voted NO if present at time of vote.

Date: 2/11/2020

COMMITTEE ON EDUCATION AND LABOR RECORD OF COMMITTEE VOTE

Roll Call: 5

Bill: H.R. 5800

Amendment Number: Motion

Disposition: adopted by a vote of 32-13

Sponsor/Amendment: Takano/ to report to the House with an amendment and with the recommendation that the amendment be agreed to, and the bill as amended, do pass

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mr. SCOTT (VA) (Chairman)	X			Mrs. FOXX (NC) (Ranking)	X		
Mrs. DAVIS (CA)	X			Mr. ROE (TN)		X	
Mr. GRIJALVA (AZ)	X			Mr. THOMPSON (PA)		X	
Mr. COURTNEY (CT)	X			Mr. WALBERG (MI)	X		
Ms. FUDGE (OH)			X	Mr. GUTHRIE (KY)	X		
Mr. SABLON (MP)	X			Mr. BYRNE (AL)			X
Ms. WILSON (FL)	X			Mr. GROTHMAN (WI)		X	
Ms. BONAMICI (OR)	X			Ms. STEFANIK (NY)	X		
Mr. TAKANO (CA)	X			Mr. ALLEN (GA)		X	
Ms. ADAMS (NC)			X	Mr. SMUCKER (PA)		X	
Mr. DESAULNIER (CA)	X			Mr. BANKS (IN)	X		
Mr. NORCROSS (NJ)	X			Mr. WALKER (NC)			X
Ms. JAYAPAL (WA)	X			Mr. COMER (KY)	X		
Mr. MORELLE (NY)		X		Mr. CLINE (VA)		X	
Ms. WILD (PA)	X			Mr. FULCHER (ID)		X	
Mr. HARDER (CA)	X			Mr. WATKINS (KS)		X	
Mrs. MCBATH (GA)	X			Mr. WRIGHT (TX)			X
Ms. SCHRIER (WA)	X			Mr. MEUSER (PA)	X		
Ms. UNDERWOOD (IL)	X			Mr. JOHNSON (SD)		X	
Mrs. HAYES (CT)	X			Mr. KELLER (PA)	X		
Ms. SHALALA (FL)		X		Mr. MURPHY (NC)		X	
Mr. LEVIN (MI)	X			Mr. VAN DREW (NJ)		X	
Ms. OMAR (MN)	X						
Mr. TRONE (MD)	X						
Ms. STEVENS (MI)	X						
Mrs. LEE (NY)	X						
Mrs. TRAHAN (MA)	X						
Mr. CASTRO (TX)	X						

TOTALS: Ayes: 32

Nos: 13

Not Voting: 5

Total: 50 / Quorum: / Report:

(28 D - 22 R)

*Although not present for the recorded vote, Member expressed he/she would have voted AYE if present at time of vote.

*Although not present for the recorded vote, Member expressed he/she would have voted NO if present at time of vote.

STATEMENT OF PERFORMANCE GOALS AND OBJECTIVES

Pursuant to clause (3)(c) of rule XIII of the Rules of the House of Representatives, the goals of H.R. 5800 are to end surprise medical billing and increase transparency in health coverage.

DUPLICATION OF FEDERAL PROGRAMS

Pursuant to clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, the Committee states that no provision of H.R. 5800 establishes or reauthorizes a program of the Federal Government known to be duplicative of another federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Pub. L. No. 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

HEARINGS

Pursuant to section 103(i) of H. Res. 6 for the 116th Congress, on April 2, 2019, the Committee on Education and Labor's Subcommittee on Health, Employment, Labor, and Pensions held a hearing entitled "Examining Surprise Billing: Protecting Patients from Financial Pain," which was used to develop H.R. 5800. The hearing explored the causes of surprise billing, the impact of surprise medical bills on patients, and policies to both protect consumers and improve transparency in health coverage. The Committee heard testimony from: Ms. Christen Linke Young, Fellow, USC-Brookings Schaeffer Initiative on Health Policy, Washington, DC; Ms. Ilyse Schuman Senior Vice President, Health Policy, American Benefits Council Washington, DC; Mr. Frederick Isasi, Executive Director, Families USA, Washington, DC; and Dr. Jack Hoadley, Research Professor Emeritus, Georgetown University Health Policy Institute, McCourt School of Public Policy, McLean, VA.

STATEMENT OF OVERSIGHT FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE

In compliance with clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the Committee's oversight findings and recommendations are reflected in the descriptive portions of this report.

NEW BUDGET AUTHORITY AND CBO COST ESTIMATE

Pursuant to clause 3(c)(2) of rule XIII of the Rules of the House of Representatives and section 308(a) of the *Congressional Budget Act of 1974*, and pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives and section 402 of the *Congressional Budget Act of 1974*, the Committee has received the following estimate for H.R. 5800 from the Director of the Congressional Budget Office:

H.R. 5800, THE BAN SURPRISE BILLING ACT, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON EDUCATION AND LABOR ON FEBRUARY 11, 2020 ESTIMATED
BUDGETARY EFFECTS

	By fiscal year, millions of dollars—											
	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2020– 2030
Increases or Decreases (–) in Direct Spending												
Protections Against Surprise Medical Bills:												
Estimated Budget Authority	0	0	*	–44	–89	–103	–111	–119	–123	–128	–134	–236
Estimated Outlays	0	0	*	–44	–89	–103	–111	–119	–123	–128	–134	–236
Increases in Revenues												
Protections Against Surprise Medical Bills:												
On-budget revenues	0	0	872	1,809	2,170	2,335	2,689	2,944	3,153	3,387	3,642	7,186
Off-budget revenues	0	0	619	1,284	1,544	1,664	1,970	2,176	2,335	2,511	2,701	5,112
Off-budget revenues	0	0	253	525	625	671	720	768	819	877	940	2,074
Increases or Decreases (–) in the Deficit from Direct Spending and Revenues												
Estimated Effect on the Deficit:	0	0	–872	–1,853	–2,259	–2,438	–2,801	–3,063	–3,276	–3,515	–3,776	–7,423
Estimated Changes in On-Budget Deficits	0	0	–619	–1,328	–1,633	–1,767	–2,081	–2,295	–2,458	–2,638	–2,835	–5,348
Estimated Changes in Off-Budget Deficits	0	0	–253	–525	–625	–671	–720	–768	–819	–877	–940	–2,074
												–6,198

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.
Components may not sum to totals because of rounding. * = between zero and \$500,000.
H.R. 5800 would establish patient protections from surprise medical billing, and in certain circumstances would require insurers to reimburse out-of-network providers on the basis of the median payment rate for in-network care. The bill also would establish a process for health care providers and insurers to settle disputes over out-of-network bills greater than \$750.
CBO and JCT expect that under the bill, in facilities where surprise bills are likely, the average of payment rates for both in- and out-of-network care would move toward the median in-network rate, which tends to be lower than average rates. CBO and JCT estimate that in most affected markets in most years, lower payments to some providers would reduce payments by roughly 1 percent. Lower costs for health insurance would reduce federal deficits because the federal government subsidizes most private insurance through tax preferences for employer-based coverage and through the health insurance marketplaces established under the Affordable Care Act.

COMMITTEE COST ESTIMATE

Clause 3(d)(1) of rule XIII of the Rules of the House of Representatives requires an estimate and a comparison of the costs that would be incurred in carrying out H.R. 5800. However, clause 3(d)(2)(B) of that rule provides that this requirement does not apply when the committee has included in its report a timely submitted cost estimate of the bill prepared by the Director of the Congressional Budget Office under section 402 of the *Congressional Budget Act of 1974*. Pursuant to clause 3(d)(1) of rule XIII, the Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the *Congressional Budget Act of 1974*.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, H.R. 5800, as reported, are shown as follows:

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, and existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * *

TITLE XXVII—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

PART A—INDIVIDUAL AND GROUP MARKET REFORMS

* * * * *

Subpart II—Improving Coverage

* * * * *

SEC. 2719A. PATIENT PROTECTIONS.

(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

[(b) COVERAGE OF EMERGENCY SERVICES.—

[(1) IN GENERAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance issuer, provides or covers any benefits with respect to services

in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

[(A) without the need for any prior authorization determination;

[(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

[(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

[(i) by a nonparticipating health care provider with or without prior authorization; or

[(ii)(I) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

[(II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

[(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of this Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

[(2) DEFINITIONS.—In this subsection:

[(A) EMERGENCY MEDICAL CONDITION.—The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

[(B) EMERGENCY SERVICES.—The term “emergency services” means, with respect to an emergency medical condition—

[(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

[(ii) within the capabilities of the staff and facilities available at the hospital, such further medical exam-

ination and treatment as are required under section 1867 of such Act to stabilize the patient.

[(C) STABILIZE.—The term “to stabilize”, with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(b) *COVERAGE OF EMERGENCY SERVICES.—*

(1) *IN GENERAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)), the plan or issuer shall cover emergency services (as defined in paragraph (3)(C))—*

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider or a participating emergency facility, as applicable, with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee by a nonparticipating provider or a nonparticipating emergency facility—

(i) such services will be provided without imposing any requirement under the plan or coverage for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities with respect to such plan or coverage, respectively;

(ii) the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;

(iii) such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to the recognized amount (as defined in paragraph (3)(H)) for such services, plan or coverage, and year;

(iv) the group health plan or health insurance issuer, respectively, pays to such provider or facility, respectively the amount by which the recognized amount for such services and year involved exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)) and year; and

(v) any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage, respectively (and such in-network deductible and out-of-pocket maximums shall be applied) in the same manner as if such

cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility; and

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2704 of this Act, including as incorporated pursuant to section 715 of the Employee Retirement Income Security Act of 1974 and section 9815 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

(2) AUDIT PROCESS AND REGULATIONS FOR MEDIAN CONTRACTED RATES.—

(A) AUDIT PROCESS.—

(i) IN GENERAL.—Not later than July 1, 2021, the Secretary, in consultation with appropriate State agencies and the Secretary of Labor and the Secretary of the Treasury, shall establish through rulemaking a process, in accordance with clause (ii), under which group health plans and health insurance issuers offering health insurance coverage in the group or individual market are audited by the Secretary or applicable State authority to ensure that—

(I) such plans and coverage are in compliance with the requirement of applying a median contracted rate under this section; and

(II) such median contracted rate so applied satisfies the definition under paragraph (3)(E) with respect to the year involved, including with respect to a group health plan or health insurance issuer described in clause (ii) of such paragraph (3)(E).

(ii) AUDIT SAMPLES.—Under the process established pursuant to clause (i), the Secretary—

(I) shall conduct audits described in such clause, with respect to a year (beginning with 2022), of a sample with respect to such year of claims data from not more than 25 group health plans and health insurance issuers offering health insurance coverage in the group or individual market; and

(II) may audit any group health plan or health insurance issuer offering health insurance coverage in the group or individual market if the Secretary has received any complaint about such plan or coverage, respectively, that involves the compliance of the plan or coverage, respectively, with either of the requirements described in subclauses (I) and (II) of such clause.

(iii) REPORTS.—Beginning for 2022, the Secretary shall annually submit to Congress a report on the number of plans and issuers with respect to which audits were conducted during such year pursuant to this subparagraph.

(B) RULEMAKING.—*Not later than July 1, 2021, the Secretary, in consultation with the Secretary of Labor and the Secretary of the Treasury, shall establish through rulemaking—*

(i) the methodology the group health plan or health insurance issuer offering health insurance coverage in the group or individual market shall use to determine the median contracted rate, differentiating by line of business;

(ii) the information such plan or issuer, respectively, shall share with the nonparticipating provider or nonparticipating facility, as applicable, when making such a determination;

(iii) the geographic regions applied for purposes of this subparagraph, taking into account access to items and services in rural and underserved areas, including health professional shortage areas, as defined in section 332; and

(iv) a process to receive complaints of violations of the requirements described in subclauses (I) and (II) of subparagraph (A)(i) by group health plans and health insurance issuers offering health insurance coverage in the group or individual market.

Such rulemaking shall take into account payments that are made by such plan or issuer, respectively, that are not on a fee-for-service basis. Such methodology may account for relevant payment adjustments that take into account quality or facility type (including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities. In carrying out clause (iii), the Secretary shall consult with the National Association of Insurance Commissioners to establish the geographic regions under such clause and shall periodically update such regions, as appropriate.

(3) **DEFINITIONS.**—In this part:

(A) **EMERGENCY DEPARTMENT OF A HOSPITAL.**—The term “emergency department of a hospital” includes a hospital outpatient department that provides emergency services.

(B) **EMERGENCY MEDICAL CONDITION.**—The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(C) **EMERGENCY SERVICES.**—

(i) **IN GENERAL.**—The term “emergency services”, with respect to an emergency medical condition, means—

(I) a medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services rou-

tinely available to the emergency department to evaluate such emergency medical condition; and

(II) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of such Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient.

(ii) INCLUSION OF CERTAIN SERVICES OUTSIDE OF EMERGENCY DEPARTMENT.—

(I) IN GENERAL.—For purposes of this subsection and section 2799A–1, in the case of an individual enrolled in a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market who is furnished services described in clause (i) by a participating or nonparticipating provider or a participating or nonparticipating emergency facility to stabilize such individual with respect to an emergency medical condition, the term “emergency services” shall include, unless each of the conditions described in subclause (II) are met, in addition to the items and services described in clause (i), items and services for which benefits are provided or covered under the plan or coverage, respectively, furnished by a nonparticipating provider or nonparticipating facility, regardless of the department of the hospital in which such individual is furnished such items or services, if, after such stabilization but during such visit in which such individual is so stabilized, the provider or facility determines that such items or services are needed.

(II) CONDITIONS.—For purposes of subclause (I), the conditions described in this subclause, with respect to an individual who is stabilized and furnished additional items and services described in subclause (I) after such stabilization by a provider or facility described in subclause (I), are the following:

(aa) Such a provider or facility determines such individual is able to travel using non-medical transportation or nonemergency medical transportation.

(bb) Such provider furnishing such additional items and services satisfies the notice and consent criteria of section 2799A–2(d) with respect to such items and services.

(cc) Such an individual is in a condition to receive (as determined in accordance with guidance issued by the Secretary) the information described in section 2799A–2 and to provide informed consent under such section, in accordance with applicable State law.

(D) *INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT.*—The term “independent freestanding emergency department” means a facility that—

(i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

(ii) provides any emergency services (as defined in subparagraph (C)).

(E) *MEDIAN CONTRACTED RATE.*—

(i) *IN GENERAL.*—The term “median contracted rate” means, subject to clauses (ii) and (iii), with respect to a sponsor of a group health plan and health insurance issuer offering health insurance coverage in the group or individual market—

(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan or issuer, respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same line of business as the plan or coverage) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan or issuer, respectively) under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2)(B), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

(II) for an item or service furnished during 2023 or a subsequent year, the median contracted rate determined under this clause for such an item or service furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(ii) *NEW PLANS AND COVERAGE.*—The term “median contracted rate” means, with respect to a sponsor of a group health plan or health insurance issuer offering health insurance coverage in the group or individual market in a geographic region in which such sponsor or issuer, respectively, did not offer any group health plan or health insurance coverage during 2019—

(I) for the first year in which such group health plan or health insurance coverage, respectively, is offered in such region, a rate (determined in accordance with a methodology established by the Secretary) for items and services that are covered

by such plan and furnished during such first year; and

(II) for each subsequent year such group health plan or health insurance coverage, respectively, is offered in such region, the median contracted rate determined under this clause for such items and services furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(iii) *INSUFFICIENT INFORMATION; NEWLY COVERED ITEMS AND SERVICES.*—In the case of a sponsor of a group health plan or health insurance issuer offering health insurance coverage in the group or individual market that does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019 (or, in the case of a newly covered item or service (as defined in clause (iv)(III)), in the first coverage year (as defined in clause (iv)(I)) for such item or service with respect to such plan or coverage) for an item or service (including with respect to provider type, or amount, of claims for items or services (as determined by the Secretary) provided in a particular geographic region (other than in a case with respect to which clause (ii) applies)) the term “median contracted rate”—

(I) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or service with respect to such plan or coverage), means such rate for such item or service determined by the sponsor or issuer, respectively, through use of any database that is determined, in accordance with rulemaking described in paragraph (2)(B), to not have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region (such as a State all-payer claims database);

(II) for an item or service furnished in a subsequent year (before the first sufficient information year (as defined in clause (iv)(II)) for such item or service with respect to such plan or coverage), means the rate determined under subclause (I) or this subclause, as applicable, for such item or service for the year previous to such subsequent year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

(III) for an item or service furnished in the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given the term median contracted rate in clause (i)(I), except that in applying such clause to

such item or service, the reference to “furnished during 2022” shall be treated as a reference to furnished during such first sufficient information year, the reference to “in 2019” shall be treated as a reference to such sufficient information year, and the increase described in such clause shall not be applied; and

(IV) for an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given such term in clause (i)(II), except that in applying such clause to such item or service, the reference to “furnished during 2023 or a subsequent year” shall be treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

(iv) DEFINITIONS.—For purposes of this subparagraph:

(I) FIRST COVERAGE YEAR.—The term “first coverage year” means, with respect to a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market and an item or service for which coverage is not offered in 2019 under such plan or coverage, the first year after 2019 for which coverage for such item or service is offered under such plan or health insurance coverage.

(II) FIRST SUFFICIENT INFORMATION YEAR.—The term “first sufficient information year” means, with respect to a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market—

(aa) in the case of an item or service for which the plan or coverage does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019, the first year subsequent to 2022 for which the sponsor or issuer has such sufficient information to calculate the median of such contracted rates in the year previous to such first subsequent year; and

(bb) in the case of a newly covered item or service, the first year subsequent to the first coverage year for such item or service with respect to such plan or coverage for which the sponsor or issuer has sufficient information to calculate the median of the contracted rates described in clause (i)(I) in the year previous to such first subsequent year.

(III) NEWLY COVERED ITEM OR SERVICE.—The term “newly covered item or service” means, with respect to a group health plan or health insurance issuer offering health insurance coverage in the group or individual market, an item or service for

which coverage was not offered in 2019 under such plan or coverage, but is offered under such plan or coverage in a year after 2019.

(F) NONPARTICIPATING EMERGENCY FACILITY; PARTICIPATING EMERGENCY FACILITY.—

(i) NONPARTICIPATING EMERGENCY FACILITY.—The term “nonparticipating emergency facility” means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship directly or indirectly with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(ii) PARTICIPATING EMERGENCY FACILITY.—The term “participating emergency facility” means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship directly or indirectly with the plan or issuer, respectively, with respect to the furnishing of such an item or service at such facility.

(G) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

(i) NONPARTICIPATING PROVIDER.—The term “nonparticipating provider” means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, a physician or other health care provider who is acting within the scope of practice of that provider’s license or certification under applicable State law and who does not have a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(ii) PARTICIPATING PROVIDER.—The term “participating provider” means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, a physician or other health care provider who is acting within the scope of practice of that provider’s license or certification under applicable State law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(H) RECOGNIZED AMOUNT.—*The term “recognized amount” means, with respect to an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market—*

(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan, coverage, or issuer, respectively, such a nonparticipating provider or emergency facility, and such an item or service, the amount determined in accordance with such law;

(ii) subject to clause (iii), in the case of such item or service furnished in a State that does not have in effect a specified State law, with respect to such plan, coverage, or issuer, respectively, such a nonparticipating provider or emergency facility, and such an item or service, an amount that is the median contracted rate (as defined in subparagraph (E)) for such year and determined in accordance with rulemaking described in paragraph (2)(B)) for such item or service; or

(iii) in the case of such item or service furnished in a State with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the State approves under such system for such item or service so furnished.

(I) SPECIFIED STATE LAW.—The term “specified State law” means, with respect to a State, an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, a State law that provides for a method for determining the amount of payment that is required to be covered by such a plan, coverage, or issuer, respectively (to the extent such State law applies to such plan, coverage, or issuer, subject to section 514 of the Employee Retirement Income Security Act of 1974) in the case of a participant, beneficiary, or enrollee covered under such plan or coverage and receiving such item or service from such a nonparticipating provider or emergency facility.

(J) STABILIZE.—The term “to stabilize”, with respect to an emergency medical condition (as defined in subparagraph (B)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(c) ACCESS TO PEDIATRIC CARE.—

(1) PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage offered by a health insurance issuer in the group or individual market, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child’s primary care provider if such provider participates in the network of the plan or issuer.

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

(d) PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.—

(1) GENERAL RIGHTS.—

(A) DIRECT ACCESS.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(B) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan or health insurance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(2) APPLICATION OF PARAGRAPH.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in this paragraph is a group health plan or coverage that—

(A) provides coverage for obstetric or gynecologic care; and

(B) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to—

(A) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

(e) COVERAGE OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

(1) IN GENERAL.—*In the case of items or services (other than emergency services to which subsection (b) applies) for which any benefits are provided or covered by a group health plan or health insurance issuer offering health insurance coverage in the group or individual market furnished to a participant, beneficiary, or enrollee of such plan or coverage by a nonparticipating provider (as defined in subsection (b)(3)(G)(i)) (and who, with respect to such items and services, has not satisfied the notice and consent criteria of section 2799A-2(d)) with respect to a visit (as defined by the Secretary in accordance with para-*

graph (2)(B)) at a participating health care facility (as defined in paragraph (2)(A)), with respect to such plan or coverage, respectively, the plan or coverage, respectively—

(A) shall not impose on such participant, beneficiary, or enrollee a cost-sharing amount (expressed as a copayment amount or coinsurance rate) for such items and services so furnished that is greater than the cost-sharing amount that would apply under such plan or coverage, respectively, had such items or services been furnished by a participating provider (as defined in subsection (b)(3)(G)(ii));

(B) shall calculate such cost-sharing amount as if the total amount that would have been charged for such items and services by such participating provider were equal to the recognized amount (as defined in subsection (b)(3)(H)) for such items and services, plan or coverage, and year;

(C) shall pay to such provider furnishing such items and services to such participant, beneficiary, or enrollee the amount by which the recognized amount (as defined in subsection (b)(3)(H)) for such items and services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such items and services (as determined in accordance with subparagraphs (A) and (B)); and

(D) shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the plan or coverage, respectively, any cost-sharing payments made by the participant, beneficiary, or enrollee (and such in-network deductible and out-of-pocket maximums shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

(2) DEFINITIONS.—In this section:

(A) PARTICIPATING HEALTH CARE FACILITY.—

(i) IN GENERAL.—The term “participating health care facility” means, with respect to an item or service and a group health plan or health insurance issuer offering health insurance coverage in the group or individual market, a health care facility described in clause (ii) that has a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such an item or service at the facility.

(ii) HEALTH CARE FACILITY DESCRIBED.—A health care facility described in this clause, with respect to a group health plan or health insurance coverage offered in the group or individual market, is each of the following:

(I) A hospital (as defined in 1861(e) of the Social Security Act).

(II) A hospital outpatient department.

(III) A critical access hospital (as defined in section 1861(mm) of such Act).

(IV) An ambulatory surgical center (as defined in section 1833(i)(1)(A) of such Act).

(V) Any other facility that provides items or services for which coverage is provided under the plan or coverage, respectively.

(B) VISIT.—The term “visit” shall, with respect to items and services furnished to an individual at a participating health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility.

(f) AIR AMBULANCE SERVICES.—

(1) IN GENERAL.—In the case of a participant, beneficiary, or enrollee in a group health plan or health insurance coverage offered in the group or individual market who receives air ambulance services from a nonparticipating provider (as defined in subsection (b)(3)(G)) with respect to such plan or coverage, if such services would be covered if provided by a participating provider (as defined in such section) with respect to such plan or coverage—

(A) the cost-sharing requirement (expressed as a copayment amount, coinsurance rate, or deductible) with respect to such services shall be the same requirement that would apply if such services were provided by such a participating provider, and any coinsurance or deductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

(B) such cost-sharing amounts shall be counted toward the in-network deductible and in-network out-of-pocket maximum amount under the plan or coverage for the plan year (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider; and

(C) the plan or coverage shall pay to such provider furnishing such services to such participant, beneficiary, or enrollee the amount by which the recognized amount (as defined in and determined pursuant to subsection (b)(3)(H)(ii)) for such services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such services (as determined in accordance with subparagraphs (A) and (B)).

(2) AIR AMBULANCE SERVICE DEFINED.—For purposes of this section, the term “air ambulance service” means medical transport by helicopter or airplane for patients.

(g) CERTAIN ACCESS FEES TO CERTAIN DATABASES.—In the case of a sponsor of a group health plan or health insurance issuer offering health insurance coverage in the group or individual market that, pursuant to subsection (b)(3)(E)(iii), uses a database described in such subsection to determine a rate to apply under such subsection for an item or service by reason of having insufficient information described in such subsection with respect to such item or service, such sponsor or issuer shall cover the cost for access to such database.

(g) **TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS.—**

(1) **IN GENERAL.**—A group health plan or a health insurance issuer offering group or individual health insurance coverage and providing or covering any benefit with respect to items or services shall include, in clear writing, on any plan or insurance identification card issued to enrollees in the plan or coverage the amount of the in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket maximum limitation that apply to such plan or coverage.

(2) **GUIDANCE.**—The Secretary, in consultation with the Secretary of Labor and Secretary of the Treasury, shall issue guidance to implement paragraph (1).

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SEC. 2730. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

(a) **NETWORK STATUS OF PROVIDERS.—**

(1) **IN GENERAL.**—Beginning on the date that is one year after the date of enactment of this section, a group health plan or a health insurance issuer offering group or individual health insurance coverage shall—

(A) establish business processes to ensure that all enrollees in such plan or coverage receive proof of a health care provider's network status, based on what a plan or issuer knows or should know—

(i) upon a telephone inquiry by an enrollee—

(I) through a written electronic communication from the plan or issuer to the enrollee, as soon as practicable and not later than 1 business day after such inquiry is made by such participant, beneficiary, or enrollee for such information;

(II) through an oral communication from the plan or issuer to the enrollee, as soon as practicable and not later than 1 business day after such inquiry is made by such enrollee for such information, which communication shall be documented by such plan or issuer, and such documentation shall be kept in the enrollee's file for a minimum of 2 years; and

(ii) in real-time through an online health care provider directory search tool maintained by the plan or issuer; and

(B) include in any print directory—

(i) a disclosure that the information included in the directory is accurate as of the date of the last data update and that enrollees or prospective enrollees should consult the group health plan's or issuer's electronic provider directory on its website or call a specified customer service telephone number to obtain the most current provider directory information; and

(ii) a list of the categories of providers of ancillary services for which the plan or coverage has no in-network providers.

(2) *GROUP HEALTH PLAN AND HEALTH INSURANCE ISSUER BUSINESS PROCESSES.*—Beginning on the date that is one year after the date of the enactment of this section, a group health plan or a health insurance issuer offering group or individual health insurance coverage shall establish business processes to—

(A) verify and update, at least once every 90 days, the provider directory information for all providers included in the online health care provider directory search tool described in paragraph (1)(A)(ii); and

(B) remove any provider from such online directory search tool if such provider has not verified the directory information within the previous 6 months or the plan or issuer has been unable to verify the provider's network participation.

(b) *COST-SHARING LIMITATIONS.*—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall not apply, and shall ensure that no provider applies, cost-sharing to an enrollee for treatment or services provided by a health care provider in excess of the normal cost-sharing applied for such treatment or services provided in-network (including any balance bill issued by the health care provider involved), if such enrollee, or health care provider referring such enrollee, demonstrates (based on the electronic, written information described in subsection (a)(1)(A)(i)(I), the oral confirmation described in subsection (a)(1)(A)(i)(II) received by the enrollee not more than 30 days before the date the treatment or services were received, or a copy of the online provider directory described in subsection (a)(1)(A)(ii) on a date not more than 30 days before the date the treatment or services were received), that the enrollee relied on the information described in subsection (a)(1) for which such enrollee provides such documentation, that indicated that the provider is an in-network provider, if the provider was out-of-network at the time the treatment or service involved was received.

(c) *DEFINITION.*—For purposes of this section, the term “provider directory information” includes the names, addresses, specialty, and telephone numbers of individual health care providers, and the names, addresses, and telephone numbers of each medical group, clinic, or facility contracted to participate in any of the networks of the group health plan or health insurance coverage involved.

(d) *RULE OF CONSTRUCTION.*—Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories.

SEC. 2731. PROVISION OF COST-SHARING INFORMATION.

A group health plan or a health insurance issuer offering group or individual health insurance coverage shall provide a participant, beneficiary, or enrollee in the plan or coverage with a good faith estimate of the enrollee's cost-sharing (including deductibles, copayments, and coinsurance) for which the participant, beneficiary, or enrollee may be responsible for paying with respect to a specific health care service (including any service that is reasonably expected to be provided in conjunction with such specific service), as

soon as practicable and not later than 2 business days after a request for such information by a participant, beneficiary, or enrollee.

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PART B—INDIVIDUAL MARKET RULES

Subpart 1—Portability, Access, and Renewability Requirements

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SEC. 2746. DISCLOSURE TO ENROLLEES OF INDIVIDUAL MARKET COVERAGE.

(a) IN GENERAL.—A health insurance issuer offering individual health insurance coverage shall make disclosures to enrollees in such coverage, as described in subsection (b), and reports to the Secretary, as described in subsection (c), regarding direct or indirect compensation provided to an agent or broker associated with enrolling individuals in such coverage.

(b) DISCLOSURE.—A health insurance issuer described in subsection (a) shall disclose to an enrollee the amount of direct or indirect compensation provided to an agent or broker for services provided by such agent or broker associated with plan selection and enrollment. Such disclosure shall be—

- (1) made prior to the individual finalizing plan selection; and*
- (2) included on any documentation confirming the individual's enrollment.*

(c) REPORTING.—A health insurance issuer described in subsection (a) shall annually report to the Secretary, prior to the beginning of open enrollment, any direct or indirect compensation provided to an agent or broker associated with enrolling individuals in such coverage.

(d) RULEMAKING.—Not later than 1 year after the date of enactment of the Ban Surprise Billing Act, the Secretary shall finalize, through notice-and-comment rulemaking, the form and manner in which issuers described in subsection (a) are required to make the disclosures described in subsection (b) and the reports described in subsection (c). Such rulemaking may also include adjustments to notice requirements to reflect the different processes for plan renewals, in order to provide enrollees with full, timely information.

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PART D—HEALTH CARE PROVIDER REQUIREMENTS

SEC. 2799A-1. BALANCE BILLING IN CASES OF EMERGENCY SERVICES.

(a) IN GENERAL.—In the case of a participant, beneficiary, or enrollee with benefits under a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market who is furnished during a plan year beginning on or after January 1, 2022, emergency services for which any benefit is provided under such plan or coverage with respect to an emergency medical condition with respect to a visit at an emergency department of a hospital or an independent freestanding emergency department—

(1) in the case that the hospital or independent freestanding emergency department is a nonparticipating emergency facility, the emergency department of a hospital or independent freestanding emergency department shall not hold the participant, beneficiary, or enrollee liable for a payment amount for such emergency services so furnished that is more than the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii) of section 2719A(b)(1)(C), section 716(b)(1)(C) of the Employee Retirement Income Security Act of 1974, and section 9816(b)(1)(C) of the Internal Revenue Code of 1986, as applicable); and

(2) in the case that such services are furnished by a nonparticipating provider, the health care provider shall not hold such participant, beneficiary, or enrollee liable for a payment amount for an emergency service furnished to such individual by such provider with respect to such emergency medical condition and visit for which the individual receives emergency services at the hospital or emergency department that is more than the cost-sharing amount for such services furnished by the provider (as determined in accordance with clauses (ii) and (iii) of section 2719A(b)(1)(C), section 716(b)(1)(C) of the Employee Retirement Income Security Act of 1974, and section 9816(b)(1)(C) of the Internal Revenue Code of 1986, as applicable).

(b) **DEFINITION.**—In this section, the term “visit” shall have such meaning as applied to such term for purposes of section 2719A(e).

SEC. 2799A-2. BALANCE BILLING IN CASES OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.

(a) **IN GENERAL.**—Subject to subsection (b), in the case of a participant, beneficiary, or enrollee with benefits under a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market who is furnished during a plan year beginning on or after January 1, 2022, items or services (other than emergency services to which section 2799A-1 applies) for which any benefit is provided under such plan or coverage at a participating health care facility by a nonparticipating provider, such provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for such an item or service furnished by such provider with respect to a visit at such facility that is more than the cost-sharing amount for such item or service (as determined in accordance with subparagraphs (A) and (B) of section 2719A(e)(1), section 716(e)(1) of the Employee Retirement Income Security Act of 1974, and section 9816(e)(1) of the Internal Revenue Code of 1986, as applicable).

(b) **EXCEPTION.**—

(1) **IN GENERAL.**—Subsection (a) shall not apply with respect to items or services (other than ancillary services described in paragraph (2)) furnished by a nonparticipating provider to a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, if the provider satisfies the notice and consent criteria of subsection (d).

(2) **ANCILLARY SERVICES DESCRIBED.**—For purposes of paragraph (1), ancillary services described in this paragraph are, with respect to a participating health care facility—

(A) subject to paragraph (3), items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a physician or non-physician practitioner, and items and services provided by assistant surgeons, hospitalists, and intensivists;

(B) subject to paragraph (3), diagnostic services (including radiology and laboratory services);

(C) items and services provided by such other specialty practitioners, as the Secretary specifies through rule-making; and

(D) items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

(3) *EXCEPTION.*—The Secretary may, through rulemaking, establish a list (and update such list) of advanced diagnostic laboratory tests, which shall not be included as an ancillary service described in paragraph (2) and with respect to which subsection (a) would apply.

(c) *CLARIFICATION.*—In the case of a nonparticipating provider that satisfies the notice and consent criteria of subsection (d) with respect to an item or service (referred to in this subsection as a “covered item or service”), such notice and consent criteria may not be construed as applying with respect to any item or service that is furnished as a result of unforeseen, urgent medical needs that arise at the time such covered item or service is furnished. For purposes of the previous sentence, a covered item or service shall not include an ancillary service described in subsection (b)(2).

(d) *NOTICE AND CONSENT TO BE TREATED BY A NONPARTICIPATING PROVIDER OR NONPARTICIPATING FACILITY.*—

(1) *IN GENERAL.*—A nonparticipating provider or nonparticipating facility satisfies the notice and consent criteria of this subsection, with respect to items or services furnished by the provider or facility to a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, if the provider (or, if applicable, the participating health care facility on behalf of such provider) or nonparticipating facility—

(A) provides to the participant, beneficiary, or enrollee (or to an authorized representative of the participant, beneficiary, or enrollee) on the date on which the individual is furnished such items or services and, in the case that the participant, beneficiary, or enrollee makes an appointment to be furnished such items or services, on such date the appointment is made—

(i) an oral explanation of the written notice described in clause (ii); and

(ii) a written notice in paper or electronic form (and including electronic notification, as practicable) specified by the Secretary, not later than July 1, 2021, through guidance (which shall be updated as determined necessary by the Secretary) that—

(I) contains the information required under paragraph (2);

(II) clearly states that consent to receive such items and services from such nonparticipating pro-

vider or nonparticipating facility is optional and that the participant, beneficiary, or enrollee may instead seek care from a participating provider or at a participating facility, with respect to such plan or coverage, as applicable, in which case the cost-sharing responsibility of the participant, beneficiary, or enrollee would not exceed such responsibility that would apply with respect to such an item or service that is furnished by a participating provider or participating facility, as applicable with respect to such plan;

(III) is available in the 15 most common languages in the geographic region of the applicable facility and, in the case the primary language of the beneficiary, participant, or enrollee, respectively, is not one of such 15 language, makes a good faith effort to also provide such notice orally in such primary language of the beneficiary, participant, or enrollee; and

(IV) is signed and dated by the participant, beneficiary, or enrollee (or by an authorized representative of the participant, beneficiary, or enrollee) and, with respect to items or services to be furnished by such a provider that are not poststabilization services described in section 2719A(b)(3)(C)(ii), is so signed and dated not less than 72 hours prior to the participant, beneficiary, or enrollee being furnished such items or services by such provider; and

(B) obtains from the participant, beneficiary, or enrollee (or from such an authorized representative) the consent described in paragraph (3) to be treated by a nonparticipating provider or nonparticipating facility.

(2) INFORMATION REQUIRED UNDER WRITTEN NOTICE.—For purposes of paragraph (1)(A)(ii)(I), the information described in this paragraph, with respect to a nonparticipating provider or nonparticipating facility and a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, is each of the following:

(A) Notification, as applicable, that the health care provider is a nonparticipating provider with respect to the health plan or the health care facility is a nonparticipating facility with respect to the health plan.

(B) Notification of the good faith estimated amount that such provider or facility may charge the participant, beneficiary, or enrollee for such items and services involved, including a notification that the provision of such estimate or consent to be treated under paragraph (3) does not constitute a contract with respect to the charges estimated for such items and services.

(C) In the case of a participating facility and a nonparticipating provider, a list of any participating providers at the facility who are able to furnish such items and services involved and notification that the participant, bene-

ficiary, or enrollee may be referred, at their option, to such a participating provider.

(D) Information about whether prior authorization or other care management limitations may be required in advance of receiving such items or services at the facility.

(3) *CONSENT DESCRIBED TO BE TREATED BY A NONPARTICIPATING PROVIDER OR NONPARTICIPATING FACILITY.*—For purposes of paragraph (1)(B), the consent described in this paragraph, with respect to a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market who is to be furnished items or services by a nonparticipating provider or nonparticipating facility, is a document specified by the Secretary through rulemaking, in consultation with the Secretary of Labor, that—

(A) acknowledges that the participant, beneficiary, or enrollee has been—

(i) provided with a written good faith estimate and an oral explanation of the charge that may be applied for the items or services anticipated to be furnished by such provider or facility; and

(ii) informed that the payment of such charge by the participant, beneficiary, or enrollee may not accrue toward meeting any limitation that the plan or coverage places on cost-sharing, including an explanation that such payment may not apply to an in-network deductible applied under the plan or coverage; and

(B) documents the consent of the participant, beneficiary, or enrollee to be furnished such item or services by such provider or facility.

(4) *RULE OF CONSTRUCTION.*—The consent described in paragraph (3), with respect to a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, shall constitute only consent to the receipt of the information provided pursuant to this subsection and shall not constitute a contractual agreement of the participant, beneficiary, or enrollee to any estimated charge or amount included in such information.

(e) *RETENTION OF CERTAIN DOCUMENTS.*—A nonparticipating facility (with respect to such facility or any nonparticipating provider at such facility) or a participating facility (with respect to nonparticipating providers at such facility) that obtains from a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market (or an authorized representative of such participant, beneficiary, or enrollee) a written notice in accordance with subsection (d)(1)(A)(ii), with respect to furnishing an item or service to such participant, beneficiary, or enrollee, shall retain such notice for at least a 2-year period after the date on which such item or service is so furnished.

(f) *DEFINITIONS.*—In this section:

(1) The terms “nonparticipating provider” and “participating provider” have the meanings given such terms, respectively, in subsection (b)(3) of section 2719A.

(2) The term “participating health care facility” has the meaning given such term in subsection (e)(2) of section 2719A.

(3) The term “nonparticipating facility” means—

(A) with respect to emergency services (as defined in section 2719A(b)(3)(C)(i)) and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively; and

(B) with respect to services described in section 2719A(b)(3)(C)(ii) and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, a hospital or an independent freestanding emergency department, that does not have a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively.

(4) The term “participating facility” means—

(A) with respect to emergency services (as defined in clause (i) of section 2719A(b)(3)(C)) that are not described in clause (ii) of such section and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively; and

(B) with respect to services that pursuant to clause (ii) of section 2719A(b)(3)(C) are included as emergency services (as defined in clause (i) of such section) and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, a hospital or an independent freestanding emergency department, that has a contractual relationship with the plan or coverage, respectively, with respect to the furnishing of such services under the plan or coverage, respectively.

SEC. 2799A-3. PROVIDER REQUIREMENT WITH RESPECT TO PUBLIC PROVISION OF INFORMATION.

(a) **IN GENERAL.**—Each health care provider and health care facility shall make publicly available, and (if applicable) post on a public website of such provider or facility and provide to individuals who are participants, beneficiaries, or enrollees of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market a one-page notice in plain language containing information on—

(1) the requirements and prohibitions of such provider or facility under sections 2799A-1, 2799A-2, and 2799A-4 (relating to prohibitions on balance billing in certain circumstances);

(2) if provided for under applicable State law, any other requirements on such provider or facility regarding the amounts such provider or facility may, with respect to an item or service,

charge a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market with respect to which such provider or facility does not have a contractual relationship for furnishing such item or service under the plan or coverage, respectively, after receiving payment from the plan or coverage, respectively, for such item or service and any applicable cost-sharing payment from such participant, beneficiary, or enrollee; and

(3) information on contacting appropriate State and Federal agencies in the case that an individual believes that such provider or facility has violated any requirement described in paragraph (1) or (2) with respect to such individual.

(b) **GUIDANCE.**—Not later than 6 months after the date of the enactment of this section, the Secretary, in consultation with the Secretary of Labor, shall issue guidance on the requirements for the notice under this section.

SEC. 2799A-4. AIR AMBULANCE SERVICES.

In the case of a participant, beneficiary, or enrollee with benefits under a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market who is furnished on or after January 1, 2022, air ambulance services from a nonparticipating provider (as defined in section 2719A(b)(3)(G)) with respect to such plan or coverage, such provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for such service furnished by such provider that is more than the cost-sharing amount for such service (as determined in accordance with paragraphs (1) and (2) of section 2719A(f), section 716(f) of the Employee Retirement Income Security Act of 1974, or section 9816(f) of the Internal Revenue Code of 1986, as applicable).

SEC. 2799A-5. PROVIDER REQUIREMENTS TO PROTECT PATIENTS AND IMPROVE THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

(a) **PROVIDER BUSINESS PROCESSES.**—A health care provider shall have in place business processes to ensure the timely provision of provider directory information to a group health plan or a health insurance issuer offering group or individual health insurance coverage to support compliance by such plans or issuers with section 2730(a)(1), section 717(a)(1) of the Employee Retirement Income Security Act of 1974, or section 9817(a)(1) of the Internal Revenue Code of 1986 (as applicable). Such providers shall submit provider directory information to a plan or issuers, at a minimum—

(1) when the provider begins a network agreement with a plan or with an issuer with respect to certain coverage;

(2) when the provider terminates a network agreement with a plan or with an issuer with respect to certain coverage;

(3) when there are material changes to the content of provider directory information described in section 2730(a)(1), section 717(a)(1) of the Employee Retirement Income Security Act of 1974, or section 9817(a)(1) of the Internal Revenue Code of 1986 (as applicable); and

(4) every 90 days throughout the duration of the network agreement with a plan or issuer.

(b) **ENFORCEMENT.**—

(1) CIVIL PENALTIES.—

(A) IN GENERAL.—Subject to paragraph (2), a health care provider that violates a requirement under subsection (a) or takes actions that prevent a group health plan or health insurance issuer from complying with subsection (a)(1) or (b) of sections 2730, 717 of the Employee Retirement Income Security Act of 1974, or 9817 of the Internal Revenue Code of 1986 (as applicable) shall be subject to a civil monetary penalty of not more than \$10,000 for each act constituting such violation.

(B) SAFE HARBOR.—The Secretary may waive the penalty described under paragraph (1) with respect to a health care provider that unknowingly violates section 2730(b)(1), section 717(b)(1) of the Employee Retirement Income Security Act of 1974, or section 9817(b)(1) of the Internal Revenue Code of 1986 (as applicable) with respect to an enrollee if such provider rescinds the bill involved and, if applicable, reimburses the enrollee within 30 days of the date on which the provider billed the enrollee in violation of such subsection.

(C) PROCEDURE.—The provisions of section 1128A of the Social Security Act, other than subsections (a) and (b) and the first sentence of subsection (c)(1) of such section, shall apply to civil money penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A of the Social Security Act.

(2) REFUNDS TO ENROLLEES.—If a health care provider submits a bill to an enrollee based on cost-sharing for treatment or services provided by the health care provider that is in excess of the normal cost-sharing applied for such treatment or services provided in-network, as prohibited under section 2730(b), section 717(b) of the Employee Retirement Income Security Act of 1974, or section 9817(b) of the Internal Revenue Code of 1986 (as applicable) and the enrollee pays such bill, the provider shall reimburse the enrollee for the full amount paid by the enrollee in excess of the in-network cost-sharing amount for the treatment or services involved, plus interest, at an interest rate determined by the Secretary.

(c) LIMITATION.—Nothing in this section shall prohibit a provider from requiring in the terms of a contract, or contract termination, with a group health plan or health insurance issuer—

(1) that the plan or issuer remove, at the time of termination of such contract, the provider from a directory of the plan or issuer described in section 2730(a)(1), section 717(a)(1) of the Employee Retirement Income Security Act of 1974, or section 9817(a)(1) of the Internal Revenue Code of 1986 (as applicable); or

(2) that the plan or issuer bear financial responsibility, including under section 2730(b), section 717(b) of the Employee Retirement Income Security Act of 1974, or section 9817(b) of the Internal Revenue Code of 1986 (as applicable) for providing inaccurate network status information to an enrollee.

(d) DEFINITION.—For purposes of this section, the term “provider directory information” includes the names, addresses, specialty, and telephone numbers of individual health care providers, and the

names, addresses, and telephone numbers of each medical group, clinic, or facility contracted to participate in any of the networks of the group health plan or health insurance coverage involved.

(e) *RULE OF CONSTRUCTION.*—Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories.

SEC. 2799A–6. PROVISION OF COST-SHARING INFORMATION.

A provider that is in-network with respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage shall, upon request by a participant, beneficiary, or enrollee, provide to a participant, beneficiary, or enrollee in the plan or coverage the following information, together with accurate and complete information about the participant's, beneficiary's, or enrollee's coverage under the applicable plan or coverage:

(1) As soon as practicable and not later than 2 business days after the participant, beneficiary, or enrollee requests such information, a good faith estimate of the expected participant, beneficiary, or enrollee cost-sharing for the provision of a particular health care service (including any service that is reasonably expected to be provided in conjunction with such specific service).

(2) As soon as practicable and not later than 2 business days after a participant, beneficiary, or enrollee requests such information, the contact information for any ancillary providers for a scheduled health care service.

SEC. 2799A–7. ENFORCEMENT.

(a) *STATE ENFORCEMENT.*—

(1) *STATE AUTHORITY.*—Each State may require a provider or health care facility (including a provider of air ambulance services) subject to the requirements of this part (except section 2799A–5) to satisfy such requirements applicable to the provider or facility.

(2) *FAILURE TO IMPLEMENT REQUIREMENTS.*—In the case of a determination by the Secretary that a State has failed to substantially enforce the requirements specified in paragraph (1) with respect to applicable providers and facilities in the State, the Secretary shall enforce such requirements under subsection (b) insofar as they relate to violations of such requirements occurring in such State.

(3) *NOTIFICATION OF SECRETARY OF LABOR.*—A State may notify the Secretary of Labor of instances of violations of sections 2799A–1, 2799A–2, or 2799A–4 with respect to participants or beneficiaries under a group health plan or health insurance coverage offered by a health insurance issuer in the group market and any enforcement actions taken against providers or facilities as a result of such violations, including the disposition of any such enforcement actions.

(b) *SECRETARIAL ENFORCEMENT AUTHORITY.*—

(1) *IN GENERAL.*—If a provider or facility is found to be in violation of a requirement specified in subsection (a)(1) by the Secretary, the Secretary may apply a civil monetary penalty with respect to such provider or facility (including, as applicable, a provider of air ambulance services) in an amount not to exceed \$10,000 per violation. The provisions of subsections (c)

(with the exception of the first sentence of paragraph (1) of such subsection), (d), (e), (g), (h), (k), and (l) of section 1128A of the Social Security Act shall apply to a civil monetary penalty or assessment under this subsection in the same manner as such provisions apply to a penalty, assessment, or proceeding under subsection (a) of such section.

(2) *LIMITATION.*—The provisions of paragraph (1) shall apply to enforcement of a provision (or provisions) specified in subsection (a)(1) only as provided under subsection (a)(2).

(3) *COMPLAINT PROCESS.*—The Secretary shall, through rule-making conducted in consultation with the Secretary of Labor, establish a process to receive consumer complaints of violations of such provisions and resolve such complaints within 60 days of receipt of such complaints. Such process shall provide that the Secretary of Labor be informed of complaints by participants or beneficiaries under a group health plan or health insurance coverage offered by a health insurance issuer in the group market and any enforcement actions against providers resulting from such complaints, including the disposition of any such enforcement actions.

(4) *EXCEPTION.*—The Secretary may waive the penalties described under paragraph (1) with respect to a facility or provider (including a provider of air ambulance services) who does not knowingly violate, and should not have reasonably known it violated, sections 2799A–1, 2799A–2, or 2799A–4 with respect to a participant, beneficiary, or enrollee, if such facility or provider, within 30 days of the violation, withdraws the bill that was in violation of such provision and reimburses the health plan or participant, beneficiary, or enrollee, as applicable, in an amount equal to the difference between the amount billed and the amount allowed to be billed under the provision, plus interest, at an interest rate determined by the Secretary.

(5) *HARDSHIP EXEMPTION.*—The Secretary may establish a hardship exemption to the penalties under this subsection.

(c) *CONTINUED APPLICABILITY OF STATE LAW.*—The sections specified in subsection (a)(1) shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any requirement or prohibition except to the extent that such requirement or prohibition prevents the application of a requirement or prohibition of such a section.

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EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SHORT TITLE AND TABLE OF CONTENTS

SECTION 1. This Act may be cited as the “Employee Retirement Income Security Act of 1974”.

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PART 4—FIDUCIARY RESPONSIBILITY

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EXEMPTIONS FROM PROHIBITED TRANSACTIONS

SEC. 408. (a) The Secretary shall establish an exemption procedure for purposes of this subsection. Pursuant to such procedure, he may grant a conditional or unconditional exemption of any fiduciary or transaction, or class of fiduciaries or transactions, from all or part of the restrictions imposed by sections 406 and 407(a). Action under this subsection may be taken only after consultation and coordination with the Secretary of the Treasury. An exemption granted under this section shall not relieve a fiduciary from any other applicable provision of this Act. The Secretary may not grant an exemption under this subsection unless he finds that such exemption is—

- (1) administratively feasible,
- (2) in the interests of the plan and of its participants and beneficiaries, and
- (3) protective of the rights of participants and beneficiaries of such plan.

Before granting an exemption under this subsection from section 406(a) or 407(a), the Secretary shall publish notice in the Federal Register of the pendency of the exemption, shall require that adequate notice be given to interested persons, and shall afford interested persons opportunity to present views. The Secretary may not grant an exemption under this subsection from section 406(b) unless he affords an opportunity for a hearing and makes a determination on the record with respect to the findings required by paragraphs (1), (2), and (3) of this subsection.

(b) The prohibitions provided in section 406 shall not apply to any of the following transactions:

(1) Any loans made by the plan to parties in interest who are participants or beneficiaries of the plan if such loans (A) are available to all such participants and beneficiaries on a reasonably equivalent basis, (B) are not made available to highly compensated employees (within the meaning of section 414(q) of the Internal Revenue Code of 1986) in an amount greater than the amount made available to other employees, (C) are made in accordance with specific provisions regarding such loans set forth in the plan, (D) bear a reasonable rate of interest, and (E) are adequately secured. A loan made by a plan shall not fail to meet the requirements of the preceding sentence by reason of a loan repayment suspension described under section 414(u)(4) of the Internal Revenue Code of 1986.

[(2) Contracting or making] (2) (A) *Contracting or making* reasonable arrangements with a party in interest for office space, or legal, accounting, or other services necessary for the establishment or operation of the plan, if no more than reasonable compensation is paid therefor.

(B)(i) *No contract or arrangement for services between a covered plan and a covered service provider, and no extension or renewal of such a contract or arrangement, is reasonable within the meaning of this paragraph unless the requirements of this subparagraph are met.*

(ii)(I) *For purposes of this subparagraph:*

(aa) *The term “covered plan” means a group health plan as defined section 733(a).*

(bb) *The term “covered service provider” means a service provider that enters into a contract or arrangement with the covered plan and reasonably expects \$1,000 (or such amount as the Secretary may establish in regulations to account for inflation since the date of the enactment of the Ban Surprise Billing Act, as appropriate) or more in compensation, direct or indirect, to be received in connection with providing one or more of the following services, pursuant to the contract or arrangement, regardless of whether such services will be performed, or such compensation received, by the covered service provider, an affiliate, or a subcontractor:*

(AA) *Brokerage services, for which the covered service provider, an affiliate, or a subcontractor reasonably expects to receive indirect compensation or direct compensation described in item (dd), provided to a covered plan with respect to selection of insurance products (including vision and dental), recordkeeping services, medical management vendor, benefits administration (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness services, transparency tools and vendors, group purchasing organization preferred vendor panels, disease management vendors and products, compliance services, employee assistance programs, or third party administration services.*

(BB) Consulting, for which the covered service provider, an affiliate, or a subcontractor reasonably expects to receive indirect compensation or direct compensation described in item (dd), related to the development or implementation of plan design, insurance or insurance product selection (including vision and dental), recordkeeping, medical management, benefits administration selection (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness design and management services, transparency tools, group purchasing organization agreements and services, participation in and services from preferred vendor panels, disease management, compliance services, employee assistance programs, or third party administration services.

(cc) The term “affiliate”, with respect to a covered service provider, means an entity that directly or indirectly (through one or more intermediaries) controls, is controlled by, or is under common control with, such provider, or is an officer, director, or employee of, or partner in, such provider.

(dd)(AA) The term “compensation” means anything of monetary value, but does not include non-monetary compensation valued at \$250 (or such amount as the Secretary may establish in regulations to account for inflation since the date of enactment of the Ban Surprise Billing Act, as appropriate) or less, in the aggregate, during the term of the contract or arrangement.

(BB) The term “direct compensation” means compensation received directly from a covered plan.

(CC) The term “indirect compensation” means compensation received from any source other than the covered plan, the plan sponsor, the covered service provider, or an affiliate. Compensation received from a subcontractor is indirect compensation, unless it is received in connection with services performed under a contract or arrangement with a subcontractor.

(ee) The term “responsible plan fiduciary” means a fiduciary with authority to cause the covered plan to enter into, or extend or renew, the contract or arrangement.

(ff) The term “subcontractor” means any person or entity (or an affiliate of such person or entity) that is not an affiliate of the covered service provider and that, pursuant to a contract or arrangement with the covered service provider or an affiliate, reasonably expects to receive \$1,000 (or such amount as the Secretary may establish in regulations to account for inflation since the date of enactment of the Ban Surprise Billing Act, as appropriate) or more in compensation for performing one or more services described in item (bb) under a contract or arrangement with the covered plan.

(II) For purposes of this subparagraph, a description of compensation or cost may be expressed as a monetary amount, formula, or a per capita charge for each enrollee or, if the compensation or cost cannot reasonably be expressed in such terms,

by any other reasonable method, including a disclosure that additional compensation may be earned but may not be calculated at the time of contract if such a disclosure includes a description of the circumstances under which the additional compensation may be earned and a reasonable and good faith estimate if the covered service provider cannot otherwise readily describe compensation or cost and explains the methodology and assumptions used to prepare such estimate. Any such description shall contain sufficient information to permit evaluation of the reasonableness of the compensation or cost.

(III) No person or entity is a “covered service provider” within the meaning of subclause (I)(bb) solely on the basis of providing services as an affiliate or a subcontractor that is performing one or more of the services described in subitem (AA) or (BB) of such subclause under the contract or arrangement with the covered plan.

(iii) A covered service provider shall disclose to a responsible plan fiduciary, in writing, the following:

(I) A description of the services to be provided to the covered plan pursuant to the contract or arrangement.

(II) If applicable, a statement that the covered service provider, an affiliate, or a subcontractor will provide, or reasonably expects to provide, services pursuant to the contract or arrangement directly to the covered plan as a fiduciary (within the meaning of section 3(21)).

(III) A description of all direct compensation, either in the aggregate or by service, that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with the services described in subclause (I).

(IV)(aa) A description of all indirect compensation that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with the services described in subclause (I)—

(AA) including compensation from a vendor to a brokerage firm based on a structure of incentives not solely related to the contract with the covered plan; and

(BB) not including compensation received by an employee from an employer on account of work performed by the employee.

(bb) A description of the arrangement between the payer and the covered service provider, an affiliate, or a subcontractor, as applicable, pursuant to which such indirect compensation is paid.

(cc) Identification of the services for which the indirect compensation will be received, if applicable.

(dd) Identification of the payer of the indirect compensation.

(V) A description of any compensation that will be paid among the covered service provider, an affiliate, or a subcontractor, in connection with the services described in subclause (I) if such compensation is set on a transaction basis (such as commissions, finder's fees, or other similar incentive compensation based on business placed or retained), including identification of the services for which such com-

compensation will be paid and identification of the payers and recipients of such compensation (including the status of a payer or recipient as an affiliate or a subcontractor), regardless of whether such compensation also is disclosed pursuant to subclause (III) or (IV).

(VI) A description of any compensation that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with termination of the contract or arrangement, and how any prepaid amounts will be calculated and refunded upon such termination.

(iv) A covered service provider shall disclose to a responsible plan fiduciary, in writing a description of the manner in which the compensation described in clause (iii), as applicable, will be received.

(v)(I) A covered service provider shall disclose the information required under clauses (iii) and (iv) to the responsible plan fiduciary not later than the date that is reasonably in advance of the date on which the contract or arrangement is entered into, and extended or renewed.

(II) A covered service provider shall disclose any change to the information required under clause (iii) and (iv) as soon as practicable, but not later than 60 days from the date on which the covered service provider is informed of such change, unless such disclosure is precluded due to extraordinary circumstances beyond the covered service provider's control, in which case the information shall be disclosed as soon as practicable.

(vi)(I) Upon the written request of the responsible plan fiduciary or covered plan administrator, a covered service provider shall furnish any other information relating to the compensation received in connection with the contract or arrangement that is required for the covered plan to comply with the reporting and disclosure requirements under this Act.

(II) The covered service provider shall disclose the information required under clause (iii)(I) reasonably in advance of the date upon which such responsible plan fiduciary or covered plan administrator states that it is required to comply with the applicable reporting or disclosure requirement, unless such disclosure is precluded due to extraordinary circumstances beyond the covered service provider's control, in which case the information shall be disclosed as soon as practicable.

(vii) No contract or arrangement will fail to be reasonable under this subparagraph solely because the covered service provider, acting in good faith and with reasonable diligence, makes an error or omission in disclosing the information required pursuant to clause (iii) (or a change to such information disclosed pursuant to clause (v)(II)) or clause (vi), provided that the covered service provider discloses the correct information to the responsible plan fiduciary as soon as practicable, but not later than 30 days from the date on which the covered service provider knows of such error or omission.

(viii)(I) Pursuant to subsection (a), subparagraphs (C) and (D) of section 406(a)(1) shall not apply to a responsible plan fiduciary, notwithstanding any failure by a covered service provider to disclose information required under clause (iii), if the following conditions are met:

(aa) *The responsible plan fiduciary did not know that the covered service provider failed or would fail to make required disclosures and reasonably believed that the covered service provider disclosed the information required to be disclosed.*

(bb) *The responsible plan fiduciary, upon discovering that the covered service provider failed to disclose the required information, requests in writing that the covered service provider furnish such information.*

(cc) *If the covered service provider fails to comply with a written request described in subclause (II) within 90 days of the request, the responsible plan fiduciary notifies the Secretary of the covered service provider's failure, in accordance with subclauses (II) and (III).*

(II) *A notice described in subclause (I)(cc) shall contain—*

(aa) the name of the covered plan;

(bb) the plan number used for the annual report on the covered plan;

(cc) the plan sponsor's name, address, and employer identification number;

(dd) the name, address, and telephone number of the responsible plan fiduciary;

(ee) the name, address, phone number, and, if known, employer identification number of the covered service provider;

(ff) a description of the services provided to the covered plan;

(gg) a description of the information that the covered service provider failed to disclose;

(hh) the date on which such information was requested in writing from the covered service provider; and

(ii) a statement as to whether the covered service provider continues to provide services to the plan.

(III) *A notice described in subclause (I)(cc) shall be filed with the Department not later than 30 days following the earlier of—*

(aa) The covered service provider's refusal to furnish the information requested by the written request described in subclause (I)(bb); or

(bb) 90 days after the written request referred to in subclause (I)(cc) is made.

(IV) *If the covered service provider fails to comply with the written request under subclause (I)(bb) within 90 days of such request, the responsible plan fiduciary shall determine whether to terminate or continue the contract or arrangement under section 404. If the requested information relates to future services and is not disclosed promptly after the end of the 90-day period, the responsible plan fiduciary shall terminate the contract or arrangement as expeditiously as possible, consistent with such duty of prudence.*

(ix) *Nothing in this subparagraph shall be construed to supersede any provision of State law that governs disclosures by parties that provide the services described in this section, except to the extent that such law prevents the application of a requirement of this section.*

(3) A loan to an employee stock ownership plan (as defined in section 407(d)(6)), if—

(A) such loan is primarily for the benefit of participants and beneficiaries of the plan, and

(B) such loan is at an interest rate which is not in excess of a reasonable rate.

If the plan gives collateral to a party in interest for such loan, such collateral may consist only of qualifying employer securities (as defined in section 407(d)(5)).

(4) The investment of all or part of a plan's assets in deposits which bear a reasonable interest rate in a bank or similar financial institution supervised by the United States or a State, if such bank or other institution is a fiduciary of such plan and if—

(A) the plan covers only employees of such bank or other institution and employees of affiliates of such bank or other institution, or

(B) such investment is expressly authorized by a provision of the plan or by a fiduciary (other than such bank or institution or affiliate thereof) who is expressly empowered by the plan to so instruct the trustee with respect to such investment.

(5) Any contract for life insurance, health insurance, or annuities with one or more insurers which are qualified to do business in a State, if the plan pays no more than adequate consideration, and if each such insurer or insurers is—

(A) the employer maintaining the plan, or

(B) a party in interest which is wholly owned (directly or indirectly) by the employer maintaining the plan, or by any person which is a party in interest with respect to the plan, but only if the total premiums and annuity considerations written by such insurers for life insurance, health insurance, or annuities for all plans (and their employers) with respect to which such insurers are parties in interest (not including premiums or annuity considerations written by the employer maintaining the plan) do not exceed 5 percent of the total premiums and annuity considerations written for all lines of insurance in that year by such insurers (not including premiums or annuity considerations written by the employer maintaining the plan).

(6) The providing of any ancillary service by a bank or similar financial institution supervised by the United States or a State, if such bank or other institution is a fiduciary of such plan, and if—

(A) such bank or similar financial institution has adopted adequate internal safeguards which assure that the providing of such ancillary service is consistent with sound banking and financial practice, as determined by Federal or State supervisory authority, and

(B) the extent to which such ancillary service is provided is subject to specific guidelines issued by such bank or similar financial institution (as determined by the Secretary after consultation with Federal and State supervisory authority), and adherence to such guidelines would reasonably preclude such bank or similar financial institu-

tion from providing such ancillary service (i) in an excessive or unreasonable manner, and (ii) in a manner that would be inconsistent with the best interests of participants and beneficiaries of employee benefit plans.

Such ancillary services shall not be provided at more than reasonable compensation.

(7) The exercise of a privilege to convert securities, to the extent provided in regulations of the Secretary, but only if the plan receives no less than adequate consideration pursuant to such conversion.

(8) Any transaction between a plan and (i) a common or collective trust fund or pooled investment fund maintained by a party in interest which is a bank or trust company supervised by a State or Federal agency or (ii) a pooled investment fund of an insurance company qualified to do business in a State, if—

(A) the transaction is a sale or purchase of an interest in the fund,

(B) the bank, trust company, or insurance company receives not more than reasonable compensation, and

(C) such transaction is expressly permitted by the instrument under which the plan is maintained, or by a fiduciary (other than the bank, trust company, or insurance company, or an affiliate thereof) who has authority to manage and control the assets of the plan.

(9) The making by a fiduciary of a distribution of the assets of the plan in accordance with the terms of the plan if such assets are distributed in the same manner as provided under section 4044 of this Act (relating to allocation of assets).

(10) Any transaction required or permitted under part 1 of subtitle E of title IV.

(11) A merger of multiemployer plans, or the transfer of assets or liabilities between multiemployer plans, determined by the Pension Benefit Guaranty Corporation to meet the requirements of section 4231.

(12) The sale by a plan to a party in interest on or after December 18, 1987, of any stock, if—

(A) the requirements of paragraphs (1) and (2) of subsection (e) are met with respect to such stock,

(B) on the later of the date on which the stock was acquired by the plan, or January 1, 1975, such stock constituted a qualifying employer security (as defined in section 407(d)(5) as then in effect), and

(C) such stock does not constitute a qualifying employer security (as defined in section 407(d)(5) as in effect at the time of the sale).

(13) Any transfer made before January 1, 2026, of excess pension assets from a defined benefit plan to a retiree health account in a qualified transfer permitted under section 420 of the Internal Revenue Code of 1986 (as in effect on the date of the enactment of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015).

(14) Any transaction in connection with the provision of investment advice described in section 3(21)(A)(ii) to a participant or beneficiary of an individual account plan that permits

such participant or beneficiary to direct the investment of assets in their individual account, if—

(A) the transaction is—

(i) the provision of the investment advice to the participant or beneficiary of the plan with respect to a security or other property available as an investment under the plan,

(ii) the acquisition, holding, or sale of a security or other property available as an investment under the plan pursuant to the investment advice, or

(iii) the direct or indirect receipt of fees or other compensation by the fiduciary adviser or an affiliate thereof (or any employee, agent, or registered representative of the fiduciary adviser or affiliate) in connection with the provision of the advice or in connection with an acquisition, holding, or sale of a security or other property available as an investment under the plan pursuant to the investment advice; and

(B) the requirements of subsection (g) are met.

(15)(A) Any transaction involving the purchase or sale of securities, or other property (as determined by the Secretary), between a plan and a party in interest (other than a fiduciary described in section 3(21)(A)) with respect to a plan if—

(i) the transaction involves a block trade,

(ii) at the time of the transaction, the interest of the plan (together with the interests of any other plans maintained by the same plan sponsor), does not exceed 10 percent of the aggregate size of the block trade,

(iii) the terms of the transaction, including the price, are at least as favorable to the plan as an arm's length transaction, and

(iv) the compensation associated with the purchase and sale is not greater than the compensation associated with an arm's length transaction with an unrelated party.

(B) For purposes of this paragraph, the term "block trade" means any trade of at least 10,000 shares or with a market value of at least \$200,000 which will be allocated across two or more unrelated client accounts of a fiduciary.

(16) Any transaction involving the purchase or sale of securities, or other property (as determined by the Secretary), between a plan and a party in interest if—

(A) the transaction is executed through an electronic communication network, alternative trading system, or similar execution system or trading venue subject to regulation and oversight by—

(i) the applicable Federal regulating entity, or

(ii) such foreign regulatory entity as the Secretary may determine by regulation,

(B) either—

(i) the transaction is effected pursuant to rules designed to match purchases and sales at the best price available through the execution system in accordance with applicable rules of the Securities and Exchange Commission or other relevant governmental authority, or

(ii) neither the execution system nor the parties to the transaction take into account the identity of the parties in the execution of trades,

(C) the price and compensation associated with the purchase and sale are not greater than the price and compensation associated with an arm's length transaction with an unrelated party,

(D) if the party in interest has an ownership interest in the system or venue described in subparagraph (A), the system or venue has been authorized by the plan sponsor or other independent fiduciary for transactions described in this paragraph, and

(E) not less than 30 days prior to the initial transaction described in this paragraph executed through any system or venue described in subparagraph (A), a plan fiduciary is provided written or electronic notice of the execution of such transaction through such system or venue.

(17)(A) Transactions described in subparagraphs (A), (B), and (D) of section 406(a)(1) between a plan and a person that is a party in interest other than a fiduciary (or an affiliate) who has or exercises any discretionary authority or control with respect to the investment of the plan assets involved in the transaction or renders investment advice (within the meaning of section 3(21)(A)(ii)) with respect to those assets, solely by reason of providing services to the plan or solely by reason of a relationship to such a service provider described in subparagraph (F), (G), (H), or (I) of section 3(14), or both, but only if in connection with such transaction the plan receives no less, nor pays no more, than adequate consideration.

(B) For purposes of this paragraph, the term "adequate consideration" means—

(i) in the case of a security for which there is a generally recognized market—

(I) the price of the security prevailing on a national securities exchange which is registered under section 6 of the Securities Exchange Act of 1934, taking into account factors such as the size of the transaction and marketability of the security, or

(II) if the security is not traded on such a national securities exchange, a price not less favorable to the plan than the offering price for the security as established by the current bid and asked prices quoted by persons independent of the issuer and of the party in interest, taking into account factors such as the size of the transaction and marketability of the security, and

(ii) in the case of an asset other than a security for which there is a generally recognized market, the fair market value of the asset as determined in good faith by a fiduciary or fiduciaries in accordance with regulations prescribed by the Secretary.

(18) FOREIGN EXCHANGE TRANSACTIONS.—Any foreign exchange transactions, between a bank or broker-dealer (or any affiliate of either), and a plan (as defined in section 3(3)) with respect to which such bank or broker-dealer (or affiliate) is a trustee, custodian, fiduciary, or other party in interest, if—

(A) the transaction is in connection with the purchase, holding, or sale of securities or other investment assets (other than a foreign exchange transaction unrelated to any other investment in securities or other investment assets),

(B) at the time the foreign exchange transaction is entered into, the terms of the transaction are not less favorable to the plan than the terms generally available in comparable arm's length foreign exchange transactions between unrelated parties, or the terms afforded by the bank or broker-dealer (or any affiliate of either) in comparable arm's-length foreign exchange transactions involving unrelated parties,

(C) the exchange rate used by such bank or broker-dealer (or affiliate) for a particular foreign exchange transaction does not deviate by more than 3 percent from the interbank bid and asked rates for transactions of comparable size and maturity at the time of the transaction as displayed on an independent service that reports rates of exchange in the foreign currency market for such currency, and

(D) the bank or broker-dealer (or any affiliate of either) does not have investment discretion, or provide investment advice, with respect to the transaction.

(19) CROSS TRADING.—Any transaction described in sections 406(a)(1)(A) and 406(b)(2) involving the purchase and sale of a security between a plan and any other account managed by the same investment manager, if—

(A) the transaction is a purchase or sale, for no consideration other than cash payment against prompt delivery of a security for which market quotations are readily available,

(B) the transaction is effected at the independent current market price of the security (within the meaning of section 270.17a-7(b) of title 17, Code of Federal Regulations),

(C) no brokerage commission, fee (except for customary transfer fees, the fact of which is disclosed pursuant to subparagraph (D)), or other remuneration is paid in connection with the transaction,

(D) a fiduciary (other than the investment manager engaging in the cross-trades or any affiliate) for each plan participating in the transaction authorizes in advance of any cross-trades (in a document that is separate from any other written agreement of the parties) the investment manager to engage in cross trades at the investment manager's discretion, after such fiduciary has received disclosure regarding the conditions under which cross trades may take place (but only if such disclosure is separate from any other agreement or disclosure involving the asset management relationship), including the written policies and procedures of the investment manager described in subparagraph (H),

(E) each plan participating in the transaction has assets of at least \$100,000,000, except that if the assets of a plan are invested in a master trust containing the assets of

plans maintained by employers in the same controlled group (as defined in section 407(d)(7)), the master trust has assets of at least \$100,000,000,

(F) the investment manager provides to the plan fiduciary who authorized cross trading under subparagraph (D) a quarterly report detailing all cross trades executed by the investment manager in which the plan participated during such quarter, including the following information, as applicable: (i) the identity of each security bought or sold; (ii) the number of shares or units traded; (iii) the parties involved in the cross-trade; and (iv) trade price and the method used to establish the trade price,

(G) the investment manager does not base its fee schedule on the plan's consent to cross trading, and no other service (other than the investment opportunities and cost savings available through a cross trade) is conditioned on the plan's consent to cross trading,

(H) the investment manager has adopted, and cross-trades are effected in accordance with, written cross-trading policies and procedures that are fair and equitable to all accounts participating in the cross-trading program, and that include a description of the manager's pricing policies and procedures, and the manager's policies and procedures for allocating cross trades in an objective manner among accounts participating in the cross-trading program, and

(I) the investment manager has designated an individual responsible for periodically reviewing such purchases and sales to ensure compliance with the written policies and procedures described in subparagraph (H), and following such review, the individual shall issue an annual written report no later than 90 days following the period to which it relates signed under penalty of perjury to the plan fiduciary who authorized cross trading under subparagraph (D) describing the steps performed during the course of the review, the level of compliance, and any specific instances of non-compliance.

The written report under subparagraph (I) shall also notify the plan fiduciary of the plan's right to terminate participation in the investment manager's cross-trading program at any time.

(20)(A) Except as provided in subparagraphs (B) and (C), a transaction described in section 406(a) in connection with the acquisition, holding, or disposition of any security or commodity, if the transaction is corrected before the end of the correction period.

(B) Subparagraph (A) does not apply to any transaction between a plan and a plan sponsor or its affiliates that involves the acquisition or sale of an employer security (as defined in section 407(d)(1)) or the acquisition, sale, or lease of employer real property (as defined in section 407(d)(2)).

(C) In the case of any fiduciary or other party in interest (or any other person knowingly participating in such transaction), subparagraph (A) does not apply to any transaction if, at the time the transaction occurs, such fiduciary or party in interest (or other person) knew (or reasonably should have known) that

the transaction would (without regard to this paragraph) constitute a violation of section 406(a).

(D) For purposes of this paragraph, the term “correction period” means, in connection with a fiduciary or party in interest (or other person knowingly participating in the transaction), the 14-day period beginning on the date on which such fiduciary or party in interest (or other person) discovers, or reasonably should have discovered, that the transaction would (without regard to this paragraph) constitute a violation of section 406(a).

(E) For purposes of this paragraph—

(i) The term “security” has the meaning given such term by section 475(c)(2) of the Internal Revenue Code of 1986 (without regard to subparagraph (F)(iii) and the last sentence thereof).

(ii) The term “commodity” has the meaning given such term by section 475(e)(2) of such Code (without regard to subparagraph (D)(iii) thereof).

(iii) The term “correct” means, with respect to a transaction—

(I) to undo the transaction to the extent possible and in any case to make good to the plan or affected account any losses resulting from the transaction, and

(II) to restore to the plan or affected account any profits made through the use of assets of the plan.

(c) Nothing in section 406 shall be construed to prohibit any fiduciary from—

(1) receiving any benefit to which he may be entitled as a participant or beneficiary in the plan, so long as the benefit is computed and paid on a basis which is consistent with the terms of the plan as applied to all other participants and beneficiaries;

(2) receiving any reasonable compensation for services rendered, or for the reimbursement of expenses properly and actually incurred, in the performance of his duties with the plan; except that no person so serving who already receives full time pay from an employer or an association of employers, whose employees are participants in the plan, or from an employee organization whose members are participants in such plan shall receive compensation from such plan, except for reimbursement of expenses properly and actually incurred; or

(3) serving as a fiduciary in addition to being an officer, employee, agent, or other representative of a party in interest.

(d)(1) Section 407(b) and subsections (b), (c), and (e) of this section shall not apply to a transaction in which a plan directly or indirectly—

(A) lends any part of the corpus or income of the plan to,

(B) pays any compensation for personal services rendered to the plan to, or

(C) acquires for the plan any property from, or sells any property to,

any person who is with respect to the plan an owner-employee (as defined in section 401(c)(3) of the Internal Revenue Code of 1986), a member of the family (as defined in section 267(c)(4) of such Code) of any such owner-employee, or any corporation in which any

such owner-employee owns, directly or indirectly, 50 percent or more of the total combined voting power of all classes of stock entitled to vote or 50 percent or more of the total value of shares of all classes of stock of the corporation.

(2)(A) For purposes of paragraph (1), the following shall be treated as owner-employees:

- (i) A shareholder-employee.
- (ii) A participant or beneficiary of an individual retirement plan (as defined in section 7701(a)(37) of the Internal Revenue Code of 1986).
- (iii) An employer or association of employees which establishes such an individual retirement plan under section 408(c) of such Code.

(B) Paragraph (1)(C) shall not apply to a transaction which consists of a sale of employer securities to an employee stock ownership plan (as defined in section 407(d)(6)) by a shareholder-employee, a member of the family (as defined in section 267(c)(4) of such Code) of any such owner-employee, or a corporation in which such a shareholder-employee owns stock representing a 50 percent or greater interest described in paragraph (1).

(C) For purposes of paragraph (1)(A), the term “owner-employee” shall only include a person described in clause (ii) or (iii) of subparagraph (A).

(3) For purposes of paragraph (2), the term “shareholder-employee” means an employee or officer of an S corporation (as defined in section 1361(a)(1) of such Code) who owns (or is considered as owning within the meaning of section 318(a)(1) of such Code) more than 5 percent of the outstanding stock of the corporation on any day during the taxable year of such corporation.

(e) Sections 406 and 407 shall not apply to the acquisition or sale by a plan of qualifying employer securities (as defined in section 407(d)(5)) or acquisition, sale or lease by a plan of qualifying employer real property (as defined in section 407(d)(4))—

(1) if such acquisition, sale, or lease is for adequate consideration (or in the case of a marketable obligation, at a price not less favorable to the plan than the price determined under section 407(e)(1)),

(2) if no commission is charged with respect thereto, and

(3) if—

(A) the plan is an eligible individual account plan (as defined in section 407(d)(3)), or

(B) in the case of an acquisition or lease of qualifying employer real property by a plan which is not an eligible individual account plan, or of an acquisition of qualifying employer securities by such a plan, the lease or acquisition is not prohibited by section 407(a).

(f) Section 406(b)(2) shall not apply to any merger or transfer described in subsection (b)(11).

(g) PROVISION OF INVESTMENT ADVICE TO PARTICIPANT AND BENEFICIARIES.—

(1) IN GENERAL.—The prohibitions provided in section 406 shall not apply to transactions described in subsection (b)(14) if the investment advice provided by a fiduciary adviser is provided under an eligible investment advice arrangement.

(2) ELIGIBLE INVESTMENT ADVICE ARRANGEMENT.—For purposes of this subsection, the term “eligible investment advice arrangement” means an arrangement—

(A) which either—

(i) provides that any fees (including any commission or other compensation) received by the fiduciary adviser for investment advice or with respect to the sale, holding, or acquisition of any security or other property for purposes of investment of plan assets do not vary depending on the basis of any investment option selected, or

(ii) uses a computer model under an investment advice program meeting the requirements of paragraph (3) in connection with the provision of investment advice by a fiduciary adviser to a participant or beneficiary, and

(B) with respect to which the requirements of paragraph (4), (5), (6), (7), (8), and (9) are met.

(3) INVESTMENT ADVICE PROGRAM USING COMPUTER MODEL.—

(A) IN GENERAL.—An investment advice program meets the requirements of this paragraph if the requirements of subparagraphs (B), (C), and (D) are met.

(B) COMPUTER MODEL.—The requirements of this subparagraph are met if the investment advice provided under the investment advice program is provided pursuant to a computer model that—

(i) applies generally accepted investment theories that take into account the historic returns of different asset classes over defined periods of time,

(ii) utilizes relevant information about the participant, which may include age, life expectancy, retirement age, risk tolerance, other assets or sources of income, and preferences as to certain types of investments,

(iii) utilizes prescribed objective criteria to provide asset allocation portfolios comprised of investment options available under the plan,

(iv) operates in a manner that is not biased in favor of investments offered by the fiduciary adviser or a person with a material affiliation or contractual relationship with the fiduciary adviser, and

(v) takes into account all investment options under the plan in specifying how a participant’s account balance should be invested and is not inappropriately weighted with respect to any investment option.

(C) CERTIFICATION.—

(i) IN GENERAL.—The requirements of this subparagraph are met with respect to any investment advice program if an eligible investment expert certifies, prior to the utilization of the computer model and in accordance with rules prescribed by the Secretary, that the computer model meets the requirements of subparagraph (B).

(ii) RENEWAL OF CERTIFICATIONS.—If, as determined under regulations prescribed by the Secretary, there

are material modifications to a computer model, the requirements of this subparagraph are met only if a certification described in clause (i) is obtained with respect to the computer model as so modified.

(iii) ELIGIBLE INVESTMENT EXPERT.—The term “eligible investment expert” means any person—

(I) which meets such requirements as the Secretary may provide, and

(II) does not bear any material affiliation or contractual relationship with any investment adviser or a related person thereof (or any employee, agent, or registered representative of the investment adviser or related person).

(D) EXCLUSIVITY OF RECOMMENDATION.—The requirements of this subparagraph are met with respect to any investment advice program if—

(i) the only investment advice provided under the program is the advice generated by the computer model described in subparagraph (B), and

(ii) any transaction described in subsection (b)(14)(A)(ii) occurs solely at the direction of the participant or beneficiary.

Nothing in the preceding sentence shall preclude the participant or beneficiary from requesting investment advice other than that described in subparagraph (A), but only if such request has not been solicited by any person connected with carrying out the arrangement.

(4) EXPRESS AUTHORIZATION BY SEPARATE FIDUCIARY.—The requirements of this paragraph are met with respect to an arrangement if the arrangement is expressly authorized by a plan fiduciary other than the person offering the investment advice program, any person providing investment options under the plan, or any affiliate of either.

(5) ANNUAL AUDIT.—The requirements of this paragraph are met if an independent auditor, who has appropriate technical training or experience and proficiency and so represents in writing—

(A) conducts an annual audit of the arrangement for compliance with the requirements of this subsection, and

(B) following completion of the annual audit, issues a written report to the fiduciary who authorized use of the arrangement which presents its specific findings regarding compliance of the arrangement with the requirements of this subsection.

For purposes of this paragraph, an auditor is considered independent if it is not related to the person offering the arrangement to the plan and is not related to any person providing investment options under the plan.

(6) DISCLOSURE.—The requirements of this paragraph are met if—

(A) the fiduciary adviser provides to a participant or a beneficiary before the initial provision of the investment advice with regard to any security or other property offered as an investment option, a written notification

(which may consist of notification by means of electronic communication)—

(i) of the role of any party that has a material affiliation or contractual relationship with the fiduciary adviser in the development of the investment advice program and in the selection of investment options available under the plan,

(ii) of the past performance and historical rates of return of the investment options available under the plan,

(iii) of all fees or other compensation relating to the advice that the fiduciary adviser or any affiliate thereof is to receive (including compensation provided by any third party) in connection with the provision of the advice or in connection with the sale, acquisition, or holding of the security or other property,

(iv) of any material affiliation or contractual relationship of the fiduciary adviser or affiliates thereof in the security or other property,

(v) the manner, and under what circumstances, any participant or beneficiary information provided under the arrangement will be used or disclosed,

(vi) of the types of services provided by the fiduciary adviser in connection with the provision of investment advice by the fiduciary adviser,

(vii) that the adviser is acting as a fiduciary of the plan in connection with the provision of the advice, and

(viii) that a recipient of the advice may separately arrange for the provision of advice by another adviser, that could have no material affiliation with and receive no fees or other compensation in connection with the security or other property, and

(B) at all times during the provision of advisory services to the participant or beneficiary, the fiduciary adviser—

(i) maintains the information described in subparagraph (A) in accurate form and in the manner described in paragraph (8),

(ii) provides, without charge, accurate information to the recipient of the advice no less frequently than annually,

(iii) provides, without charge, accurate information to the recipient of the advice upon request of the recipient, and

(iv) provides, without charge, accurate information to the recipient of the advice concerning any material change to the information required to be provided to the recipient of the advice at a time reasonably contemporaneous to the change in information.

(7) OTHER CONDITIONS.—The requirements of this paragraph are met if—

(A) the fiduciary adviser provides appropriate disclosure, in connection with the sale, acquisition, or holding of the security or other property, in accordance with all applicable securities laws,

(B) the sale, acquisition, or holding occurs solely at the direction of the recipient of the advice,

(C) the compensation received by the fiduciary adviser and affiliates thereof in connection with the sale, acquisition, or holding of the security or other property is reasonable, and

(D) the terms of the sale, acquisition, or holding of the security or other property are at least as favorable to the plan as an arm's length transaction would be.

(8) STANDARDS FOR PRESENTATION OF INFORMATION.—

(A) IN GENERAL.—The requirements of this paragraph are met if the notification required to be provided to participants and beneficiaries under paragraph (6)(A) is written in a clear and conspicuous manner and in a manner calculated to be understood by the average plan participant and is sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of the information required to be provided in the notification.

(B) MODEL FORM FOR DISCLOSURE OF FEES AND OTHER COMPENSATION.—The Secretary shall issue a model form for the disclosure of fees and other compensation required in paragraph (6)(A)(iii) which meets the requirements of subparagraph (A).

(9) MAINTENANCE FOR 6 YEARS OF EVIDENCE OF COMPLIANCE.—The requirements of this paragraph are met if a fiduciary adviser who has provided advice referred to in paragraph (1) maintains, for a period of not less than 6 years after the provision of the advice, any records necessary for determining whether the requirements of the preceding provisions of this subsection and of subsection (b)(14) have been met. A transaction prohibited under section 406 shall not be considered to have occurred solely because the records are lost or destroyed prior to the end of the 6-year period due to circumstances beyond the control of the fiduciary adviser.

(10) EXEMPTION FOR PLAN SPONSOR AND CERTAIN OTHER FIDUCIARIES.—

(A) IN GENERAL.—Subject to subparagraph (B), a plan sponsor or other person who is a fiduciary (other than a fiduciary adviser) shall not be treated as failing to meet the requirements of this part solely by reason of the provision of investment advice referred to in section 3(21)(A)(ii) (or solely by reason of contracting for or otherwise arranging for the provision of the advice), if—

(i) the advice is provided by a fiduciary adviser pursuant to an eligible investment advice arrangement between the plan sponsor or other fiduciary and the fiduciary adviser for the provision by the fiduciary adviser of investment advice referred to in such section,

(ii) the terms of the eligible investment advice arrangement require compliance by the fiduciary adviser with the requirements of this subsection, and

(iii) the terms of the eligible investment advice arrangement include a written acknowledgment by the fiduciary adviser that the fiduciary adviser is a fiduciary.

ciary of the plan with respect to the provision of the advice.

(B) CONTINUED DUTY OF PRUDENT SELECTION OF ADVISER AND PERIODIC REVIEW.—Nothing in subparagraph (A) shall be construed to exempt a plan sponsor or other person who is a fiduciary from any requirement of this part for the prudent selection and periodic review of a fiduciary adviser with whom the plan sponsor or other person enters into an eligible investment advice arrangement for the provision of investment advice referred to in section 3(21)(A)(ii). The plan sponsor or other person who is a fiduciary has no duty under this part to monitor the specific investment advice given by the fiduciary adviser to any particular recipient of the advice.

(C) AVAILABILITY OF PLAN ASSETS FOR PAYMENT FOR ADVICE.—Nothing in this part shall be construed to preclude the use of plan assets to pay for reasonable expenses in providing investment advice referred to in section 3(21)(A)(ii).

(11) DEFINITIONS.—For purposes of this subsection and subsection (b)(14)—

(A) FIDUCIARY ADVISER.—The term “fiduciary adviser” means, with respect to a plan, a person who is a fiduciary of the plan by reason of the provision of investment advice referred to in section 3(21)(A)(ii) by the person to a participant or beneficiary of the plan and who is—

(i) registered as an investment adviser under the Investment Advisers Act of 1940 (15 U.S.C. 80b–1 et seq.) or under the laws of the State in which the fiduciary maintains its principal office and place of business,

(ii) a bank or similar financial institution referred to in subsection (b)(4) or a savings association (as defined in section 3(b)(1) of the Federal Deposit Insurance Act (12 U.S.C. 1813(b)(1))), but only if the advice is provided through a trust department of the bank or similar financial institution or savings association which is subject to periodic examination and review by Federal or State banking authorities,

(iii) an insurance company qualified to do business under the laws of a State,

(iv) a person registered as a broker or dealer under the Securities Exchange Act of 1934 (15 U.S.C. 78a et seq.),

(v) an affiliate of a person described in any of clauses (i) through (iv), or

(vi) an employee, agent, or registered representative of a person described in clauses (i) through (v) who satisfies the requirements of applicable insurance, banking, and securities laws relating to the provision of the advice.

For purposes of this part, a person who develops the computer model described in paragraph (3)(B) or markets the investment advice program or computer model shall be treated as a person who is a fiduciary of the plan by rea-

son of the provision of investment advice referred to in section 3(21)(A)(ii) to a participant or beneficiary and shall be treated as a fiduciary adviser for purposes of this subsection and subsection (b)(14), except that the Secretary may prescribe rules under which only 1 fiduciary adviser may elect to be treated as a fiduciary with respect to the plan.

(B) AFFILIATE.—The term “affiliate” of another entity means an affiliated person of the entity (as defined in section 2(a)(3) of the Investment Company Act of 1940 (15 U.S.C. 80a-2(a)(3))).

(C) REGISTERED REPRESENTATIVE.—The term “registered representative” of another entity means a person described in section 3(a)(18) of the Securities Exchange Act of 1934 (15 U.S.C. 78c(a)(18)) (substituting the entity for the broker or dealer referred to in such section) or a person described in section 202(a)(17) of the Investment Advisers Act of 1940 (15 U.S.C. 80b-2(a)(17)) (substituting the entity for the investment adviser referred to in such section).

(h) PROVISION OF PHARMACY BENEFIT SERVICES.—

(1) IN GENERAL.—Provided that all of the conditions described in paragraph (2) are met, the restrictions imposed by subsections (a), (b)(1), and (b)(2) of section 406 shall not apply to—

(A) the offering of pharmacy benefit services to a group health plan that is sponsored by an entity described in section 3(37)(G)(vi) or to any other group health plan that is sponsored by a regional council, local union, or other labor organization affiliated with such entity;

(B) the purchase of pharmacy benefit services by plan participants and beneficiaries of a group health plan that is sponsored by an entity described in section 3(37)(G)(vi) or of any other group health plan that is sponsored by a regional council, local union, or other labor organization affiliated with such entity; or

(C) the operation or implementation of pharmacy benefit services by an entity described in section 3(37)(G)(vi) or by any other group health plan that is sponsored by a regional council, local union, or other labor organization affiliated with such entity,

in any arrangement where such entity described in section 3(37)(G)(vi) or any related organization or subsidiary of such entity provides pharmacy benefit services that include prior authorization and appeals, a retail pharmacy network, pharmacy benefit administration, mail order fulfillment, formulary support, manufacturer payments, audits, and specialty pharmacy and goods, to any such group health plan.

(2) CONDITIONS.—The conditions described in this paragraph are the following:

(A) The terms of the arrangement are at least as favorable to the group health plan as such group health plan could obtain in a similar arm’s length arrangement with an unrelated third party.

(B) At least 50 percent of the providers participating in the pharmacy benefit services offered by the arrangement

are unrelated to the contributing employers or any other party in interest with respect to the group health plan.

(C) The group health plan retains an independent fiduciary who will be responsible for monitoring the group health plan's consultants, contractors, subcontractors, and other service providers for purposes of pharmacy benefit services described in paragraph (1) offered by such entity or any of its related organizations or subsidiaries and monitors the transactions of such entity and any of its related organizations or subsidiaries to ensure that all conditions of this exemption are satisfied during each plan year.

(D) Any decisions regarding the provision of pharmacy benefit services described in paragraph (1) are made by the group health plan's independent fiduciary, based on objective standards developed by the independent fiduciary in reliance on information provided by the arrangement.

(E) The independent fiduciary of the group health plan provides an annual report to the Secretary and the congressional committees of jurisdiction attesting that the conditions described in subparagraphs (C) and (D) have been met for the applicable plan year, together with a statement that use of the arrangement's services are in the best interest of the participants and beneficiaries in the aggregate for that plan year compared to other similar arrangements the group health plan could have obtained in transactions with an unrelated third party.

(F) The arrangement is not designed to benefit any party in interest with respect to the group health plan.

(3) VIOLATIONS.—In the event an entity described in section 3(37)(G)(vi) or any affiliate of such entity violates any of the conditions of such exemption, such exemption shall not apply with respect to such entity or affiliate and all enforcement and claims available under this Act shall apply with respect to such entity or affiliate.

(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to modify any obligation of a group health plan otherwise set forth in this Act.

(5) GROUP HEALTH PLAN.—In this subsection, the term “group health plan” has the meaning given such term in section 733(a).

* * * * *

PART 5—ADMINISTRATION AND ENFORCEMENT

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SEC. 522. INVESTIGATIVE AUTHORITY REGARDING VIOLATIONS OF CERTAIN HEALTH CARE PROVIDER REQUIREMENTS; COMPLAINT PROCESS.

(a) *INVESTIGATIVE AUTHORITY.*—Upon receiving a notice from a State or the Secretary of Health and Human Services of violations of sections 2799A–1, 2799A–2, or 2799A–4 of the Public Health Service Act, the Secretary of Labor shall have the power to conduct an investigation to identify patterns of such violations with respect to participants or beneficiaries under a group health plan or health insurance coverage offered in connection with a group health plan

by a health insurance issuer in the group market. The Secretary may assist States, the Secretary of Health and Human Services, plans, or issuers to ensure that appropriate measures have been taken to correct such violations retrospectively and prospectively with respect to participants or beneficiaries under a group health plan or health insurance coverage offered in connection with a group health plan by a health insurance issuer in the group market.

(b) **COMPLAINT PROCESS.**—Not later than January 1, 2022, the Secretary shall establish a process under which the Secretary—

(1) may receive complaints from participants and beneficiaries of group health plans or health insurance coverage offered in connection with such plans relating to alleged violations of the sections specified in subsection (a); and

(2) transmits such complaints to States or the Secretary of Health and Human Services (as determined appropriate by the Secretary) for potential enforcement actions.

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PART 7—GROUP HEALTH PLAN REQUIREMENTS

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SUBPART B—OTHER REQUIREMENTS

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SEC. 716. CONSUMER PROTECTIONS.

(a) **CHOICE OF HEALTH CARE PROFESSIONAL.**—If a group health plan or health insurance issuer offering group health insurance coverage requires or provides for designation by a participant or beneficiary of a participating primary care provider, then the plan or issuer shall permit each participant or beneficiary to designate any participating primary care provider who is available to accept such individual.

(b) **COVERAGE OF EMERGENCY SERVICES.**—

(1) **IN GENERAL.**—If a group health plan, or a health insurance issuer offering group health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)), the plan or issuer shall cover emergency services (as defined in paragraph (3)(C))—

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider or a participating emergency facility, as applicable, with respect to such services;

(C) in a manner so that, if such services are provided to a participant or beneficiary by a nonparticipating provider or a nonparticipating emergency facility—

(i) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating

providers and participating emergency facilities with respect to such plan or coverage, respectively;

(ii) the cost-sharing requirement (expressed as a co-payment amount or coinsurance rate) is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;

(iii) such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to the recognized amount (as defined in paragraph (3)(H)) for such services, plan or coverage, and year;

(iv) the group health plan or health insurance issuer, respectively, pays to such provider or facility, respectively, the amount by which the recognized amount for such services and year involved exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)) and year; and

(v) any cost-sharing payments made by the participant or beneficiary with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage, respectively (and such in-network deductible and out-of-pocket maximums shall be applied) in the same manner as if such cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility; and

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2704 of the Public Health Service Act, including as incorporated pursuant to section 715 of this Act and section 9815 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

(2) AUDIT PROCESS AND REGULATIONS FOR MEDIAN CONTRACTED RATES.—

(A) AUDIT PROCESS.—

(i) IN GENERAL.—Not later than July 1, 2021, the Secretary, in consultation with appropriate State agencies and the Secretary of Health and Human Services and the Secretary of the Treasury, shall establish through rulemaking a process, in accordance with clause (ii), under which group health plans and health insurance issuers offering health insurance coverage in the group market are audited by the Secretary or applicable State authority to ensure that—

(I) such plans and coverage are in compliance with the requirement of applying a median contracted rate under this section; and

(II) such median contracted rate so applied satisfies the definition under paragraph (3)(E) with respect to the year involved, including with respect

to a group health plan or health insurance issuer described in clause (ii) of such paragraph (3)(E).

(ii) AUDIT SAMPLES.—Under the process established pursuant to clause (i), the Secretary—

(I) shall conduct audits described in such clause, with respect to a year (beginning with 2022), of a sample with respect to such year of claims data from not more than 25 group health plans and health insurance issuers offering health insurance coverage in the group market; and

(II) may audit any group health plan or health insurance issuer offering health insurance coverage in the group market if the Secretary has received any complaint about such plan or coverage, respectively, that involves the compliance of the plan or coverage, respectively, with either of the requirements described in subclauses (I) and (II) of such clause.

(iii) REPORTS.—Beginning for 2022, the Secretary shall annually submit to Congress information on the number of plans and issuers with respect to which audits were conducted during such year pursuant to this subparagraph.

(B) RULEMAKING.—Not later than July 1, 2021, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Health and Human Services, shall establish through rulemaking—

(i) the methodology the group health plan or health insurance issuer offering health insurance coverage in the group market shall use to determine the median contracted rate, differentiating by line of business;

(ii) the information such plan or issuer, respectively, shall share with the nonparticipating provider or nonparticipating facility, as applicable, when making such a determination;

(iii) the geographic regions applied for purposes of this subparagraph, taking into account access to items and services in rural and underserved areas, including health professional shortage areas, as defined in section 332 of the Public Health Service Act; and

(iv) a process to receive complaints of violations of the requirements described in subclauses (I) and (II) of paragraph (2)(A)(i) by group health plans and health insurance issuers offering health insurance coverage in the group market.

Such rulemaking shall take into account payments that are made by such plan or issuer, respectively, that are not on a fee-for-service basis. Such methodology may account for relevant payment adjustments that take into account quality or facility type (including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities. In carrying out clause (iii), the Secretary shall consult with the National Association of Insurance Commissioners to establish the ge-

ographic regions under such clause and shall periodically update such regions, as appropriate.

(3) *DEFINITIONS.—In this section:*

(A) *EMERGENCY DEPARTMENT OF A HOSPITAL.—The term “emergency department of a hospital” includes a hospital outpatient department that provides emergency services.*

(B) *EMERGENCY MEDICAL CONDITION.—The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.*

(C) *EMERGENCY SERVICES.—*

(i) *IN GENERAL.—The term “emergency services”, with respect to an emergency medical condition, means—*

(I) a medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(II) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of such Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient.

(ii) *INCLUSION OF CERTAIN SERVICES OUTSIDE OF EMERGENCY DEPARTMENT.—*

(I) IN GENERAL.—For purposes of this subsection and section 2799A–1, in the case of an individual enrolled in a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market who is furnished services described in clause (i) by a participating or nonparticipating provider or a participating or nonparticipating emergency facility to stabilize such individual with respect to an emergency medical condition, the term “emergency services” shall include, unless each of the conditions described in subclause (II) are met, in addition to the items and services described in clause (i), items and services for which benefits are provided or covered under the plan or coverage, respectively, furnished by a nonparticipating provider or nonparticipating facility, regardless of the department of the hospital in which such individual is fur-

nished such items or services, if, after such stabilization but during such visit in which such individual is so stabilized, the provider or facility determines that such items or services are needed.

(II) *CONDITIONS.*—For purposes of subclause (I), the conditions described in this subclause, with respect to an individual who is stabilized and furnished additional items and services described in subclause (I) after such stabilization by a provider or facility described in subclause (I), are the following:

(aa) Such a provider or facility determines such individual is able to travel using non-medical transportation or nonemergency medical transportation.

(bb) Such provider furnishing such additional items and services satisfies the notice and consent criteria of section 2799A–2(d) of the Public Health Service Act with respect to such items and services.

(cc) Such an individual is in a condition to receive (as determined in accordance with guidance issued by the Secretary) the information described in section 2799A–2 of the Public Health Service Act and to provide informed consent under such section, in accordance with applicable State law.

(D) *INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT.*—The term “independent freestanding emergency department” means a facility that—

(i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

(ii) provides any emergency services (as defined in subparagraph (C)).

(E) *MEDIAN CONTRACTED RATE.*—

(i) *IN GENERAL.*—The term “median contracted rate” means, subject to clauses (ii) and (iii), with respect to a sponsor of a group health plan and health insurance issuer offering health insurance coverage in the group market—

(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan or issuer, respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same line of business as the plan or coverage) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by such plan or such issuer, respectively) under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in

which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2)(B), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

(II) for an item or service furnished during 2023 or a subsequent year, the median contracted rate determined under this clause for such an item or service furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(ii) NEW PLANS AND COVERAGE.—The term “median contracted rate” means, with respect to a sponsor of a group health plan or health insurance issuer offering health insurance coverage in the group market in a geographic region in which such sponsor or issuer, respectively, did not offer any group health plan or health insurance coverage during 2019—

(I) for the first year in which such group health plan or health insurance coverage, respectively, is offered in such region, a rate (determined in accordance with a methodology established by the Secretary) for items and services that are covered by such plan and furnished during such first year; and

(II) for each subsequent year such group health plan or health insurance coverage, respectively, is offered in such region, the median contracted rate determined under this clause for such items and services furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(iii) INSUFFICIENT INFORMATION; NEWLY COVERED ITEMS AND SERVICES.—In the case of a sponsor of a group health plan or health insurance issuer offering health insurance coverage in the group market that does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019 (or, in the case of a newly covered item or service (as defined in clause (iv)(III)), in the first coverage year (as defined in clause (iv)(I)) for such item or service with respect to such plan or coverage) for an item or service (including with respect to provider type, or amount, of claims for items or services (as determined by the Secretary) provided in a particular geographic region (other than in a case with respect to which clause (ii) applies)) the term “median contracted rate”—

(I) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or

service with respect to such plan or coverage), means such rate for such item or service determined by the sponsor or issuer, respectively, through use of any database that is determined, in accordance with rulemaking described in paragraph (2)(B), to not have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region (such as a State all-payer claims database);

(II) for an item or service furnished in a subsequent year (before the first sufficient information year (as defined in clause (iv)(II)) for such item or service with respect to such plan or coverage), means the rate determined under subclause (I) or this subclause, as applicable, for such item or service for the year previous to such subsequent year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

(III) for an item or service furnished in the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given the term median contracted rate in clause (i)(I), except that in applying such clause to such item or service, the reference to “furnished during 2022” shall be treated as a reference to furnished during such first sufficient information year, the reference to “in 2019” shall be treated as a reference to such sufficient information year, and the increase described in such clause shall not be applied; and

(IV) for an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given such term in clause (i)(II), except that in applying such clause to such item or service, the reference to “furnished during 2023 or a subsequent year” shall be treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

(iv) DEFINITIONS.—For purposes of this subparagraph:

(I) FIRST COVERAGE YEAR.—The term “first coverage year” means, with respect to a group health plan or health insurance coverage offered by a health insurance issuer in the group market and an item or service for which coverage is not offered in 2019 under such plan or coverage, the first year after 2019 for which coverage for such item or service is offered under such plan or health insurance coverage.

(II) *FIRST SUFFICIENT INFORMATION YEAR.*—The term “first sufficient information year” means, with respect to a group health plan or health insurance coverage offered by a health insurance issuer in the group market—

(aa) in the case of an item or service for which the plan or coverage does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019, the first year subsequent to 2022 for which such sponsor or issuer has such sufficient information to calculate the median of such contracted rates in the year previous to such first subsequent year; and

(bb) in the case of a newly covered item or service, the first year subsequent to the first coverage year for such item or service with respect to such plan or coverage for which the sponsor or issuer has sufficient information to calculate the median of the contracted rates described in clause (i)(I) in the year previous to such first subsequent year.

(III) *NEWLY COVERED ITEM OR SERVICE.*—The term “newly covered item or service” means, with respect to a group health plan or health insurance issuer offering health insurance coverage in the group market, an item or service for which coverage was not offered in 2019 under such plan or coverage, but is offered under such plan or coverage in a year after 2019.

(F) *NONPARTICIPATING EMERGENCY FACILITY; PARTICIPATING EMERGENCY FACILITY.*—

(i) *NONPARTICIPATING EMERGENCY FACILITY.*—The term “nonparticipating emergency facility” means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group market, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship directly or indirectly with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(ii) *PARTICIPATING EMERGENCY FACILITY.*—The term “participating emergency facility” means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group market, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship directly or indirectly with the plan or issuer, respectively, with respect to the furnishing of such an item or service at such facility.

(G) *NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.*—

(i) *NONPARTICIPATING PROVIDER.*—The term “non-participating provider” means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group market, a physician or other health care provider who is acting within the scope of practice of that provider’s license or certification under applicable State law and who does not have a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(ii) *PARTICIPATING PROVIDER.*—The term “participating provider” means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group market, a physician or other health care provider who is acting within the scope of practice of that provider’s license or certification under applicable State law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(H) *RECOGNIZED AMOUNT.*—The term “recognized amount” means, with respect to an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan or health insurance coverage offered by a health insurance issuer in the group market—

(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan, coverage, or issuer, respectively, such a nonparticipating provider or emergency facility, and such an item or service, the amount determined in accordance with such law;

(ii) subject to clause (iii), in the case of such item or service furnished in a State that does not have in effect a specified State law, with respect to such plan, coverage, or issuer, respectively, such a nonparticipating provider or emergency facility, and such an item or service, an amount that is the median contracted rate (as defined in subparagraph (E)) for such year and determined in accordance with rulemaking described in paragraph (2)(B)) for such item or service; or

(iii) in the case of such item or service furnished in a State with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the State approves under such system for such item or service so furnished.

(I) *SPECIFIED STATE LAW.*—The term “specified State law” means, with respect to a State, an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan or health insurance coverage offered by a health insurance issuer in the group market, a State law that provides for a method for determining the amount of payment that is required to be covered by such a plan, coverage, or issuer, respectively (to the

extent such State law applies to such plan, coverage, or issuer, subject to section 514) in the case of a participant or beneficiary covered under such plan or coverage and receiving such item or service from such a nonparticipating provider or emergency facility.

(J) *STABILIZE*.—The term “to stabilize”, with respect to an emergency medical condition (as defined in subparagraph (B)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(c) *ACCESS TO PEDIATRIC CARE*.—

(1) *PEDIATRIC CARE*.—In the case of a person who has a child who is a participant or beneficiary under a group health plan, or health insurance coverage offered by a health insurance issuer in the group market, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child’s primary care provider if such provider participates in the network of the plan or issuer.

(2) *CONSTRUCTION*.—Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

(d) *PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE*.—

(1) *GENERAL RIGHTS*.—

(A) *DIRECT ACCESS*.—A group health plan, or health insurance issuer offering group health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant or beneficiary who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan’s or issuer’s policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(B) *OBSTETRICAL AND GYNECOLOGICAL CARE*.—A group health plan or health insurance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(2) *APPLICATION OF PARAGRAPH*.—A group health plan, or health insurance issuer offering group health insurance coverage, described in this paragraph is a group health plan or coverage that—

(A) provides coverage for obstetric or gynecologic care; and

(B) requires the designation by a participant or beneficiary of a participating primary care provider.

(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to—

(A) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

(e) COVERAGE OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

(1) IN GENERAL.—In the case of items or services (other than emergency services to which subsection (b) applies) for which any benefits are provided or covered by a group health plan or health insurance issuer offering health insurance coverage in the group market furnished to a participant or beneficiary of such plan or coverage by a nonparticipating provider (as defined in subsection (b)(3)(G)(i)) (and who, with respect to such items and services, has not satisfied the notice and consent criteria of section 2799A–2(d) of the Public Health Service Act) with respect to a visit (as defined by the Secretary in accordance with paragraph (2)(B)) at a participating health care facility (as defined in paragraph (2)(A)), with respect to such plan or coverage, respectively, the plan or coverage, respectively—

(A) shall not impose on such participant or beneficiary a cost-sharing amount (expressed as a copayment amount or coinsurance rate) for such items and services so furnished that is greater than the cost-sharing amount that would apply under such plan or coverage, respectively, had such items or services been furnished by a participating provider (as defined in subsection (b)(3)(G)(ii));

(B) shall calculate such cost-sharing amount as if the total amount that would have been charged for such items and services by such participating provider were equal to the recognized amount (as defined in subsection (b)(3)(H)) for such items and services, plan or coverage, and year;

(C) shall pay to such provider furnishing such items and services to such participant or beneficiary the amount by which the recognized amount (as defined in subsection (b)(3)(H)) for such items and services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such items and services (as determined in accordance with subparagraphs (A) and (B)); and

(D) shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the plan or coverage, respectively, any cost-sharing payments made by the participant or beneficiary (and such in-network deductible and out-of-pocket maximums shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

(2) *DEFINITIONS.—In this section:*(A) *PARTICIPATING HEALTH CARE FACILITY.—*

(i) *IN GENERAL.—*The term “participating health care facility” means, with respect to an item or service and a group health plan or health insurance issuer offering health insurance coverage in the group market, a health care facility described in clause (ii) that has a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such an item or service at the facility.

(ii) *HEALTH CARE FACILITY DESCRIBED.—*A health care facility described in this clause, with respect to a group health plan or health insurance coverage offered in the group market, is each of the following:

(I) A hospital (as defined in 1861(e) of the Social Security Act).

(II) A hospital outpatient department.

(III) A critical access hospital (as defined in section 1861(mm) of such Act).

(IV) An ambulatory surgical center (as defined in section 1833(i)(1)(A) of such Act).

(V) Any other facility that provides items or services for which coverage is provided under the plan or coverage, respectively.

(B) *VISIT.—*The term “visit” shall, with respect to items and services furnished to an individual at a participating health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility.

(f) *AIR AMBULANCE SERVICES.—*

(1) *IN GENERAL.—*In the case of a participant or beneficiary in a group health plan or health insurance coverage offered in the group market who receives air ambulance services from a nonparticipating provider (as defined in subsection (b)(3)(G)) with respect to such plan or coverage, if such services would be covered if provided by a participating provider (as defined in such subsection) with respect to such plan or coverage—

(A) the cost-sharing requirement (expressed as a copayment amount, coinsurance rate, or deductible) with respect to such services shall be the same requirement that would apply if such services were provided by such a participating provider, and any coinsurance or deductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

(B) such cost-sharing amounts shall be counted toward the in-network deductible and in-network out-of-pocket maximum amount under the plan or coverage for the plan year (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider; and

(C) the plan or coverage shall pay to such provider furnishing such services to such participant or beneficiary the amount by which the recognized amount (as defined in and determined pursuant to subsection (b)(3)(H)(ii)) for such services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such services (as determined in accordance with subparagraphs (A) and (B)).

(2) AIR AMBULANCE SERVICE DEFINED.—For purposes of this section, the term “air ambulance service” means medical transport by helicopter or airplane for patients.

(g) CERTAIN ACCESS FEES TO CERTAIN DATABASES.—In the case of a sponsor of a group health plan or health insurance issuer offering health insurance coverage in the group market that, pursuant to subsection (b)(3)(E)(iii), uses a database described in such subsection to determine a rate to apply under such subsection for an item or service by reason of having insufficient information described in such subsection with respect to such item or service, such sponsor or issuer shall cover the cost for access to such database.

(h) DISCLOSURE OF CERTAIN PROTECTIONS AGAINST BALANCE BILLING.—Each group health plan and health insurance issuer offering group health insurance coverage shall make publicly available, and (if applicable) post on a public website of such plan or issuer—

(1) information in plain language on—

(A) the requirements and prohibitions applied under sections 2799A–1, 2799A–2 and 2799A–4 of the Public Health Service Act (relating to prohibitions on balance billing in certain circumstances);

(B) if provided for under applicable State law, any other requirements on providers and facilities regarding the amounts such providers and facilities may, with respect to an item or service, charge a participant, beneficiary, or enrollee of such plan or coverage with respect to which such a provider or facility does not have a contractual relationship for furnishing such item or service under the plan or coverage after receiving payment from the plan or coverage for such item or service and any applicable cost-sharing payment from such participant, beneficiary, or enrollee; and

(C) the requirements applied under subsections (b), (e), and (f); and

(2) information on contacting appropriate State and Federal agencies in the case that an individual believes that such a provider or facility has violated any requirement described in paragraph (1) with respect to such individual.

(i) STANDARDIZED REPORTING FORMAT.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this subsection, the Secretary shall establish a standardized reporting format for the reporting, by group health plans (or health insurance coverage offered in connection with such a plan) to State All Payer Claims Databases, of medical claims, pharmacy claims, dental claims, and eligibility and provider files that are collected from private and public payers, and shall provide guidance to States on the process by which

States may collect such data from such plans or coverage in the standardized reporting format.

(2) DEFINITION.—In this subsection, the term “State All Payer Claims Database” means, with respect to a State, a database that may include medical claims, pharmacy claims, dental claims, and eligibility and provider files, which are collected from private and public payers.

(j) TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS.—

(1) IN GENERAL.—A group health plan or a health insurance issuer offering group health insurance coverage and providing or covering any benefit with respect to items or services shall include, in clear writing, on any plan or insurance identification card issued to participants or beneficiaries in the plan or coverage the amount of the in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket maximum limitation that apply to such plan or coverage.

(2) GUIDANCE.—The Secretary, in consultation with the Secretary of Health and Human Services and Secretary of the Treasury, shall issue guidance to implement paragraph (1).

SEC. 717. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

(a) NETWORK STATUS OF PROVIDERS.—

(1) IN GENERAL.—Beginning on the date that is one year after the date of enactment of this section, a group health plan (or health insurance coverage offered in connection with such a plan) shall—

(A) establish business processes to ensure that all participants and beneficiaries in such plan or coverage receive proof of a health care provider’s network status, based on what a plan or issuer of such coverage knows or should know—

(i) upon a telephone inquiry by a participant or beneficiary—

(I) through a written electronic communication from the plan or issuer to the participant or beneficiary, as soon as practicable and not later than 1 business day after such inquiry is made by such participant or beneficiary for such information;

(II) through an oral communication from the plan or issuer to the participant or beneficiary, as soon as practicable and not later than 1 business day after such inquiry is made by such participant or beneficiary for such information, which communication shall be documented by such plan or issuer, and such documentation shall be kept in the participant’s or beneficiary’s file for a minimum of 5 years; and

(ii) in real-time through an online health care provider directory search tool maintained by the plan or issuer; and

(B) include in any print directory—

(i) a disclosure that the information included in the directory is accurate as of the date of the last data update and that participants or beneficiaries or prospec-

tive participants or beneficiaries should consult the group health plan's or issuer's electronic provider directory on its website or call a specified customer service telephone number to obtain the most current provider directory information; and

(ii) a list of the categories of providers of ancillary services for which the plan or coverage has no in-network providers.

(2) **GROUP HEALTH PLAN AND HEALTH INSURANCE ISSUER BUSINESS PROCESSES.**—Beginning on the date that is one year after the date of enactment of this section, a group health plan (or health insurance coverage offered in connection with such a plan) shall establish business processes to—

(A) verify and update, at least once every 90 days, the provider directory information for all providers included in the online health care provider directory search tool described in paragraph (1)(A)(ii); and

(B) remove any provider from such online directory search tool if such provider has not verified the directory information within the previous 6 months or the plan or issuer has been unable to verify the provider's network participation.

(b) **COST-SHARING LIMITATIONS.**—A group health plan (or health insurance coverage offered in connection with such a plan) shall not apply, and shall ensure that no provider applies, cost-sharing to a participant or beneficiary for treatment or services provided by a health care provider in excess of the normal cost-sharing applied for such treatment or services provided in-network (including any balance bill issued by the health care provider involved), if such participant or beneficiary, or health care provider referring such participant or beneficiary, demonstrates (based on the electronic, written information described in subsection (a)(1)(A)(i)(I), the oral confirmation described in subsection (a)(1)(A)(i)(II) received by the participant or beneficiary not more than 30 days before the date the treatment or services were received, or a copy of the online provider directory described in subsection (a)(1)(A)(ii) on a date not more than 30 days before the date the treatment or services were received), that the participant or beneficiary relied on the information described in subsection (a)(1) for which such participant or beneficiary provides such documentation, that indicated that the provider is an in-network provider, if the provider was out-of-network at the time the treatment or service involved was received.

(c) **DEFINITION.**—For purposes of this section, the term “provider directory information” includes the names, addresses, specialty, and telephone numbers of individual health care providers, and the names, addresses, and telephone numbers of each medical group, clinic, or facility contracted to participate in any of the networks of the group health plan or health insurance coverage involved.

SEC. 718. PROVISION OF COST-SHARING INFORMATION.

A group health plan (or health insurance coverage offered in connection with such a plan) shall provide a participant or beneficiary in the plan or coverage with a good faith estimate of the participant's or beneficiary's cost-sharing (including deductibles, copayments, and coinsurance) for which the participant or beneficiary may be responsible for paying with respect to a specific health care

service (including any service that is reasonably expected to be provided in conjunction with such specific service), as soon as practicable and not later than 2 business days after a request for such information by a participant or beneficiary. For purposes of the previous sentence, the Secretary shall develop and make available in multiple languages (as specified by the Secretary) a model form that is in easily understandable language and format.

SEC. 719. CONTINUITY OF CARE.

(a) ENSURING CONTINUITY OF CARE WITH RESPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER NETWORK STATUS.—

(1) IN GENERAL.—In the case of an individual with benefits under a group health plan or health insurance coverage offered by a health insurance issuer in connection with a group health plan and with respect to a health care provider or facility that has a contractual relationship with such plan or such issuer (as applicable) for furnishing items and services under such plan or such coverage, if, while such individual is a continuing care patient (as defined in subsection (b)) with respect to such provider or facility—

(A) such contractual relationship is terminated (as defined in paragraph (b));

(B) benefits provided under such plan or such health insurance coverage with respect to such provider or facility are terminated because of a change in the terms of the participation of the provider or facility in such plan or coverage; or

(C) a contract between such group health plan and a health insurance issuer offering health insurance coverage in connection with such plan is terminated, resulting in a loss of benefits provided under such plan with respect to such provider or facility;

the plan or issuer, respectively, shall meet the requirements of paragraph (2) with respect to such individual.

(2) REQUIREMENTS.—The requirements of this paragraph are that the plan or issuer—

(A) notify each individual enrolled under such plan or coverage who is a continuing care patient with respect to a provider or facility at the time of a termination described in paragraph (1) affecting such provider or facility on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility under this section;

(B) provide such individual with an opportunity to notify the plan or issuer of the individual's need for transitional care; and

(C) permit the patient to elect to continue to have benefits provided under such plan or such coverage, under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan or coverage had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a continuing care patient during the period beginning on

the date on which the notice under subparagraph (A) is provided and ending on the earlier of—

(i) the 90-day period beginning on such date; or

(ii) the date on which such individual is no longer a continuing care patient with respect to such provider or facility.

(b) DEFINITIONS.—In this section:

(1) CONTINUING CARE PATIENT.—The term “continuing care patient” means an individual who, with respect to a provider or facility—

(A) is undergoing a course of treatment for a serious and complex condition from the provider or facility;

(B) is undergoing a course of institutional or inpatient care from the provider or facility;

(C) is scheduled to undergo nonelective surgery from the provider or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery;

(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

(2) SERIOUS AND COMPLEX CONDITION.—The term “serious and complex condition” means, with respect to a participant, beneficiary, or enrollee under a group health plan or health insurance coverage—

(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(B) in the case of a chronic illness or condition, a condition that—

(i) is life-threatening, degenerative, potentially disabling, or congenital; and

(ii) requires specialized medical care over a prolonged period of time.

(3) TERMINATED.—The term “terminated” includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

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INTERNAL REVENUE CODE OF 1986

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Subtitle K—Group Health Plan Requirements

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CHAPTER 100—GROUP HEALTH PLAN REQUIREMENTS

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Subchapter B—OTHER REQUIREMENTS

Sec. 9811. Standards relating to benefits for mothers and newborns.

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Sec. 9815. Additional market reforms.

Sec. 9816. Consumer protections.

Sec. 9817. Protecting patients and improving the accuracy of provider directory information.

Sec. 9818. Provision of cost-sharing information.

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SEC. 9816. CONSUMER PROTECTIONS.

(a) *CHOICE OF HEALTH CARE PROFESSIONAL.*—If a group health plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, then the plan shall permit each participant or beneficiary to designate any participating primary care provider who is available to accept such individual.

(b) *COVERAGE OF EMERGENCY SERVICES.*—

(1) *IN GENERAL.*—If a group health plan provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)), the plan shall cover emergency services (as defined in paragraph (3)(C))—

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider or a participating emergency facility, as applicable, with respect to such services;

(C) in a manner so that, if such services are provided to a participant or beneficiary by a nonparticipating provider or a nonparticipating emergency facility—

(i) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities with respect to such plan;

(ii) the cost-sharing requirement (expressed as a co-payment amount or coinsurance rate) is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;

(iii) such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to the recognized amount (as defined in paragraph (3)(H)) for such services, plan, and year;

(iv) the group health plan pays to such provider or facility, respectively, the amount by which the recognized amount for such services and year involved exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)) and year; and

(v) any cost-sharing payments made by the participant or beneficiary with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan (and such in-network deductible and out-of-pocket maximums shall be applied) in the same manner as if such cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility; and

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2704 of this Act, including as incorporated pursuant to section 715 of the Employee Retirement Income Security Act of 1974 and section 9815 of this Act, and other than applicable cost-sharing).

(2) AUDIT PROCESS AND REGULATIONS FOR MEDIAN CONTRACTED RATES.—

(A) AUDIT PROCESS.—

(i) IN GENERAL.—Not later than July 1, 2021, the Secretary, in consultation with appropriate State agencies and the Secretary of Health and Human Services and the Secretary of Labor, shall establish through rulemaking a process, in accordance with clause (ii), under which group health plans are audited by the Secretary or applicable State authority to ensure that—

(I) such plans are in compliance with the requirement of applying a median contracted rate under this section; and

(II) such median contracted rate so applied satisfies the definition under paragraph (3)(E) with respect to the year involved, including with respect to a group health plan described in clause (ii) of such paragraph (3)(E).

(ii) AUDIT SAMPLES.—Under the process established pursuant to clause (i), the Secretary—

(I) shall conduct audits described in such clause, with respect to a year (beginning with 2022), of a sample with respect to such year of claims data from not more than 25 group health plans; and

(II) may audit any group health plan if the Secretary has received any complaint about such plan or coverage, respectively, that involves the compliance of the plan with either of the requirements described in subclauses (I) and (II) of such clause.

(iii) REPORTS.—Beginning for 2022, the Secretary shall annually submit to Congress a report on the number of plans and issuers with respect to which au-

dots were conducted during such year pursuant to this subparagraph.

(B) RULEMAKING.—Not later than July 1, 2021, the Secretary, in consultation with the Secretary of Labor and the Secretary of Health and Human Services, shall establish through rulemaking—

(i) the methodology the group health plan shall use to determine the median contracted rate, differentiating by line of business;

(ii) the information such plan or issuer, respectively, shall share with the nonparticipating provider or nonparticipating facility, as applicable, when making such a determination;

(iii) the geographic regions applied for purposes of this subparagraph, taking into account access to items and services in rural and underserved areas, including health professional shortage areas, as defined in section 332 of the Public Health Service Act; and

(iv) a process to receive complaints of violations of the requirements described in subclauses (I) and (II) of paragraph (2)(A)(i) by group health plans.

Such rulemaking shall take into account payments that are made by such plan that are not on a fee-for-service basis. Such methodology may account for relevant payment adjustments that take into account quality or facility type (including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities. In carrying out clause (iii), the Secretary shall consult with the National Association of Insurance Commissioners to establish the geographic regions under such clause and shall periodically update such regions, as appropriate.

(3) DEFINITIONS.—In this section:

(A) EMERGENCY DEPARTMENT OF A HOSPITAL.—The term “emergency department of a hospital” includes a hospital outpatient department that provides emergency services.

(B) EMERGENCY MEDICAL CONDITION.—The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(C) EMERGENCY SERVICES.—

(i) IN GENERAL.—The term “emergency services”, with respect to an emergency medical condition, means—

(I) a medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department,

as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(II) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of such Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient.

(ii) INCLUSION OF CERTAIN SERVICES OUTSIDE OF EMERGENCY DEPARTMENT.—

(I) IN GENERAL.—For purposes of this subsection and section 2799A–1, in the case of an individual enrolled in a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market who is furnished services described in clause (i) by a participating or nonparticipating provider or a participating or nonparticipating emergency facility to stabilize such individual with respect to an emergency medical condition, the term “emergency services” shall include, unless each of the conditions described in subclause (II) are met, in addition to the items and services described in clause (i), items and services for which benefits are provided or covered under the plan or coverage, respectively, furnished by a nonparticipating provider or nonparticipating facility, regardless of the department of the hospital in which such individual is furnished such items or services, if, after such stabilization but during such visit in which such individual is so stabilized, the provider or facility determines that such items or services are needed.

(II) CONDITIONS.—For purposes of subclause (I), the conditions described in this subclause, with respect to an individual who is stabilized and furnished additional items and services described in subclause (I) after such stabilization by a provider or facility described in subclause (I), are the following:

(aa) Such a provider or facility determines such individual is able to travel using non-medical transportation or nonemergency medical transportation.

(bb) Such provider furnishing such additional items and services satisfies the notice and consent criteria of section 2799A–2(d) of the Public Health Service Act with respect to such items and services.

(cc) Such an individual is in a condition to receive (as determined in accordance with guidance issued by the Secretary) the information described in section 2799A–2 of the Public

Health Service Act and to provide informed consent under such section, in accordance with applicable State law.

(D) *INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT.*—*The term “independent freestanding emergency department” means a facility that—*

(i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

(ii) provides any emergency services (as defined in subparagraph (C)).

(E) *MEDIAN CONTRACTED RATE.*—

(i) IN GENERAL.—*The term “median contracted rate” means, subject to clauses (ii) and (iii), with respect to a sponsor of a group health plan—*

(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan (determined with respect to all such plans of such sponsor that are offered within the same line of business as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan) under such plans on January 31, 2019 for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2)(B), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

(II) for an item or service furnished during 2023 or a subsequent year, the median contracted rate determined under this clause for such an item or service furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(ii) NEW PLANS AND COVERAGE.—*The term “median contracted rate” means, with respect to a sponsor of a group health plan in a geographic region in which such sponsor, respectively, did not offer any group health plan or health insurance coverage during 2019—*

(I) for the first year in which such group health plan is offered in such region, a rate (determined in accordance with a methodology established by the Secretary) for items and services that are covered by such plan and furnished during such first year; and

(II) for each subsequent year such group health plan is offered in such region, the median contracted rate determined under this clause for such

items and services furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(iii) *INSUFFICIENT INFORMATION; NEWLY COVERED ITEMS AND SERVICES.—In the case of a sponsor of a group health plan that does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019 (or, in the case of a newly covered item or service (as defined in clause (iv)(III)), in the first coverage year (as defined in clause (iv)(I)) for such item or service with respect to such plan) for an item or service (including with respect to provider type, or amount, of claims for items or services (as determined by the Secretary) provided in a particular geographic region (other than in a case with respect to which clause (ii) applies)) the term “median contracted rate”—*

(I) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or service with respect to such plan), means such rate for such item or service determined by the sponsor through use of any database that is determined, in accordance with rulemaking described in paragraph (2)(B), to not have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region (such as a State all-payer claims database);

(II) for an item or service furnished in a subsequent year (before the first sufficient information year (as defined in clause (iv)(II)) for such item or service with respect to such plan), means the rate determined under subclause (I) or this subclause, as applicable, for such item or service for the year previous to such subsequent year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

(III) for an item or service furnished in the first sufficient information year for such item or service with respect to such plan, has the meaning given the term median contracted rate in clause (i)(I), except that in applying such clause to such item or service, the reference to “furnished during 2022” shall be treated as a reference to furnished during such first sufficient information year, the reference to “on January 31, 2019” shall be treated as a reference to in such sufficient information year, and the increase described in such clause shall not be applied; and

(IV) for an item or service furnished in any year subsequent to the first sufficient information year

for such item or service with respect to such plan, has the meaning given such term in clause (i)(II), except that in applying such clause to such item or service, the reference to “furnished during 2023 or a subsequent year” shall be treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

(iv) *DEFINITIONS.*—For purposes of this subparagraph:

(I) *FIRST COVERAGE YEAR.*—The term “first coverage year” means, with respect to a group health plan and an item or service for which coverage is not offered in 2019 under such plan or coverage, the first year after 2019 for which coverage for such item or service is offered under such plan.

(II) *FIRST SUFFICIENT INFORMATION YEAR.*—The term “first sufficient information year” means, with respect to a group health plan—

(aa) in the case of an item or service for which the plan does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019, the first year subsequent to 2022 for which such sponsor has such sufficient information to calculate the median of such contracted rates in the year previous to such first subsequent year; and

(bb) in the case of a newly covered item or service, the first year subsequent to the first coverage year for such item or service with respect to such plan for which the sponsor has sufficient information to calculate the median of the contracted rates described in clause (i)(I) in the year previous to such first subsequent year.

(III) *NEWLY COVERED ITEM OR SERVICE.*—The term “newly covered item or service” means, with respect to a group health plan, an item or service for which coverage was not offered in 2019 under such plan or coverage, but is offered under such plan or coverage in a year after 2019.

(F) *NONPARTICIPATING EMERGENCY FACILITY; PARTICIPATING EMERGENCY FACILITY.*—

(i) *NONPARTICIPATING EMERGENCY FACILITY.*—The term “nonparticipating emergency facility” means, with respect to an item or service and a group health plan, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship directly or indirectly with the plan for furnishing such item or service under the plan.

(ii) *PARTICIPATING EMERGENCY FACILITY.*—The term “participating emergency facility” means, with respect to an item or service and a group health plan, an emergency department of a hospital, or an independent free-

standing emergency department, that has a contractual relationship directly or indirectly with the plan, with respect to the furnishing of such an item or service at such facility.

(G) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

(i) NONPARTICIPATING PROVIDER.—The term “non-participating provider” means, with respect to an item or service and a group health plan, a physician or other health care provider who is acting within the scope of practice of that provider’s license or certification under applicable State law and who does not have a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan.

(ii) PARTICIPATING PROVIDER.—The term “participating provider” means, with respect to an item or service and a group health plan, a physician or other health care provider who is acting within the scope of practice of that provider’s license or certification under applicable State law and who has a contractual relationship with the plan for furnishing such item or service under the plan.

(H) RECOGNIZED AMOUNT.—*The term “recognized amount” means, with respect to an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan—*

(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan; such a nonparticipating provider or emergency facility; and such an item or service, the amount determined in accordance with such law;

(ii) subject to clause (iii), in the case of such item or service furnished in a State that does not have in effect a specified State law, with respect to such plan; such a nonparticipating provider or emergency facility; and such an item or service, an amount that is the median contracted rate (as defined in subparagraph (E)) for such year and determined in accordance with rule-making described in paragraph (2)(B)) for such item or service; or

(iii) in the case of such item or service furnished in a State with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the State approves under such system for such item or service so furnished.

(I) SPECIFIED STATE LAW.—*The term “specified State law” means, with respect to a State, an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan, a State law that provides for a method for determining the amount of payment that is required to be covered by such a plan (to the extent such State law applies to such plan, subject to section 514 of the Employee Retirement Income Security Act of 1974) in the*

case of a participant or beneficiary covered under such plan and receiving such item or service from such a nonparticipating provider or emergency facility.

(J) STABILIZE.—The term “to stabilize”, with respect to an emergency medical condition (as defined in subparagraph (B)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(c) ACCESS TO PEDIATRIC CARE.—

(1) PEDIATRIC CARE.—In the case of a person who has a child who is a participant or beneficiary under a group health plan, if the plan requires or provides for the designation of a participating primary care provider for the child, the plan shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child’s primary care provider if such provider participates in the network of the plan or issuer.

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan with respect to coverage of pediatric care.

(d) PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.—

(1) GENERAL RIGHTS.—

(A) DIRECT ACCESS.—A group health plan described in paragraph (2) may not require authorization or referral by the plan or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant or beneficiary who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan’s policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan.

(B) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(2) APPLICATION OF PARAGRAPH.—A group health plan described in this paragraph is a group health plan that—

(A) provides coverage for obstetric or gynecologic care; and

(B) requires the designation by a participant or beneficiary of a participating primary care provider.

(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to—

(A) waive any exclusions of coverage under the terms and conditions of the plan with respect to coverage of obstetrical or gynecological care; or

(B) preclude the group health plan involved from requiring that the obstetrical or gynecological provider notify the

primary care health care professional or the plan of treatment decisions.

(e) COVERAGE OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

(1) IN GENERAL.—In the case of items or services (other than emergency services to which subsection (b) applies) for which any benefits are provided or covered by a group health plan furnished to a participant or beneficiary of such plan by a non-participating provider (as defined in subsection (b)(3)(G)(i)) (and who, with respect to such items and services, has not satisfied the notice and consent criteria of section 2799A–2(d) of the Public Health Service Act) with respect to a visit (as defined by the Secretary in accordance with paragraph (2)(B)) at a participating health care facility (as defined in paragraph (2)(A)), with respect to such plan, the plan—

(A) shall not impose on such participant or beneficiary a cost-sharing amount (expressed as a copayment amount or coinsurance rate) for such items and services so furnished that is greater than the cost-sharing amount that would apply under such plan had such items or services been furnished by a participating provider (as defined in subsection (b)(3)(G)(ii));

(B) shall calculate such cost-sharing amount as if the total amount that would have been charged for such items and services by such participating provider were equal to the recognized amount (as defined in subsection (b)(3)(H)) for such items and services, plan, and year;

(C) shall pay to such provider furnishing such items and services to such participant or beneficiary the amount by which the recognized amount (as defined in subsection (b)(3)(H)) for such items and services and year involved exceeds the cost-sharing amount imposed under the plan for such items and services (as determined in accordance with subparagraphs (A) and (B)); and

(D) shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the plan, any cost-sharing payments made by the participant or beneficiary (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

(2) DEFINITIONS.—In this section:

(A) PARTICIPATING HEALTH CARE FACILITY.—

(i) IN GENERAL.—The term “participating health care facility” means, with respect to an item or service and a group health plan, a health care facility described in clause (ii) that has a contractual relationship with the plan, with respect to the furnishing of such an item or service at the facility.

(ii) HEALTH CARE FACILITY DESCRIBED.—A health care facility described in this clause, with respect to a group health plan, is each of the following:

(I) A hospital (as defined in 1861(e) of the Social Security Act).

(II) A hospital outpatient department.

(III) A critical access hospital (as defined in section 1861(mm) of such Act).

(IV) An ambulatory surgical center (as defined in section 1833(i)(1)(A) of such Act).

(V) Any other facility that provides items or services for which coverage is provided under the plan or coverage, respectively.

(B) VISIT.—The term “visit” shall, with respect to items and services furnished to an individual at a participating health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility.

(f) AIR AMBULANCE SERVICES.—

(1) IN GENERAL.—In the case of a participant or beneficiary in a group health plan who receives air ambulance services from a nonparticipating provider (as defined in subsection (b)(3)(G)) with respect to such plan or coverage, if such services would be covered if provided by a participating provider (as defined in such subsection) with respect to such plan—

(A) the cost-sharing requirement (expressed as a copayment amount, coinsurance rate, or deductible) with respect to such services shall be the same requirement that would apply if such services were provided by such a participating provider, and any coinsurance or deductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

(B) such cost-sharing amounts shall be counted toward the in-network deductible and in-network out-of-pocket maximum amount under the plan for the plan year (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider; and

(C) the plan or coverage shall pay to such provider furnishing such services to such participant or beneficiary the amount by which the recognized amount (as defined in and determined pursuant to subsection (b)(3)(H)(ii)) for such services and year involved exceeds the cost-sharing amount imposed under the plan for such services (as determined in accordance with subparagraphs (A) and (B)).

(2) AIR AMBULANCE SERVICE DEFINED.—For purposes of this section, the term “air ambulance service” means medical transport by helicopter or airplane for patients.

(g) CERTAIN ACCESS FEES TO CERTAIN DATABASES.—In the case of a sponsor of a group health plan that, pursuant to subsection (b)(3)(E)(iii), uses a database described in such subsection to determine a rate to apply under such subsection for an item or service by reason of having insufficient information described in such subsection with respect to such item or service, such sponsor shall cover the cost for access to such database.

(h) TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS.—

(1) IN GENERAL.—A group health plan providing or covering any benefit with respect to items or services shall include, in clear writing, on any plan or insurance identification card issued to participants or beneficiaries in the plan the amount of the in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket maximum limitation that apply to such plan.

(2) GUIDANCE.—The Secretary, in consultation with the Secretary of Health and Human Services and Secretary of Labor, shall issue guidance to implement paragraph (1).

SEC. 9817. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

(a) NETWORK STATUS OF PROVIDERS.—

(1) IN GENERAL.—Beginning on the date that is one year after the date of enactment of this section, a group health plan shall—

(A) establish business processes to ensure that all participants or beneficiaries in such plan receive proof of a health care provider's network status, based on what a plan or issuer knows or should know—

(i) upon a telephone inquiry by a participant or beneficiary—

(I) through a written electronic communication from the plan to the participant or beneficiary, as soon as practicable and not later than 1 business day after such inquiry is made by such participant or beneficiary for such information;

(II) through an oral communication from the plan to the participant or beneficiary, as soon as practicable and not later than 1 business day after such inquiry is made by such participant or beneficiary for such information, which communication shall be documented by such plan, and such documentation shall be kept in the participant's or beneficiary's file for a minimum of 2 years; and

(ii) in real-time through an online health care provider directory search tool maintained by the plan; and

(B) include in any print directory—

(i) a disclosure that the information included in the directory is accurate as of the date of the last data update and that participants or beneficiaries or prospective participants or beneficiaries should consult the group health plan's electronic provider directory on its website or call a specified customer service telephone number to obtain the most current provider directory information; and

(ii) a list of the categories of providers of ancillary services for which the plan or coverage has no in-network providers.

(2) GROUP HEALTH PLAN BUSINESS PROCESSES.—Beginning on the date that is one year after the date of enactment of this section, a group health plan shall establish business processes to—

(A) verify and update, at least once every 90 days, the provider directory information for all providers included in the online health care provider directory search tool described in paragraph (1)(A)(ii); and

(B) remove any provider from such online directory search tool if such provider has not verified the directory information within the previous 6 months or the plan or issuer has been unable to verify the provider's network participation.

(b) **COST-SHARING LIMITATIONS.**—A group health plan shall not apply, and shall ensure that no provider applies, cost-sharing to a participant or beneficiary for treatment or services provided by a health care provider in excess of the normal cost-sharing applied for such treatment or services provided in-network (including any balance bill issued by the health care provider involved), if such participant or beneficiary, or health care provider referring such participant or beneficiary, demonstrates (based on the electronic, written information described in subsection (a)(1)(A)(i)(I), the oral confirmation described in subsection (a)(1)(A)(i)(II) received by the participant or beneficiary not more than 30 days before the date the treatment or services were received, or a copy of the online provider directory described in subsection (a)(1)(A)(ii) on a date not more than 30 days before the date the treatment or services were received), that the participant or beneficiary relied on the information described in subsection (a)(1) for which such participant or beneficiary provides such documentation, that indicated that the provider is an in-network provider, if the provider was out-of-network at the time the treatment or service involved was received.

(c) **DEFINITION.**—For purposes of this section, the term “provider directory information” includes the names, addresses, specialty, and telephone numbers of individual health care providers, and the names, addresses, and telephone numbers of each medical group, clinic, or facility contracted to participate in any of the networks of the group health plan involved.

(d) **RULE OF CONSTRUCTION.**—Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories.

SEC. 9818. PROVISION OF COST-SHARING INFORMATION.

A group health plan shall provide a participant or beneficiary in the plan with a good faith estimate of the participant's or beneficiary's cost-sharing (including deductibles, copayments, and coinsurance) for which the participant or beneficiary may be responsible for paying with respect to a specific health care service (including any service that is reasonably expected to be provided in conjunction with such specific service), as soon as practicable and not later than 2 business days after a request for such information by a participant or beneficiary.

* * * * *

TITLE 5, UNITED STATES CODE

* * * * *

PART III—EMPLOYEES

* * * * *

SUBPART G—INSURANCE AND ANNUITIES

* * * * *

CHAPTER 89—HEALTH INSURANCE

* * * * *

§ 8902. Contracting authority

(a) The Office of Personnel Management may contract with qualified carriers offering plans described by section 8903 or 8903a of this title, without regard to section 6101(b) to (d) of title 41 or other statute requiring competitive bidding. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

(b) To be eligible as a carrier for the plan described by section 8903(2) of this title, a company must be licensed to issue group health insurance in all the States and the District of Columbia.

(c) A contract for a plan described by section 8903(1) or (2) of this title shall require the carrier—

(1) to reinsure with other companies which elect to participate, under an equitable formula based on the total amount of their group health insurance benefit payments in the United States during the latest year for which the information is available, to be determined by the carrier and approved by the Office; or

(2) to allocate its rights and obligations under the contract among its affiliates which elect to participate, under an equitable formula to be determined by the carrier and the affiliates and approved by the Office.

(d) Each contract under this chapter shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

(e) The Office may prescribe reasonable minimum standards for health benefits plans described by section 8903 or 8903a of this title and for carriers offering the plans. Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 and chapter 7 of this title. The Office may terminate the contract of a carrier effective at the end of the contract term, if the Office finds that at no time during the preceding two contract terms did the carrier have 300 or more employees and annuitants, exclusive of family members, enrolled in the plan.

(f) A contract may not be made or a plan approved which excludes an individual because of race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

(g) A contract may not be made or a plan approved which does not offer to each employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a

of this title whose enrollment in the plan is ended, except by a cancellation of enrollment, a temporary extension of coverage during which he may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title who exercises this option shall pay the full periodic charges of the nongroup contract.

(h) The benefits and coverage made available under subsection (g) of this section are noncancelable by the carrier except for fraud, over-insurance, or nonpayment of periodic charges.

(i) Rates charged under health benefits plans described by section 8903 or 8903a of this title shall reasonably and equitably reflect the cost of the benefits provided. Rates under health benefits plans described by section 8903(1) and (2) of this title shall be determined on a basis which, in the judgment of the Office, is consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers. The rates determined for the first contract term shall be continued for later contract terms, except that they may be readjusted for any later term, based on past experience and benefit adjustments under the later contract. Any readjustment in rates shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Office, is consistent with the general practice of carriers which issue group health benefit plans to large employers.

(j) Each contract under this chapter shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Office finds that the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title is entitled thereto under the terms of the contract.

(k)(1) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/clinical specialist, licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11), an employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist, qualified clinical social worker, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/nurse clinical specialist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.

(3) The provisions of this subsection shall not apply to comprehensive medical plans as described in section 8903(4) of this title.

(1) The Office shall contract under this chapter for a plan described in section 8903(4) of this title with any qualified health maintenance carrier which offers such a plan. For the purpose of this subsection, “qualified health maintenance carrier” means any qualified carrier which is a qualified health maintenance organization within the meaning of section 1310(d)(1) of title XIII of the Public Health Service Act (42 U.S.C. 300c–9(d)).

(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

(2)(A) Notwithstanding the provisions of paragraph (1) of this subsection, if a contract under this chapter provides for the provision of, the payment for, or the reimbursement of the cost of health services for the care and treatment of any particular health condition, the carrier shall provide, pay, or reimburse up to the limits of its contract for any such health service properly provided by any person licensed under State law to provide such service if such service is provided to an individual covered by such contract in a State where 25 percent or more of the population is located in primary medical care manpower shortage areas designated pursuant to section 332 of the Public Health Service Act (42 U.S.C. 254e).

(B) The provisions of subparagraph (A) shall not apply to contracts entered into providing prepayment plans described in section 8903(4) of this title.

(n) A contract for a plan described by section 8903(1), (2), or (3), or section 8903a, shall require the carrier—

(1) to implement hospitalization-cost-containment measures, such as measures—

(A) for verifying the medical necessity of any proposed treatment or surgery;

(B) for determining the feasibility or appropriateness of providing services on an outpatient rather than on an inpatient basis;

(C) for determining the appropriate length of stay (through concurrent review or otherwise) in cases involving inpatient care; and

(D) involving case management, if the circumstances so warrant; and

(2) to establish incentives to encourage compliance with measures under paragraph (1).

(o) A contract may not be made or a plan approved which includes coverage for any benefit, item, or service for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

(p) *Each contract under this chapter shall require the carrier to comply with requirements described in the provisions of section 2719A of the Public Health Service Act and sections 2730 and 2731 of such Act, sections 716, 717, and 718 of the Employee Retirement Income Security Act of 1974, sections 9816, 9817, and 9818 of the Internal Revenue Code of 1986 (as applicable), and section 2(d) of*

the Ban Surprise Billing Act in the same manner as such provisions apply to a group health plan or health insurance issuer offering health insurance coverage, as described in such sections. The provisions of sections 2799A–1, 2799A–2, 2799A–3, and 2799A–4 of the Public Health Service Act shall apply to a health care provider and facility and an air ambulance provider described in such respective sections with respect to a participant, beneficiary, or enrollee in a health benefits plan under this chapter in the same manner as such provisions apply to such a provider and facility with respect to an enrollee in a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, as described in such sections.

* * * * *

PATIENT PROTECTION AND AFFORDABLE CARE ACT

* * * * *

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

* * * * *

Subtitle C—Quality Health Insurance Coverage for All Americans

* * * * *

PART 2—OTHER PROVISIONS

SEC. 1251. PRESERVATION OF RIGHT TO MAINTAIN EXISTING COV- ERAGE.

(a) NO CHANGES TO EXISTING COVERAGE.—

(1) IN GENERAL.—Nothing in this Act (or an amendment made by this Act) shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on the date of enactment of this Act.

(2) CONTINUATION OF COVERAGE.—Except as provided in paragraph (3), with respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act, this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply to such plan or coverage, regardless of whether the individual renews such coverage after such date of enactment.

(3) APPLICATION OF CERTAIN PROVISIONS.—The provisions of sections 2715 and 2718 of the Public Health Service Act (as added by subtitle A) shall apply to grandfathered health plans for plan years beginning on or after the date of enactment of this Act.

(4) APPLICATION OF CERTAIN PROVISIONS.—

(A) IN GENERAL.—The following provisions of the Public Health Service Act (as added by this title) shall apply to grandfathered health plans for plan years beginning with the first plan year to which such provisions would otherwise apply:

(i) Section 2708 (relating to excessive waiting periods).

(ii) Those provisions of section 2711 relating to lifetime limits.

(iii) Section 2712 (relating to rescissions).

(iv) Section 2714 (relating to extension of dependent coverage).

(B) PROVISIONS APPLICABLE ONLY TO GROUP HEALTH PLANS.—

(i) PROVISIONS DESCRIBED.—Those provisions of section 2711 relating to annual limits and the provisions of section 2704 (relating to pre-existing condition exclusions) of the Public Health Service Act (as added by this subtitle) shall apply to grandfathered health plans that are group health plans for plan years beginning with the first plan year to which such provisions otherwise apply.

(ii) ADULT CHILD COVERAGE.—For plan years beginning before January 1, 2014, the provisions of section 2714 of the Public Health Service Act (as added by this subtitle) shall apply in the case of an adult child with respect to a grandfathered health plan that is a group health plan only if such adult child is not eligible to enroll in an eligible employer-sponsored health plan (as defined in section 5000A(f)(2) of the Internal Revenue Code of 1986) other than such grandfathered health plan.

(5) APPLICATION OF ADDITIONAL PROVISIONS.—*Subsections (b), (e), (f), (g), and (h) of section 2719A of the Public Health Service Act shall apply to grandfathered health plans for plan years beginning on or after January 1, 2022.*

(b) ALLOWANCE FOR FAMILY MEMBERS TO JOIN CURRENT COVERAGE.—With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act and which is renewed after such date, family members of such individual shall be permitted to enroll in such plan or coverage if such enrollment is permitted under the terms of the plan in effect as of such date of enactment.

(c) ALLOWANCE FOR NEW EMPLOYEES TO JOIN CURRENT PLAN.—A group health plan that provides coverage on the date of enactment of this Act may provide for the enrolling of new employees (and their families) in such plan, and this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply with respect to such plan and such new employees (and their families).

(d) EFFECT ON COLLECTIVE BARGAINING AGREEMENTS.—In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before the date of enactment of this Act, the provisions of this subtitle and subtitle A (and the amendments made by such subtitles) shall not

apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage which amends the coverage solely to conform to any requirement added by this subtitle or subtitle A (or amendments) shall not be treated as a termination of such collective bargaining agreement.

(e) DEFINITION.—In this title, the term “grandfathered health plan” means any group health plan or health insurance coverage to which this section applies.

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**EXAMINING SURPRISE BILLING:
PROTECTING PATIENTS FROM
FINANCIAL PAIN**

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR,
AND PENSIONS

COMMITTEE ON EDUCATION
AND LABOR

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, APRIL 2, 2019

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EXAMINING SURPRISE BILLING: PROTECTING PATIENTS FROM FINANCIAL PAIN

Tuesday, April 2, 2019

House of Representatives

Committee on Education and Labor

Subcommittee on Health, Employment, Labor, and Pensions

Washington, DC.

The subcommittee met, pursuant to notice, at 10:15 a.m., in room 2175, Rayburn House Office Building. Hon. Frederica S. Wilson [chairwoman of the committee] presiding.

Present: Representatives Wilson, Norcross, Morelle, Wild, McBath, Underwood, Stevens, Courtney, Shalala, Levin, Trahan, Walberg, Roe, Allen, Banks, Taylor, Watkins, Wright, Meuser, and Johnson.

Also present: Representatives Scott and Foxx.

Staff present: Nekea Brown, Deputy Clerk; Ilana Brunner, General Counsel Health and Labor; Emma Eatman, Press Aide; Daniel Foster, Health and Labor Counsel; Mishawn Freeman, Staff Assistant; Christian Haines, General Counsel Education; Stephanie Lalle, Deputy Communications Director; Andre Lindsay, Staff Assistant; Kota Mitzutani, Staff Writer; Max Moore, Office Aide; Merrick Nelson, Digital Manager; Veronique Pluviose, Staff Director; Banyon Vassar, Deputy Director of Information Technology; Marty Boughton, Minority Press Secretary; Courtney Butcher, Minority Coalitions and Members Services Coordinator; Rob Green, Minority Director of Workforce Policy; Sarah Martin, Minority Professional Staff Member; Hannah Matesic, Minority Director of Operations; Kelley McNabb, Minority Communications Director; Alexis Murray, Minority Professional Staff Member; Brandon Renz, Minority Staff Director; Ben Ridder, Minority Legislative Assistant; Meredith Schellin, Minority Deputy Press Secretary and Digital Advisor; and Heather Wadyka, Minority Staff Assistant.

Chairwoman WILSON. The Subcommittee on Health, Employment and Labor and Pensions will come to order. Welcome, everyone.

I note that a quorum is present so I ask unanimous consent that Ms. Schrier of Washington and Mrs. Davis of California be permitted to participate in today's hearing with the understanding that their questions will come only after all members of the Subcommittee on Health, Employment, Labor and Pension on both

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sides of the aisle who are present have had an opportunity to question the witnesses. Without objection. So ordered.

The subcommittee is meeting today in a hearing to receive testimony on “Examining Surprise Billing: Protecting Patients from Financial Pain.”

Pursuant to committee rule 7(c), opening statements are limited to the chair and the ranking member. This allows us to hear from our witnesses sooner and provides all members with adequate time to ask questions.

I recognize myself now for the purpose of making an opening statement. We are here this morning to examine surprise medical billing, a serious issue that can disrupt if not devastate the lives of individuals and families.

This is the first hearing the U.S. Congress has held on surprise billing, and I am proud that our subcommittee is taking the lead on this important issue. It is my hope that this will be the first of many productive, bipartisan conversations.

Surprise medical bills occur when patients covered by health insurance are subject to higher than expected out-of-pocket costs for care received from a provider who is outside of their plan’s network. The victims of surprise medical billing often have no control over whether their medical provider is in-or out-of-network.

With one infamous case, a young San Francisco woman named Nina Dang suffered a severe bike accident. She was barely lucid when a bystander called an ambulance and took her to an emergency room at a nearby hospital. Before she knew it, doctors had done X-rays and scans and put her broken arm in a splint, and then sent her on her way.

A few months later, Nina was hit with a \$20,000 medical bill because the hospital, which she did not choose, was an out-of-network facility.

But even patients who are able to take precautions to avoid out-of-network costs during a medical emergency are not immune from surprise bills.

Scott Kohan suffered a violent attack one night in Austin, Texas. He woke up in an emergency room with a broken jaw, a throbbing headache, and staples in his head. Despite his shock and immense pain, Scott took out his phone and searched through his insurer’s website to make sure he was laying in an in-network hospital bed. When he found out it was, he proceeded with a necessary jaw surgery.

Imagine Scott’s frustration and devastation when he received a surprise medical bill for nearly \$8,000. It turned out that the emergency room was in his insurance network, but the oral surgeon who worked in the ER was not.

These stories have been documented in detail by Vox reporter Sarah Kliff. These are not isolated incidents. According to a survey, 50 percent—57 percent of consumers report they have received an unexpected medical bill that they thought would be covered by their insurance.

A separate survey found that 7 in 10 patients who have received unaffordable out-of-network medical bills were unaware that their provider was out-of-network at the time they received the services.

This issue requires bold action to protect patients from the financial pain of surprise medical bills.

States have taken steps forward by enacting innovative, bipartisan billing laws. New York, New Hampshire, Connecticut, New Jersey, Maryland, Illinois, Oregon, California, and my home State of Florida have all adopted strong reforms that protect consumers.

Importantly, all of these solutions either hold patients harmless against charges or prohibit the practice of billing—of balance billing, where a patient is sent a bill for the difference between what insurance will pay and what the provider charges.

We have also seen many States pioneering new ways to resolve billing disputes between providers and insurers in ways that, most importantly, take consumers out-of-the middle. These State-level solutions are promising, and witnesses today will be able to provide this subcommittee with details on how such efforts are working in States where they may be falling short.

However, only Congress can fully close the gaps and loopholes that leave patients vulnerable to severe financial distress. Most Americans live in States that have not passed major reforms regarding surprise bills. And even in States that have enacted reforms, they are unable to regulate self-insured plans, which cover more than 60 percent of individuals in employer-sponsored coverage.

Health care has not recently been an area of bipartisan consensus. Unfortunately, that has only been re-affirmed by the administration's actions last week to not defend in court the Affordable Care Act and its protections for people with pre-existing conditions.

But I am hopeful that this is an opportunity for us to work together on behalf of our constituents. Surely, we can all agree that a patient should not have to spend the last few minutes before emergency surgery researching whether everyone in the operating room is in-network. And Dr. Roe came over to me this morning and said I am so glad that you are having this hearing.

I am grateful to the witnesses for their time and testimony here today and I look forward to working with my colleagues and with stakeholders as we develop a solution to the challenge of surprise medical billing.

Now I want to recognize Ranking Member Walberg for the purpose of an opening statement. The esteemed Representative Walberg.

[The statement of Chairwoman Wilson follows:]

**Prepared Statement of Hon. Frederica S. Wilson, Chairwoman,
Subcommittee on Health, Employment, Labor, and Pensions**

We are here this morning to examine surprise medical billing a serious issue that can disrupt, if not devastate, the lives of individuals and families.

This is the first hearing the U.S. Congress has held on surprise billing, and I am proud that our subcommittee is taking the lead on this important issue. It is my hope that this will be the first of many productive, bipartisan conversations.

Surprise medical bills occur when patients covered by health insurance are subject to higher than expected out-of-pocket costs for care received from a provider who is outside their plan's network.

The victims of surprise medical billing often have no control over whether their medical provider is in-or out-of-network.

In one infamous case, a young San Francisco woman named Nina Dang suffered a severe bike accident. She was barely lucid when a bystander called her an ambulance that took her to an emergency room at a nearby hospital.

Before she knew it, doctors had done X-rays and scans and put her broken arm in a splint, and then sent her on her way. A few months later, Nina was hit with a \$20,000 medical bill because the hospital which she did not choose was an out-of-network facility.

But even patients who are able to take precautions to avoid out-of-network costs during a medical emergency are not immune from surprise bills.

Scott Kohan suffered a violent attack one night in Austin, Texas. He woke up in an emergency room with a broken jaw, a throbbing headache, and staples in his head. Despite his shock and immense pain, Scott took out his phone and searched through his insurer's website to make sure he was laying in an in-network hospital bed.

When he found out it was, he proceeded with a necessary jaw surgery.

Imagine Scott's frustration when he received a surprise medical bill for nearly \$8,000. It turned out the emergency room was in his insurance network, but the oral surgeon who worked in that ER was not.

These stories, which have been documented in detail by Vox reporter Sarah Kliff, are not isolated incidents.

According to a recent survey, 57 percent of consumers report they have received an unexpected medical bill that they thought would be covered by their insurance. A separate survey found that seven in 10 patients who have received unaffordable out-of-network medical bills were unaware that their provider was out-of-network at the time they received the services.

This issue requires bold action to protect patients from the financial pain of surprise medical bills.

States have taken steps forward by enacting innovative, bipartisan surprise billing laws. New York, New Hampshire, Connecticut, New Jersey, Maryland, Illinois, Oregon, California, and my home State of Florida have all adopted strong reforms that protect consumers.

Importantly, all of these solutions either hold patients harmless against charges or prohibit the practice of balance billing, where a patient is sent a bill for the difference between what insurance will pay and what the provider charges.

We have also seen many States pioneering new ways to resolve billing disputes between providers and insurers in ways that, most importantly, take consumers out of the middle.

These State-level solutions are promising, and witnesses today will be able to provide this subcommittee with details on how such efforts are working in States, or where they may be falling short.

However, only Congress can fully close the gaps and loopholes that leave patients vulnerable to severe financial distress.

Most Americans live in States that have not passed major reforms regarding surprise bills. And even in States that have enacted reforms, they are unable to regulate self-insured plans, which cover more than 60 percent of individuals in employer-sponsored coverage.

Health care has not recently been an area of bipartisan consensus. Unfortunately, that has only been re-affirmed by the administration's actions last week to not defend in court the Affordable Care Act and its protections for people with pre-existing conditions.

But I am hopeful that this is an opportunity for us to work together on behalf of our constituents.

Surely, we can all agree that a patient should not have to spend the last few minutes before emergency surgery researching whether everyone in the operating room is in-network.

I am grateful to the witnesses for their time and testimony here today, and I look forward to working with my colleagues and with stakeholders as we develop a solution to the challenge of surprise medical billing.

Mr. WALBERG. I could get used to that, Madame Chairperson. Thank you. And thank you for this hearing. I think along with Dr. Roe and the rest of my Subcommittee members, and I think we concur that this is an issue we ought to be dealing with.

And we shouldn't delay in considering options even as we stand on this side of the aisle also very strongly supportive of taking care of preexisting conditions as well. This certainly falls into that area.

The high and rising cost of health care is a significant worry for families, workers, and employers across the country. Concerns about high premiums, high deductibles, and drug prices are known and well documented. But the issue of surprise billing has rapidly risen to the forefront of people's worries when it comes to health care.

Surprise billing, sometimes called balance billing happens when a patient visits an—out-of-network care facility or even when they are at an—in-network care facility but are seen by a doctor who is not in their network.

The story of surprise billings may go something like this. A worker who is having trouble breathing visits an emergency room at a hospital in his or her health insurance network. While there, they receive an x-ray of their chest and is seen by a doctor who is, who prescribes medicine to ease the strain on the lungs.

Following the visit, he or she gets a bill—a high bill for the trip to the emergency room. Even though the hospital was technically in in-network, the doctor who saw him was not, leaving him to pay for the cost of treatment.

This understandably causes frustration for individuals who thought they did everything correct. It can also cause a high degree of uncertainty and stress for workers and families as they try to find the money to pay for the health care service they believed would be handled by their insurance. According to a 2018 poll from the Kaiser Family Foundation, surprise medical bills are the leading health care concern for Americans surpassing concerns about high premium, high deductibles, and rising drug costs.

39 percent of insured working age adults reported they had received a surprise medical bill in the past year from a doctor, hospital, or lab that they thought was covered by their insurance. Of the 39 percent of individuals who received surprise medical bills, 50 percent owed more than \$500.

The fear of an unexpected medical bill can be paralyzing and we don't want Americans foregoing care they need for fear that they will end up responsible for medical expenses that they can't afford.

We need solutions that equip patients with the information they need to confidently seek treatment without the worry they will faced a huge surprise bill. About 60 percent of workers or 110 million individuals are insured through employer-sponsored health care plans under the Employee Retirement Income Security Act, ERISA.

Employer provided coverage is important to workers around the country. Employers can custom design a health care plan best suited to their workers needs which helps them retain their work force and also an important recruiting tool.

I just had a conversation with an employer this morning, a major employer in Detroit, who as a result of opportunities now has looked for additional benefits that they can supply for their employees.

A 2018 study from AHIP found that over 70 percent of workers are satisfied with their employer sponsored coverage.

22 States have laws addressing surprise billing. However, under ERISA, self-insured employer-sponsored plans are only subject to Federal rules and protections and State rules and regulations on health insurance do not apply.

Promoting public policy solutions that allow employers to continue offering high quality health coverage is good for employers and employees alike. That's why we are here today, to listen and learn from a variety of stakeholders about different proposals to address this serious issue.

With this in mind, we recognize that any potential Federal policy solution to end the practice of surprise billing must preserve important ERISA protections and ensure that self-insured plans remain subject to Federal law alone.

Committee Republicans are committed to pursuing policies that lower costs, expand choice, and end surprise billing for insured individuals. Workers and families deserve certainty about their health care coverage and I look forward to discussing how we can provide a better way forward for the American people. Thank you and I yield back.

[The statement of Mr. Walberg to follows:]

Prepared Statement of Hon. Tim Walberg, Ranking Member, Subcommittee on Health, Employment, Labor, and Pensions

Thank you for yielding.

The high and rising cost of health care is a significant worry for families, workers, and employers across the country. Concerns about high premiums, high deductibles, and drug prices are known and well-documented, but the issue of surprise billing has rapidly risen to the forefront of peoples' worries when it comes to health care.

Surprise billing, sometimes called balance billing, happens when a patient visits an out-of-network care facility, or even when they are at an in-network facility but are seen by a doctor who is not in their network. The story of surprise billing may go something like this: A worker who's having trouble breathing visits an emergency room at a hospital in his health insurance network. While there, he receives an X-ray of his chest and is seen by a doctor who prescribes medicine to ease the strain on his lungs. Following the visit, he gets a bill a high bill for the trip to the emergency room. Even though the hospital was technically in-network, the doctor who saw him was not, leaving him to pay for the cost of the treatment.

This understandably causes frustration for individuals who thought they did everything correct. It can also cause a high degree of uncertainty and stress for workers and families as they try to find the money to pay for the health care service they believed would be handled by their insurance.

According to a 2018 poll from the Kaiser Family Foundation, surprise medical bills are the leading health care concern for Americans, surpassing concerns about high premiums, high deductibles, and rising drug costs. Thirty-nine percent of insured working-age adults reported they had received a surprise medical bill in the past year from a doctor, hospital, or lab that they thought was covered by their insurance. Of the 39 percent of individuals who received surprise medical bills, 50 percent owed more than \$500.

The fear of an unexpected medical bill can be paralyzing, and we don't want Americans forgoing care they need for fear that they'll end up responsible for a medical expense they can't afford. We need solutions that equip patients with the information they need to confidently seek treatment without the worry they'll face a huge surprise bill.

About 60 percent of workers, or 110 million individuals, are insured through employer-sponsored health care plans under the Employee Retirement Income Security Act (ERISA). Employer-provided coverage is important to workers around the country. Employers can custom design a health care plan best-suited to their workers' needs, which helps them retain their work force and is also an important recruiting tool. A 2018 study from AHIP found that over 70 percent of workers are satisfied with their employer-sponsored coverage.

Twenty-two States have laws addressing surprise billing; however, under ERISA, self-insured employer-sponsored plans are only subject to Federal rules and protections, and State rules and regulations on health insurance do not apply.

Promoting public policy solutions that allow employers to continue offering high-quality health coverage is good for employers and employees alike. That's why we're here today to listen and learn from a variety of stakeholders about different proposals to address this serious issue. With this in mind, we recognize that any potential Federal policy solutions to end the practice of surprise billing must preserve important ERISA protections and ensure that self-insured plans remain subject to Federal law alone.

Committee Republicans are committed to pursuing policies that lower costs, expand choice, and end surprise billing for insured individuals. Workers and families deserve certainty about their health care coverage, and I look forward to discussing how we can provide a better way forward for the American people.

Chairwoman WILSON. Without objection all other members who wish to insert written statements into the record may do so by submitting them to the committee electronically in Microsoft Word format by 5 o'clock p.m. on April 16, 2019. I will now introduce our witnesses.

Christen Linke Young is a fellow at USC-Brookings Schaeffer Initiative for Health Policy. Welcome.

Ilyse Schuman is a Senior Vice President for Health Policy at the American Benefits Council. Welcome.

Frederick Isasi is the Executive Director of Families USA, a leading voice of health care consumers. Thank you.

Dr. Jack Hoadley is a Research Professor Emeritus at the McCourt School of Public Policy at Georgetown University. Welcome.

We appreciate all of the witnesses for being here today and look forward to your testimony. Let me remind the witnesses that we have read your written statements and they will appear in full in the hearing record.

Pursuant to committee rule 7(d) and committee practice, each of you is asked to limit your oral presentation to 5 minutes as a summary of your written statement.

Let me also remind the witnesses that pursuant to Title 18 of the U.S. Code Section 1001 it is illegal to knowingly and willfully falsify any statement representation, writing, document or material fact presented to Congress or otherwise conceal or cover up a material fact.

Before you begin your testimony, please remember to press the button on the microphone in front of you so that it will turn on and the members can hear you. As you begin to speak, the light in front of you will turn green. After 4 minutes the light will turn yellow to signal that you have 1 minute remaining. When the light turns red, your 5 minutes have expired and we ask that you wrap it up.

We will let the entire panel make their presentations before we move to member questions. When answering a question please remember to once again turn your microphone on. I will first recognize Ms. Young.

**STATEMENT OF CHRISTEN LINKE YOUNG, J.D., FELLOW, USC—
BROOKINGS SCHAEFFER INITIATIVE ON HEALTH POLICY,
THE BROOKINGS INSTITUTION**

Ms. YOUNG. Thank you. Chairwoman Wilson, Ranking Member Walberg, members of the subcommittee, thank you for the opportunity to testify today. I am Christen Linke Young, a Fellow with the USC-Brookings Schaeffer Initiative for Health Policy. My testimony today is based on research conducted with a number of talented coauthors and reflects my personal views.

Surprise out-of-network bills arise when a consumer receives care from an out-of-network provider in situations that they cannot reasonably control. One common example is an out-of-network anesthesiologist at an in-network hospital. But these bills can arise for many services. Emergency department, pathology, and even neonatology.

Situations like these, where a patient is treated by an out-of-network provider that she did not choose are common. Studies suggest that about 20 percent of emergency department visits and 10 percent of elective inpatient care stays involve at least one out-of-network provider, and about half of ambulance rides are out-of-network.

The bills patients receive under these circumstances can be quite large. The existence of surprise bills and their large sizes reflect a market failure. For most types of physicians joining insurance company networks is standard because many patients are not willing to bear higher out-of-network costs. But for types of physicians that patients do not choose, this logic doesn't apply.

Emergency physicians and anesthesiologists receive a flow of patients based on individuals electing care at the hospital in which they practice. And that volume will be the same regardless of whether the physician is in-or out-of-network. Because volume does not depend on prices set by providers in these no choice specialties, going out-of-network frees them to bill patients at essentially any rate they choose. And, as would be expected, we see that physician specialties that are able to bill out-of-network have extraordinarily high charges compared to other doctors.

For example, for most physician types, median out-of-network charges are about double what Medicare pays for the same service. But for anesthesiologists and emergency medicine physicians, charges are about five times greater than the equivalent Medicare payment.

To be sure, many of these providers do still choose to join insurance networks. That may be because they find it distasteful to bill patients directly or they prefer the ease of collecting from insurers. But when they do go in-network, they appear to receive some of the highest in-network rates in the health care industry.

Whereas the in-network payment rate across many similar specialties averages about 125 percent of the Medicare rate for the service, the available data suggests that the average in-network rate for anesthesiologists and emergency medicine physicians is roughly three times the Medicare rate.

One way to understand these very high in-network rates is that these physician types exploit the fact that they could remain out-of-network to demand very high payment rates when they do go in-

network. Payment rates more than double what their peer physicians who cannot stay out-of-network receive.

And the impact is felt broadly by consumers of health care. Sometimes, out-of-network care generates an eye-popping surprise bill that ends up in the news. But in many other cases, the insurer agrees to pay the very high charge, and this, along with high in-network rates, drives up health care premiums for all of us.

Policymakers who want to solve this problem need to correct the market failure and create an environment where these providers face a more typical set of incentives. There are two basic ways to approach this solution.

The first is to establish an amount that these physicians will be paid when they deliver care out-of-network. Policymakers should establish the out-of-network price for the service, either directly or through arbitration, prohibit balance billing by the provider above this amount, and require that the insurer treat it as in-network.

The goal is not to establish the exactly correct payment rate for the service, but rather to establish conditions that diminish the attractiveness of the out-of-network option and lead these providers to go in-network or work with hospitals to get paid a fair rate for the service.

While there are a number of methods that can be used to establish the out-of-network price, it is critical that it not be set at a rate that is too high, either higher than now or that locks in the current distorted market, since that would drive up costs and frustrate the basic goal of restoring a market for these services.

The second approach is to get these providers out of the business of billing directly to patients or issuers at all. Instead, they would be paid by the hospital or the facility in which they practice.

Hospitals would negotiate with insurers for a rate that includes the services and hospitals would pay the anesthesiologists or other facility-based providers. An alternative version would require that facility-based providers establish contracts with all insurers that are in-network for the facility.

Before I close, I want to briefly highlight the work States are already doing. Many States have taken steps to correct the market failure by pursuing a diverse array of policies. But States are somewhat limited in their ability to act comprehensively by the threat of ERISA preemption and they face challenging border State issues. Thank you. I look forward to your questions.

[The statement of Ms. Young follows:]



**Testimony of Christen Linke Young, J.D.
Fellow, USC-Brookings Schaeffer Initiative on Health Policy**

U.S. House of Representatives
Committee on Education & Labor
Subcommittee on Health, Employment, Labor, and Pensions
Hearing on "Examining Surprise Billing: Protecting Patients from Financial Pain"

April 2, 2019

Chairwoman Wilson, Ranking Member Walberg, members of the subcommittee, thank you for the opportunity to testify today. I am Christen Linke Young, a Fellow with the USC-Brookings Schaeffer Initiative for Health Policy. My research focuses on private insurance, access to coverage, and the intersection between state and federal policy making. I am honored to have the opportunity to speak with you today about surprise out-of-network billing.

A group of scholars affiliated with the USC-Brookings Schaeffer Initiative for Health Policy – Loren Adler, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Erin L. Duffy, and me – recently published an analysis of out-of-network billing and associated policy solutions.¹ The material that follows is lightly adapted from that publication, which reflects the work of this diverse and thoughtful group of coauthors. Further, this testimony reflects my personal views and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

Executive Summary

Surprise out-of-network bills arise when a consumer receives care from an out-of-network provider in situations they cannot reasonably control. One common example is when a patient sees out-of-network anesthesiologist for a procedure at an in-network hospital, but these sorts of bills can arise with respect to many types of services – emergency department, radiology, pathology, and even neonatology and hospitalist care.

Situations like these – where a patient is receiving care from an out-of-network provider that she did not choose – are fairly common. Studies suggest that about 20 percent of emergency department visits and 10 percent of elective inpatient care stays involve at least one out-of-network provider, and about half of ground ambulance rides are out-of-network. The bills patients receive under these circumstances can be quite large.

The existence of these surprise out-of-network bills and their large sizes reflect a market failure. For most types of physicians in most geographic areas, joining insurance company networks is standard because many patients are not willing to bear higher out-of-network costs. But for

¹ Adler, Loren, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, Erin L. Duffy. 2019. "State Approaches to Mitigating Surprise Out-of-Network Billing." *USC-Brookings Schaeffer Initiative on Health Policy*. <https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing/>

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types of physicians that patients do not choose, this logic does not apply. Emergency physicians, anesthesiologists, and other ancillary physicians receive a flow of patients based on individuals receiving care at the hospital in which they practice, and that volume will be largely the same regardless of whether they join an insurance company network.

Because volume does not depend on the prices set by providers in these kinds of specialties, going out-of-network frees them to bill patients at essentially any rate they choose. And, as would be expected, we see that physician specialties that are able to bill out-of-network have high charges compared to other doctors. For example, for most physician types, median charges are about double what Medicare pays for the same service. But for anesthesiologists and emergency medicine physicians, charges are about five times greater than the equivalent Medicare payment.

To be sure, many of these providers do still choose to join insurance company networks. That may be because they find it distasteful to bill patients directly or because they prefer the ease of collecting from insurers rather than patients. But when they do go in network, they appear to receive some of the highest in-network payment rates in the health care industry. Whereas the in-network payment rate across many similar specialties averages around 125 percent of the Medicare rate for the service, the available data suggest that the average in-network rate for anesthesiologists is roughly 350 percent the Medicare rate. For emergency medicine physicians it is roughly 300 percent the Medicare rate.

One way to understand these very high in-network rates is that these physician types exploit the fact that they could remain out-of-network to demand very high payment rates when they do go in-network – payment rates more than double what their peer physicians who cannot realistically plan to stay out-of-network receive.

Further, the impact is felt broadly by consumers of health care. Sometimes, an out-of-network care episode generates an eye-popping surprise balance bill that ends up in the news, but in many other cases, the insurer agrees to pay the very high charge, and this, along with high in-network rates, drives up premiums for everyone.

Policymakers who want to solve this problem need to correct the market failure and create an environment where these providers face a more typical set of incentives. There are two basic ways to approach the solution.

The first is to establish an amount that these physicians will be paid when they deliver care out-of-network. Policymakers should establish the out-of-network price for the relevant service, either directly or through arbitration; prohibit balance billing above this amount; and require the insurer treat this amount as in-network. The goal is not to establish the exactly "correct" commercial payment rate, but rather to establish conditions that diminish the attractiveness of the out-of-network option and lead these providers to go in-network or work with hospitals to get paid a normal rate. While there are a number of methodologies that can be used to establish this out-of-network price, it is critical that it not be set at a rate that is "too high" (either higher

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than now or that locks in the current distorted rate), since that would drive up costs and frustrate the basic goal of restoring a market for these services.

The second approach is to get these types of providers out of the business of billing directly to patients or insurers, at all. Instead, they would be paid by the hospital or other facility in which they practice. Hospitals would negotiate with insurance companies for a rate that includes the services, and the hospitals would pay the anesthesiologists and other-facility based providers. An alternative version would require that facility-based providers establish contracts with all insurers that are in-network for the facility at which they practice.

Introduction

Surprise out-of-network medical bills occur when patients are treated by providers outside their health plan's contracted network under circumstances that cannot reasonably be avoided. Usually, surprise bills happen when patients are treated by an out-of-network provider that they did not choose. For example, patients undergoing surgery at an in-network hospital performed by an in-network surgeon (of their choosing) may be surprised to learn after the fact that their anesthesiologist (who they did not choose) was out-of-network. This analysis focuses on out-of-network bills that arise either from emergency care – including emergency ambulance transport – or from services delivered to patients at in-network facilities² by out-of-network specialty physicians or other providers that patients typically have no role in choosing, which commonly include ancillary physicians (anesthesiologists, radiologists, pathologists, assistant surgeons), hospitalists, and neonatologists.

The financial consequences of surprise out-of-network bills can be substantial. Contracted, in-network providers agree to accept health plan payment rates that are substantially discounted from their "list price," and health plans typically require much lower cost-sharing amounts from their enrollees for in-network services. Patients treated on an out-of-network basis, however, usually are liable for typically higher cost-sharing amounts through their health plan and the difference between the provider's full charges and the insurer-paid amount – a provider practice known as balance billing – which can be extremely large. Patients enrolled in closed-network health plans, such as health maintenance organizations (HMOs), potentially are liable for the full provider charges for out-of-network care.

Prevalence and Magnitude of Surprise Out-of-Network Bills

Health care services resulting in a potential surprise out-of-network bill are quite common. Three national studies all found that roughly 1 in 5 emergency department (ED) visits involved care from an out-of-network provider that could result in a surprise out-of-network bill if not

²The term "facility" encompasses hospitals, ambulatory surgical centers, and freestanding emergency departments.

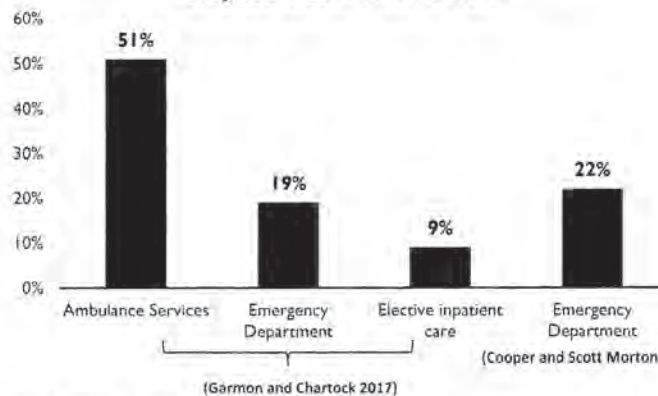
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prohibited by state law.^{3,4,5} Further, among people with large employer-sponsored health plans, more than 50 percent of all ambulance cases involved an out-of-network ambulance in 2014, and even for elective inpatient admissions, 9 percent of scheduled hospital stays at in-network facilities led to a potential surprise out-of-network bill.^{6,7} Surprise billing is prevalent in almost all areas of the country, for enrollees in both employer and individual market health plans, and across plan types.^{8,9}

Figure 1. Percentage of Visits Leading to a Potential Surprise Out-of-Network Bill



Source: Garmon and Chartock 2017; Cooper and Scott Morton 2016

Note: For the Garmon/Chartock figures, 19% represents the % of outpatient ED cases, including those to an OON ED, that could result in a potential surprise balance bill.

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³ Cooper, Zack, Fiona Scott Morton. 2016. "Out-of-network emergency-physician bills—an unwelcome surprise." *N Engl J Med* 2016; 375:1915-1918. <https://www.nejm.org/doi/full/10.1056/NEJMp1608571>.

⁴ Garmon, Christopher, Benjamin Chartock. 2017. "One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills." *Health Affairs*. Vol 36. No. 1 <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970>.

⁵ Claxton, Gary, Matthew Rae, Cynthia Cox, Lary Levitt. 2018. "An Analysis of Out-of-Network Claims in Large Employer Health Plans." *Peterson-Kaiser Health System Tracker*. <https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-health-plans/#item-start>.

⁶ Garmon and Chartock, 2017.

⁷ Cooper, Zack, Fiona Scott Morton, Nathan Shekita. 2019. "Surprise! Out-of-Network Billing for Emergency Care in the United States." *NBER Working Paper* 23623. <https://www.nber.org/papers/w23623.pdf>.

⁸ Garmon and Chartock, 2017.

⁹ Gunja, Munira Z., Sara R. Collins, Michelle M. Doty, Sophie Buetel. 2016.

"Americans' Experiences with ACA Marketplace Coverage: Affordability and Provider Network Satisfaction."

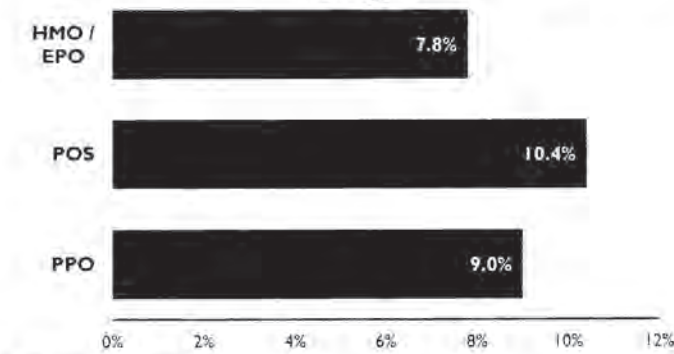
https://www.commonwealthfund.org/sites/default/files/documents/media_files/publications/issue_brief_2016_jul_1883_gunja_americans_experience_aca_marketplace_affordability_v2.pdf.

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Figure 2. Prevalence of Potential Surprise Out-of-Network Bills from Elective Inpatient Care at In-Network Facilities Across Plan Types



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When they occur, surprise out-of-network bills often are very large. According to a study examining data from a large national insurer, out-of-network emergency physicians charged on average about eight times what Medicare pays for the same service, while in-network rates paid by commercial insurers averaged about three times what Medicare pays. Thus, even if insurers were to pay out-of-network emergency physicians at their average in-network contracted rates, patients could still be liable for a balance bill reflecting substantially higher charges. For an emergency physician visit in this study, the average balance – or the difference between charges and average contracted rates – was \$623.¹⁰ However, many patients face much higher balance bills in the thousands or tens of thousands of dollars, sometimes from claims for multiple services or multiple physicians working in the ED charging many times what Medicare would pay.¹¹ For perspective, roughly one-quarter of multi-person, non-elderly households are estimated to be unable to pay \$1,000 from currently liquid assets.¹²

Why Surprise Out-Of-Network Bills Happen

Normally, negotiations between health plans and physicians are driven by a price-volume trade-off, in which a physician is willing to accept a lower per service price in exchange for the health

¹⁰ Cooper and Scott Morton, 2016.

¹¹ Rosenthal, Elisabeth. 2014. "After Surgery, Surprise \$117,000 Medical Bill From Doctor He Didn't Know." *The New York Times*. <http://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html>.

¹² Rae, Matthew, Gary Claxton, Larry Levitt. 2017. "Do Health Plan Enrollees have Enough Money to Pay Cost Sharing?" *The Kaiser Family Foundation*. <https://www.kff.org/report-section/do-health-plan-enrollees-have-enough-money-to-pay-cost-sharing-issue-brief/>.

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plan effectively steering more enrollees to that physician by including the physician in its network. Indeed, for most physicians in most geographic areas, it is not possible to maintain a practice without entering some insurer networks because few patients are willing to bear the higher costs associated with seeing an out-of-network physician. However, for some types of physicians, that basic dynamic does not apply.

For ED physicians,¹³ patient volume is driven by patients' choice of hospital¹⁴ and is unlikely to be affected by whether the physician is in-network or not. While patients seeking emergency care usually go to a facility in their insurer's network,¹⁵ once at the ED, they typically have no choice over the specific physicians treating them. Yet, there is no guarantee that these physicians will be in the same insurer networks as the facility because these physicians generally contract independently with health plans (unless they are salaried by the facility).¹⁶ Since patients have no option to choose an alternative in-network physician in this situation, the physicians' incentive to accept a lower in-network rate is reduced compared to scenarios where patients do have a choice. Volume is likely to be similarly insensitive to network status for facility-based ancillary physicians such as radiologists, anesthesiologists, pathologists, and assistant surgeons. For elective care, insured patients regularly seek a network facility and primary physician, such as a surgeon, but then have no choice of these ancillary physicians, who similarly contract independently with health plans.¹⁷ A similar dynamic applies for emergency ambulance transport since ambulances tend to be centrally dispatched and patients almost never have a choice of which ambulance company transports them in an emergency.

These providers, therefore, have a potentially lucrative out-of-network billing option that is unavailable to others. The amount charged to out-of-network patients faces few market constraints, so it is unsurprising that emergency medicine and ancillary physicians have much higher charges than other specialists relative to Medicare payment levels on average.¹⁸ For example, emergency medicine physicians who billed out-of-network for one large insurer averaged charges of nearly 800 percent of Medicare rates¹⁹ and the top 25 percent of anesthesiology claims billed to Medicare patients had billed charges more than 9 and a half times the Medicare rate (See Figure 3).²⁰

¹³ In this paper, we use the term "emergency physician" or "emergency medicine physician" to refer to those specializing in emergency medicine, while the term ED physician is used to refer to all physicians that deliver services in the emergency department, which will include emergency medicine physicians as well as many other specialties who consult on ED cases.

¹⁴ There are also infrequent instances where patients have no choice of hospital (e.g., when unconscious or in urgent need of the closest facility) and may end up at an out-of-network facility.

¹⁵ Cooper and Scott Morton, 2016.

¹⁶ Some hospitals directly employ certain hospital-based physicians or utilize faculty at an academic medical center.

¹⁷ Indeed, in conversations with Schaeffer Initiative researchers, stakeholders indicated that surgeons sometimes contract with health plans separately for their primary and assistant surgery services, or for their ED coverage, so it is possible for a surgeon to be in-network when acting as the primary surgeon but out-of-network when assisting in elective surgery or on call in the ED, all at the same facility.

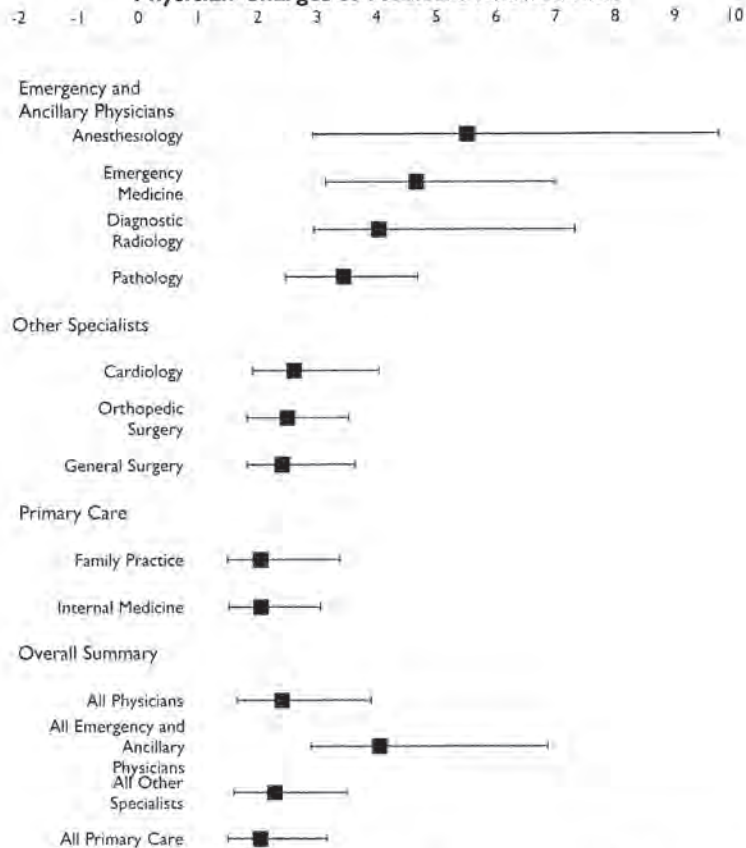
¹⁸ Bai, Ge, Gerard F. Anderson. 2017. "Variation in the Ratio of Physician Charges to Medicare Payments by Specialty and Region." *JAMA*. 2017;317(3):315-318. <https://jamanetwork.com/journals/jama/fullarticle/2598253>.

¹⁹ Cooper and Scott Morton, 2016.

²⁰ Schaeffer Initiative researchers analysis of *Medicare Provider Utilization and Payment Data: Physician and Other-Supplier Public Use Files*, calendar year 2016. Median and inter-quartile range (IQR) computed across physicians and services, weighting by the number of services rendered.

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Figure 3. Median and Interquartile Range (IQR) Ratios of Physician Charges to Medicare Allowed Rate



Source: Authors' analysis of Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use Files, calendar year 2016. Provider specialties are included in the data. The primary care specialty includes family practice and internal medicine physicians. Median (IQR) computed across physicians and services, weighting by the number of services rendered.



While these charges are high, there also are costs for physicians who rely on out-of-network billing. Collecting from individual patients is more difficult than from an insurer. Out-of-network physicians often settle with patients and/or health plans for payment below their full billed charges and some patient charges are eventually sent to collections, where providers typically receive pennies on the dollar. Collecting out-of-network bills also entails administrative and hassle costs, and even the timeliness of the insurer-owed portion of the bill tends to vary by provider network status, with payments often more prompt to in-network providers. The physicians involved also may find sending patients a surprise bill distasteful and be willing to accept less total compensation to avoid doing it. These factors help explain why many ED and ancillary physicians opt to be in health plan networks despite the lack of patient choice.

Physicians are not the only actors whose decisions determine the prevalence of out-of-network billing; decisions by health plans and hospitals play a role as well. Notably, patients *do* generally choose their health plans and hospitals, so both health plans and hospitals have economic – and other – incentives to protect patients from surprise out-of-network billing by persuading ED and ancillary physicians to be in network. However, the availability of the lucrative out-of-network billing option can make it costly for health plans and hospitals to achieve this outcome.

Most directly, ED and ancillary physicians' ability to engage in out-of-network billing enables these physicians to demand high in-network rates, which makes contracting with these physicians quite costly, and in turn increases insurance premiums. While comprehensive data on commercial payment rates by specialty are not widely available, evidence strongly suggests that the specialties with the highest rates of surprise out-of-network billing typically get paid significantly higher contracted payment rates – relative to Medicare reimbursement for the same service – than other specialists. Emergency physicians²¹ appear to receive average contracted payment from commercial health plans at roughly 250 to 300 percent of Medicare rates,^{22,23,24} radiologists receive about 200 percent of Medicare rates,^{25,26} and in a large survey conducted by the American Society of Anesthesiologists, commercial contracted payments to anesthesiologists averaged nearly 350 percent of Medicare rates in 2018.²⁷ In contrast, studies using claims data show that, across an array of non-emergency services provided by non-ancillary specialists, average mark-ups over Medicare range from approximately 115 percent to near 200 percent.^{28,29} Another study using nationally representative survey data on medical expenditures found that employer-sponsored insurance payments for office visits provided by

²¹ It is worth noting that ED physicians also must treat any patient who presents at the ED until stabilized regardless of ability to pay as a result of the Emergency Medical Treatment and Labor Act (EMTALA), but their uncompensated care burden does not appear to be large enough to justify pricing disparities this great.

²² Trish, Erin, Paul Ginsburg, Laura Gaseue, and Jeffrey Joyce. 2017. "Physician Reimbursement in Medicare Advantage Compared with Traditional Medicare and Commercial Health Insurance." *JAMA Internal Medicine*. 2017;177(9):1287-1295. <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2643349>.

²³ Cooper and Scott Morton 2016.

²⁴ Cooper, Scott Morton, and Shekita, 2019.

²⁵ Trish, Ginsburg, Gaseue, and Joyce, 2017.

²⁶ Pelech, Daria. 2018. "An Analysis of Private-Sector Prices for Physicians' Services." *Congressional Budget Office Working Paper* 2018-01. <https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/53441-workingpaper.pdf>.

²⁷ Stead, Stanley W., Sharon K. Merrick. 2018. "ASA Survey Results for Commercial Fees Paid for Anesthesia Services—2018." *ASA Monitor* 10 2018, Vol. 82, 72-79. <http://monitor.pubs.asahq.org/article.aspx?articleid=2705479>.

²⁸ Trish, Ginsburg, Gaseue, and Joyce, 2017.

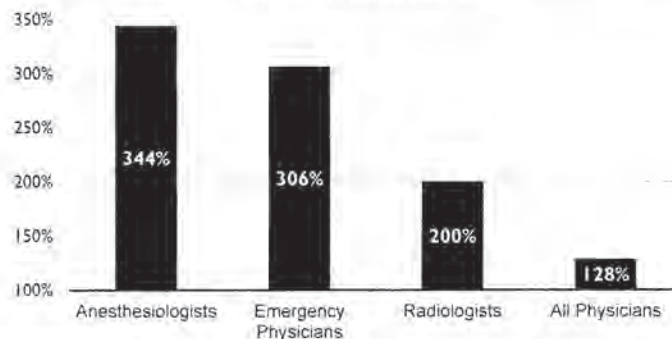
²⁹ Pelech, 2018.

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specialists averaged about 117 percent of Medicare,³⁰ and a Medicare Payment Advisory Commission (MedPAC) analysis of commercial PPO claims from one large national insurer found that contracted payment rates nationwide for all physicians averaged 128 percent of Medicare rates.³¹ While Medicare rates are not necessarily a perfect measure of the relative cost of delivering different services, discrepancies this large and consistent across the specialists most commonly involved in surprise out-of-network billing appear difficult to justify.

Figure 4. Average Contracted Payment Relative to Medicare Rates for Selected Specialties



Note: Anesthesiologist comparison based on relative mean conversion factors in 2018. Emergency physician comparison based on relative mean payment rates for CPT code 99285 in 2012. For radiologists, 200% represents mean commercial payment for CT Head/Brain scans relative to the Medicare rate (CPT code 70450). All physicians comparison based on data from commercial PPO claims for one large national insurer.

Source: Stead and Merrick 2018; Trish, Ginsburg, Gascue, and Joyce 2017; MedPAC 2017

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Hospitals could seek to limit surprise out-of-network billing by requiring the emergency and ancillary physician groups they contract with to participate in the same health plan networks as the hospital. Unlike health plans, hospitals have leverage over these physicians because they rely on the hospital for patient volume. And, in practice, many hospitals do apply pressure on their emergency and ancillary physicians to sign contracts with the health plans they accept. However, they may lack the market leverage necessary to insist on compliance.

³⁰ Biener, Adam I., Thomas M. Selden. 2017. "Public and Private Payments for Physician Office Visits." *Health Affairs*. Vol 36 No. 12. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0749>.

³¹ MedPAC. 2017. "Report to the Congress: Medicare Payment Policy." March 2017. http://medpac.gov/docs/default-source/reports/narr17_entirereport.pdf.

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Indeed, taking such a stance on surprise out-of-network billing would often have costs for the hospital. Economic theory predicts that a hospital that wishes to bar an ED or ancillary physician from billing hospital patients on an out-of-network basis would need to compensate physicians to forgo this lucrative option, particularly since physicians barred from going out-of-network are likely to have limited leverage when negotiating in-network rates.³² For instance, a hospital that wanted to prohibit out-of-network billing by its contracted physicians might have to offer higher stipends, medical director fees, or other forms of direct payment.³³ Equivalently, an emergency or ancillary physician group who wanted to bill hospital patients out-of-network – or is able to better leverage the out-of-network billing threat to extract especially high in-network health plan payments – might be willing to accept less in these payment streams.³⁴

The fact that it is costly for a hospital to require its ED and ancillary physicians to go in network also makes it costly for insurers to encourage hospitals to take such an approach. In principle, the insurer could offer the hospital higher facility payment rates in exchange for guaranteeing that the hospital's ED and ancillary physicians accept network rate offers. However, because this would create such significant costs for the hospital, the increase in payment rates would likely need to be relatively large.

Since, as previously noted, patients generally do choose their insurers and hospitals, hospitals or insurers might be willing to pay what would be required to get physicians to forgo surprise out-of-network billing if patients demanded it. In practice, however, consumer demand is unlikely to be strong enough. Few patients even know that network status can differ between the facility and emergency and ancillary clinicians. Additionally, health events that would make this protection valuable are relatively uncommon and hard to anticipate. As a result, exposure to surprise out-of-network billing may not be a particularly salient consideration when consumers are choosing hospitals or insurers, in which case hospitals or insurers that offer this protection may not be able to attract enough additional customers – or raise their premiums enough – to cover the significant costs they would certainly incur to compensate ED and ancillary physicians for forgoing their lucrative out-of-network billing option. Furthermore, even if consumer pressure were strong enough to squelch surprise out-of-network billing, emergency and ancillary physicians would continue to be able to extract very high levels of in-network payment, which consumers and their employers would bear through higher premiums.

³² When deciding whether to contract with a health plan, physicians consider the payoff to remaining out of network, which is the amount of money they can collect when billing on an out-of-network basis minus the costs, including both the time and money to collect from patients and any distaste for surprise billing patients. Additionally, physicians must consider the cost of compensating the hospital for the reputational harm stemming from surprise out-of-network billing occurring at their facility and any distaste the hospital has for surprise billing patients. A similar model is detailed by Cooper, Scott Morton, and Shekita 2019.

³³ Stipends, medical director fees, and other forms of direct payment from hospital to physician group are often related to the payer mix of the hospital, services performed that are not reimbursed by insurers, and other factors.

³⁴ For a discussion of this phenomenon occurring, see Bank of America Merrill Lynch, "Physician Staffing: Out-of-network concerns are blown out-of-proportion, EVHC Top Pick," April 2016.

Excerpt: "According to Envision, hospitals are aware of their contracting strategy, and oftentimes it is expressly done to reduce the subsidy that the hospital would otherwise have to pay. Essentially, EVHC [Envision] might say to the hospital, 'I can staff your hospital with a \$300,000 subsidy, or I can go out-of-network with United and the subsidy would be \$0.'"

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Principles for Designing a Solution

Before discussing specific policies, it is useful to lay out what features a solution to the surprise out-of-network billing problem should have. In this section, we describe four principles for a solution to surprise out-of-network billing.

1. Take the patient out of the middle

A key first step is removing the patient from the middle of disputes over surprise out-of-network billing and requiring insurers, providers, and/or regulators to resolve problems. Any solution, therefore, should prevent patients from receiving a surprise out-of-network bill in the first place, making discordant network status between facility and ED or ancillary clinicians invisible to patients. This is in contrast to some current state laws that require patients proactively to file a complaint about surprise out-of-network bills. Patients may be unaware of legal protections and end up paying an out-of-network bill unnecessarily. Additionally, navigating the complaint process is likely to create significant barriers and costs for patients.

2. Apply protections comprehensively

Protections from surprise out-of-network billing should apply comprehensively across settings – at hospitals, ambulatory surgical centers (ASCs), and freestanding EDs – and not merely in emergency situations. Specifically, protections should apply to services where patients lack meaningful choice of provider. A comprehensive approach would include:

- All out-of-network emergency care,³⁵ whether the facility is in- or out-of-network (including out-of-network facility fees);
- Post-stabilization services at an out-of-network facility (including facility and professional fees);³⁶
- All out-of-network emergency ambulance transport;
- All out-of-network ancillary and hospitalist services delivered through an in-network facility. Ancillary services should be defined as all anesthesiology, radiology, pathology, assistant surgery, and other consulting services, encompassing any tests or imaging performed in addition to the physician professional services.
- Out-of-network neonatology services at an in-network facility immediately following birth until a reasonable option is provided for transfer to an in-network facility with access to an in-network physician.

It may also be appropriate to include some or all out-of-network laboratory services (including pathology) ordered by in-network physicians in the physician office setting. Further, for out-of-network treatment at an in-network facility other than the services described above, protections

³⁵ Emergency services should be defined by the “prudent layperson” standard, which is broader than the “stabilization” standard under EMTALA. It covers situations beyond true life-and-limb emergencies, to include circumstances where patients reasonably believe they might have an emergency condition, even if it turns out they do not. See 29 CFR 2590.715-2719A.

³⁶ Such a protection could apply for the first 24 hours after stabilization, and thereafter if no reasonable option is provided for transfer to an in-network facility.

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should apply if the provider does not provide notice of their network status and associated costs and obtain patient consent at least 48 hours before treatment.

3. Minimize reliance on notice and consent exceptions

In an attempt to balance protecting patients and allowing legitimate elective uses of out-of-network care, many proposals create an exception from prohibitions on balance billing if the medical provider gives notice. Such an exception, however, may allow some providers to thwart surprise billing protections if patients do not fully understand what they are signing or do not realistically have the option to withhold consent, and therefore should be limited if allowed at all. Given the amount of paperwork patients typically must fill out when obtaining medical care and the worry and pain involved with their illness, the notice of potentially high out-of-network billing charges may not be salient enough for patients to take notice. Additionally, the notice might be provided at a point where patients lack realistic alternatives.

Moreover, a notice and consent exception should be unnecessary for many settings, as there is no reason to think that patients would ever opt for out-of-network care when they are not otherwise choosing their provider. A notice and consent exception should be reserved for out-of-network billing protections applied to non-ancillary out-of-network services at an in-network facility, such as a preferred surgeon.

4. Include means of enforcement

An effective policy needs to alter the behavior of health care payers, hospitals, physician groups, and individual clinicians. Regulatory efforts can be frustrated by lack of an efficient enforcement mechanism binding all relevant parties. Attention should be paid to how any new standards will be enforced.

Analyzing Potential Policy Approaches

There are two broad policy approaches that can address surprise out-of-network billing in a comprehensive manner. The first, termed "billing regulation," relies on capping or setting what out-of-network providers can charge patients and health plans in surprise situations, either by explicitly choosing a rate or determining it through an arbitration process. Additionally, plans would be required to treat such services as in-network for purposes of enrollee cost-sharing. The second approach, termed "contracting regulation," effectively makes it impossible for facility-based emergency, ancillary, and similar services to be out-of-network with a health plan when the facility itself is in-network. This second approach can be achieved either through a requirement on ED and ancillary clinicians, hospitalists, and neonatologists to contract with the same health plans as the facility or facilities they practice in, or through a prohibition on these physicians contracting with health plans or billing patients directly.

Billing Regulation

Billing regulation combines two key elements:

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- Limit the amount that a provider can receive for delivering a given out-of-network service; and
- Require health plans to hold patients harmless beyond their normal in-network cost-sharing amounts – this means that plans must pay the difference between the capped provider charges and the patient's in-network cost-sharing, and must apply the patient's cost-sharing amounts to their in-network deductible and out-of-pocket maximum.³⁷

The first step – limiting provider payment for out-of-network services – can be accomplished as either a limit on the amount the provider can charge when care is delivered out-of-network (a maximum amount charged or charge limit), or as a requirement that the health plan pay a minimum amount combined with a prohibition on provider balance billing (a minimum payment owed or payment standard). These approaches are functionally equivalent; this analysis will refer to charge limits.

A key decision in designing such a policy is determining how to set a reasonable cap on what an out-of-network provider can charge, which is described in some detail below.

General Considerations in Setting a Charge Limit or Payment Standard

Charge limits can be established in one of two ways: directly specifying a limit or specifying an arbitration process. The first approach is simpler and more transparent, although arbitration may provide more flexibility in payment rates across circumstances. Before discussing each of the specific approaches to setting a charge limit in more detail, however, it is useful to consider the policy implications of setting a limit that is “too high” versus one that is “too low.”

A charge limit for out-of-network ED, ancillary, and similar clinicians that is “too high” would lead to excessive health care spending. Because fully-insured health plans would be required to pay ED, ancillary, and similar physicians the difference between their capped charges and the patient's in-network cost-sharing, physicians would effectively be guaranteed payment equal to the charge limit. As a result, any charge limit set above current average contracted rates in a market would place upward pressure on those contracted rates, and, above a certain level, those increases could more than offset any reduction in payments to physicians currently billing out of network.

Even setting a charge limit close to the average amounts currently collected by these physicians would likely lead to excessive spending because it would bake in today's inflated costs for ED

³⁷ Under this approach, policymakers would have to decide whether insurers would be required to pay out-of-network providers directly or whether they would instead be permitted to pay the mandated amount to the patient, who would in turn pay the provider. Requiring insurers to pay providers directly would minimize hassle costs for patients. On the other hand, because requiring insurers to pay providers directly would make it easier for out-of-network providers to collect payment (or allow them to do so more quickly), it might reduce these providers' incentive to join insurers' networks. In circumstances where the charge limit has been set “too high” (discussed in more detail in the following section), retaining some incentive for providers to join networks at rates below the charge limit would be desirable. Requiring insurers to directly pay providers with whom they lack contractual relationships may also create some operational complexities, although at least some of the states that have taken steps to limit surprise billing appear to have surmounted those problems in practice.

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and ancillary services. As detailed earlier, it appears that emergency and ancillary physicians currently are paid more than they would earn absent the ability to routinely treat and bill patients out-of-network. This analysis will refer to the payment rate that would prevail without the ability to routinely treat and bill patients out-of-network as the “normal market” rate (although to the extent that physician markets are concentrated, even this rate still may be excessive).

On the other hand, setting a charge limit “too low” may be perceived as unfair. It could also raise concerns about physician shortages or reduced access to care if compensation is insufficient to incentivize physicians to train for affected specialties. However, for these particular facility-based clinicians, there are countervailing pressures that would mitigate the impact of a payment standard lower than “normal market” rates. Specifically, these providers by definition practice in facilities, and there are a variety of ways that facilities can compensate for rates that are, in some sense, “too low.” Today, facilities make a variety of payments directly to these clinicians (separate from health plan payments for actual services rendered) such as stipends or medical director fees.³⁸ Further, hospitals can become involved in the negotiations between clinician groups and health plans. If facility-based ED or ancillary clinician out-of-network payment rates were capped at too low a level, facilities would be expected to compete to attract ED and ancillary clinicians by using one of these channels to offer additional payment.³⁹ Indeed, the facilities are the drivers of these physicians’ practice volume, so the more natural negotiation is between the facility and facility-based clinician, rather than between the health plan and clinicians.

There are legal constraints on how much and in what ways facilities can direct funds to clinicians, and there may be some short-term disruption, but these mechanisms should ultimately help augment any rate set “too low” toward the “normal market” rate.⁴⁰ Importantly, there is evidence that the payments from facilities to clinicians for contracted services are today often related to the payer mix of the facility – for example, offering a higher subsidy if a relatively high percentage of a facility’s patients are uninsured or have public insurance with relatively lower reimbursement.⁴¹ That a mechanism already exists through which facilities can provide compensation to ED and ancillary clinicians who expect to earn lower revenue for contracted services provides strong evidence that a similar response could ensue if a payment standard was set below a “normal market” rate. However, the legal considerations are significant and facilities and clinicians will need to take care to document that these fund flows represent

³⁸ American Academy of Emergency Medicine. 2005. “The Business of Emergency Medicine—Made Easy!” <https://www.aacem.org/UserFiles/file/thebusinessofem.pdf>.

³⁹ However, in most cases, we would not expect facilities to typically compensate emergency and ancillary clinicians for the entire difference between their current contracted rates and the new charge limit because they no longer need to be compensated to forego the now-outlawed lucrative out-of-network billing option.

⁴⁰ While these payment arrangements with facilities would mitigate concerns about setting a rate that is “too low” for ED and ancillary physicians, as well as hospitalists and neonatologists, the same mechanism does not exist for out-of-network emergency facilities (i.e., the facility rather than the physician fee) nor for out-of-network ambulances. Thus, the consequences of setting a payment rate that is “too low” may be more problematic for these particular services, although we do not think there is much risk that a rate in the range of 125 percent of Medicare (our recommendation) would be too low to cover the costs of delivering these services.

⁴¹ American Academy of Emergency Medicine. 2005. “The Business of Emergency Medicine—Made Easy!” <https://www.aacem.org/UserFiles/file/thebusinessofem.pdf>.

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fair market transactions to avoid running afoul of state and federal self-referral and anti-kickback laws.

In principle, one might be concerned that the need to subsidize these physicians could make delivering these services unprofitable for hospitals and thereby jeopardize access to hospital services. In practice, however, this is unlikely to be a concern. Under standard economic models of hospital-insurer bargaining, hospitals should be able to pass increases in their (marginal) cost of delivering services along to insurers.

Ultimately, the existence of other mechanisms for compensating these clinicians has important implications for weighing the relative risks of setting a charge limit too low rather than too high. In particular, whereas setting a charge limit that is too high can have harmful outcomes, the concerns related to setting a charge limit too low can be largely mitigated through compensating payments from hospitals to physicians, although referral fee laws could be an obstacle to some extent. Despite this legal/contractual complication, where there is uncertainty about the appropriate charge limit, the availability of hospital “topping off” payments or negotiating on behalf of physician groups in establishing in-network contracts gives policymakers reason to lean toward setting a lower limit rather than a higher limit.

Specific Options for Directly Setting a Charge Limit

It is now useful to consider three different prices that are commonly considered as the basis for directly setting a charge limit: Medicare rates, billed charges, and contracted rates.

Medicare rates

Medicare rates are reasonable, if imperfect, estimates of the relative cost of providing various services, and are frequently used by commercial health plans to guide rate negotiations with providers.⁴² The Medicare fee schedule for physician services is publicly available, making Medicare rates a transparent and accessible benchmark to operationalize a charge limit. Medicare payments are adjusted by geographic area on the basis of input prices and are accepted as payment-in-full for Medicare patients by nearly all physicians in the United States. However, Medicare rates are generally lower than negotiated commercial rates for many physician services.^{43,44} Medicare rates are not tied to any market negotiation and can be affected by political and budgetary considerations, so some might fear that these rates will be too low or not vary enough across geographies to reflect market conditions. The first concern can be ameliorated by setting the out-of-network charge limit as a multiple of Medicare rates. For example, Missouri and California have incorporated Medicare rates as a part of their state policies scaled to 120 and 125 percent of Medicare allowed rates, respectively. Commercial rates as a percentage of Medicare do vary by market, and state policymakers could further address

⁴² Clemens, Jeffrey, Joshua D. Gottlieb. 2017. “In the Shadow of a Giant: Medicare’s Influence on Private Physician Payments.” *Journal of Political Economy*, 2017 Vol 125, No. 11. <https://usrs.nber.org/-/idgottli/ShadowOfAGiant.pdf>.

⁴³ Trish, Ginsburg, Gascue, and Joyce, 2017.

⁴⁴ Pelech, 2018.

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geographic variation by scaling the multiple of Medicare rates used for a charge limit based on commercial rates in their state (or in some geographic markets within the state). Another approach, discussed below, would draw on the ratio of contracted rates to Medicare rates for specialists other than emergency medicine and ancillary clinicians.

Billed charges

Physicians' billed charges are another measure available to policymakers, but basing an out-of-network charge limit on billed charges would likely lead to too high a limit and drive up health costs and insurance premiums. Charges (or list prices) face little constraint from market forces and tend to be extremely high relative to objectively reasonable prices. This is particularly true for the specialties most commonly involved in surprise out-of-network billing since, as discussed earlier, physicians in these specialties have particularly strong incentives to set high charges.

Emergency medicine physicians and anesthesiologists, the two specialties with the highest prevalence of out-of-network treatment at in-network facilities,⁴⁵ had median charges of 465 percent and 551 percent of Medicare payment rates, respectively, in 2016, based on a USC-Brookings Schaeffer Initiative analysis of Medicare claims data, compared to an average across all non-emergency medicine or ancillary specialists of 227 percent (See Table 1).

The ratio of charges to Medicare payments is especially large at percentiles of the distribution above the median. Table 1 shows the median, 20th, and 80th percentiles of physician charges for different specialties. Across all provider types, the distribution of charges is skewed such that the distance between the median and 80th percentile is greater than the distance between the median and 20th percentile. And for anesthesiologists, radiologists, and emergency medicine physicians, in particular, the 80th percentile of charges tends to be extremely high. Operationally, this means that even a small shift in the percentile used to set a payment standard can result in a large leap in absolute payment.

Because charges are not meaningfully market-determined, they often do not vary in logical ways with the underlying cost of delivering different services. At any moment in time, an out-of-network charge limit based on billed charges is likely to overvalue some services relative to others. The absence of market discipline means that billed charges are also likely to change in unpredictable ways over time, potentially causing unexpected and undesirable changes in the level of the out-of-network charge limit. The latter problem could, in principle, be addressed by benchmarking the charge limit to billed charges at a point in time and then updating the charge limit based on some inflator unrelated to future charges, but it would be preferable to simply take a more sensible approach to setting the charge limit at the outset.

⁴⁵ Garmon and Chartock, 2017.

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**Table 1. Ratio of Charges to Medicare Rates by Physician Type, CY 2016**

	Median	20 th Percentile	80 th Percentile
Emergency and Ancillary Physicians			
Anesthesiology	5.51	2.52	11.08
Emergency Medicine	4.65	2.79	7.50
Diagnostic Radiology	4.02	2.64	8.03
Pathology	3.43	2.25	5.10
Other Specialists			
Cardiology	2.59	1.73	4.57
Orthopedic Surgery	2.48	1.68	3.91
General Surgery	2.39	1.68	4.13
Primary Care			
Family Practice	2.03	1.38	3.82
Internal Medicine	2.03	1.39	3.45
Summary			
All Physicians	2.39	1.49	4.60
All Emergency and Ancillary Physicians	4.03	2.57	8.00
All Other Specialists (Not Emergency and Ancillary Physicians)	2.27	1.46	4.01
All Primary Care	2.03	1.39	3.54

Source: Authors' analysis of Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use Files, calendar year 2016. All Other Specialists includes all other specialist physicians included in the data, i.e., it is not restricted to only those examples listed under other specialists in the table.

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Average contracted rates

At first blush, in-network rates appear to have the benefit of being market-driven and thus more accurately reflecting the relative costs of different services. However, as detailed earlier, contracted rates as a percentage of Medicare rates are considerably higher for emergency and ancillary physicians compared to other specialties because of the lucrative out-of-network billing

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option available to these physicians. (Unusually high levels of market concentration in these specialties may also play a role.)

Therefore, tying provider payment in cases of surprise out-of-network bills to average contracted rates for that service would cement the currently inflated rates reaped by ancillary and emergency physicians. However, average commercial payment rates (as a percentage of Medicare) for *non-ancillary* specialists with similar training may provide useful insight regarding what reasonable, market-determined payment rates might be.

One promising approach, then, would be to employ the average mark-up over Medicare rates among contracted network rates for a group of *non-ancillary* specialists with similar training. In other words, policymakers would determine by what percentage the weighted-average in-network payment rate for non-ancillary specialist services exceeds Medicare rates, and then set the charge limit for the surprise out-of-network services in relation to that percentage of the relevant Medicare rate in the same region. For instance, if average in-network rates for cardiologists or surgeons (or a blend of appropriate specialties) are 150 percent of Medicare rates, then out-of-network charges for ED, ancillary, and similar services could be capped at 150 percent of Medicare rates for the same services. This method has the potential advantage of adjusting the payment standard to local or state-specific conditions in the commercial market. Alternatively, a charge limit could be based on *nationwide* or regional average contracted rates for non-ancillary specialists as a percentage of Medicare rates.

While a suboptimal solution (though still preferable to the status quo) that cements today's inflated payment rates, if policymakers instead prefer to tie an out-of-network charge limit to the higher average network rates for emergency medicine and ancillary specialists, policymakers should seek to minimize unintended consequences on future contract negotiations that might lead to lower network participation rates. Specifically, if payment is tied to average contracted rates in the previous year or years, then health plans have an incentive to cancel contracts with higher-than-average rates and physicians may have an incentive to cancel contracts with lower-than-average rates, in order to make the prescribed payment rate more favorable in the future.⁴⁶ Insurer-specific or provider-specific averages are particularly vulnerable – more so than market or regional averages – to these adverse effects since there is a direct mechanism for individual insurers or providers to influence their own future payment rates. This risk can be avoided by tying the payment rate to an average at a moment in time *prior to* passage of legislation, and then either indexing that amount forward by a measure of inflation or converting it to an equivalent percentage of the Medicare rate and using that ratio thereafter.

Using Arbitration to Determine Payment

Another option to determine provider payment for surprise out-of-network services is to create an arbitration process, which states such as Illinois, New Hampshire, New Jersey, and New York

⁴⁶ See California Regulatory Notice Register, 2018, No. 31-Z, <https://oal.ca.gov/wp-content/uploads/sites/166/2018/08/31z-2018.pdf> for a discussion of this concern in relation to California's recent surprise billing law, AB 72.

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have pursued and has been proposed federally by Sen. Maggie Hassan and Rep. Michelle Lujan Grisham.⁴⁷ Arbitration offers the potential advantage of allowing payment rates to vary more for specific circumstances and potentially adjust more easily over time. The uncertainty in outcome from arbitration might also increase the incentive to contract for both the health plan and provider. Arbitration might also be more politically palatable because it allows lawmakers to avoid explicitly prescribing payment rates. However, it is unclear why an outside arbiter would be better at picking the “appropriate” rate than lawmakers. Nor does this approach completely avoid the need to set rates, as policymakers typically must provide some sort of criteria or guidance to the arbiter about what the appropriate rate is.

An arbitration approach also comes with administrative costs. If those administrative costs are high enough, they could undermine the effectiveness of the policy by leading insurers to simply accede to providers’ demands rather than pursue arbitration.

If policymakers choose an arbitration process, they may wish to consider a “baseball-style” or “final offer” structure. In this approach, if the provider and health plan are unable to settle on a payment rate, each submits their best and final offer, and an independent arbiter (typically a neutral party chosen by an agency such as the state’s insurance department) chooses which offer they think better represents an appropriate rate. Baseball-style arbitration offers a few potential advantages over other forms of dispute resolution.^{48,49} First, it may prove more efficient to review two competing bids than for an arbiter to directly determine the “correct” number.

Second, the possibility of the other party’s bid being chosen creates an incentive to negotiate and settle rather than risk losing outright. And third, because the arbiter must choose either the plan or provider offer, there is an incentive to make a reasonable final offer, which both increases the chances of settlement and potentially provides important information to the arbiter in deciding which offer to choose. Making the arbitration decisions public, as New Jersey’s law does, may additionally make settlement before arbitration more likely as both sides would then know roughly what rate arbiters tend to select. Providing clear guidance to the arbiter about how to select the winning rate offer could have a similar effect.

Rather than providing specific rate guidance, policymakers may wish to specify a floor and ceiling rate to avoid the risk of the arbiter choosing an outlier payment amount. If guidance is provided for the arbitration process, the same discussion applies as above for choosing an appropriate payment standard. Similarly, policymakers are better off “erring” on the low side given that facilities would be expected to compensate facility-based clinicians if the rate chosen is lower than the “normal market” rate. And most importantly, policymakers should exclude any reference to billed charges in their guidance to arbiters because such a reference would likely lead to an excessive payment standard.

⁴⁷ Adler, Loren, Paul B. Ginsburg, Mark Hall, Erin Trish, Benjamin Chartock. 2018. “Analyzing Senator Hassan’s Binding Arbitration Approach to Preventing Surprise Medical Bills.” *Health Affairs Blog*, October 18, 2018. <https://www.healthaffairs.org/doi/10.1377/hlthaff.20181017.792315/full/>.

⁴⁸ Shorter, J. B. 2009. “Final-Offer Arbitration for Health Care Billing Disputes: Analyzing One State’s Proposed Dispute Resolution Process.” *Appalachian Journal of Law*, 9:191-215.

⁴⁹ Monhait, J. 2013. “Baseball Arbitration: An ADR Success.” *Harvard Journal of Sports & Entertainment Law*, 4:105-43.

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Contracting Regulation

The material above described “billing regulation” approaches that can be used to address surprise out-of-network billing. It is useful to consider to a different set of solutions, which eliminate the possibility for patients to be seen by an out-of-network ED, ancillary, or similar clinician at an in-network facility, termed “contracting regulation” approaches.

There are two main “contracting regulation” approaches, both of which would likely have relatively similar effects on both provider payment and patients’ experiences. Notably, though, neither of these contracting regulation approaches would address surprise bills for patients brought to the emergency department at an out-of-network hospital or transported in an out-of-network ambulance, so billing regulation would still be necessary to address these instances.

Requiring Clinicians to Contract with All Health Plans Accepted by the Facility

The first approach is to require that any ED, ancillary, or similar clinician who contracts to practice at a facility also contract with all health plans accepted by the facility. This would straightforwardly eliminate the possibility of patients being treated by an out-of-network ED, ancillary, or similar clinician at an in-network facility. However, this approach may prove administratively costly in practice. Requiring a facility-based clinician to join every single health plan network that the facility is in, especially for clinicians practicing in multiple facilities, could prove time-consuming and administratively burdensome.

Some might also object that this requirement shifts too much leverage to insurers in negotiations with facility-based ED and ancillary clinicians, as insurers would know that these clinicians have to accept whatever payment rate they offer to practice at all. However, this concern is not as serious as it might appear for the same reasons that we generally do not worry about setting a charge limit too low. If insurers do indeed use this leverage to pay ED and ancillary clinicians very low rates, then facilities will have good reason to step in to provide additional compensation – or insist that health plans offer reasonable rates as a condition of their contract with the facility – in order to ensure adequate staffing.

Another possible complication, which also applies to a lesser degree to the second contracting regulation approach discussed below, is how to apply this regulation to clinicians who provide some but not all of their facility-based services in the ED or as an ancillary provider. Many different specialists (e.g., various types of surgeons) provide treatment in EDs and separately see other patients as the primary provider in the same facility for nonemergency services. And assistant surgeons who act as ancillary providers almost always also see patients as the primary surgeon in the same facility. To protect consumers broadly against surprise out-of-network bills, this approach would have to require that such specialists contract with all the facility’s payers specifically for at least the ED and ancillary services they provide, which might require contracting and billing under two different national provider identifiers (NPIs).

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A weaker form of this approach might simply require facility-based ED, ancillary, and similar clinicians to “negotiate in good faith” to join the networks of all the health plans that the facility accepts. In this case, a dispute resolution mechanism would have to be included, such as arbitration, to resolve any disputes over what constitutes reasonable versus unreasonable rate negotiation.

Prohibiting Independent Facility-Based ED and Ancillary Clinician Billing

The second contracting regulation approach would prohibit facility-based ED and ancillary clinician services from being billed individually to health plans or patients at all.⁵⁰ Under this approach, facilities would incorporate all ED and ancillary clinician services into the facility fees they negotiate with health plans and these facility-based clinicians would have to obtain their full payment from the facility for the services they provide. This approach can alternatively be thought of as requiring facilities to contract with health plans over a “bundled” package of services that includes any associated ED or ancillary clinician services. This bundling approach may appear radical, but it is not dramatically different than how nursing services are billed and nurses are paid today. Note that it may make it more attractive for these clinicians to become facility staff in some cases, but would not require that outcome as these providers could continue to deliver services as independent physician groups and contract with the facility for payment.

Facility-based physicians who both provide services in the ED or as an ancillary provider and separately as the primary physician in nonemergency situations would still be allowed to contract with health plans or bill patients for this latter set of services, but not the former. Neonatology services provided in the 24 hours after a new birth up until a reasonable option for transfer is provided and those provided by hospitalists would also be incorporated in the services that cannot be billed to health plans or patients, in line with their incorporation under billing regulation approaches.

Requiring physician compensation for facility-based ED and ancillary services to come entirely from facilities would mark a significant change, but this solution has the benefit of maintaining price competition for ED and ancillary providers while simultaneously protecting patients. As detailed earlier, the more natural market negotiation exists between ED and ancillary clinicians and the facility they practice at, rather than with the health plan where no price-volume tradeoff exists. Facilities would need to offer sufficient compensation to attract ED and ancillary clinicians and those clinicians would compete to contract with facilities based on price, quality, and the services they provide. Facilities would then negotiate with health plans on reimbursement for this bundled service including these related physician services.

⁵⁰ Yale University professors Zack Cooper and Fiona Scott Morton have proposed an approach along these lines specific to emergency services. See “Out of Network Emergency-Physician Bills—An Unwelcome Surprise,” *N Engl J Med* 2016;1915-1918.

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Physicians may view becoming reliant on a facility (typically a hospital) for payment – and the associated loss of independence – as a drawback of this approach. However, they need not become hospital employees. Instead, they could still maintain an independent contractual arrangement similar to what typically exists today. Still, the level of contractual disruption this policy approach would entail may present a practical challenge.

Note that the ultimate outcomes under this contracting regulation approach would be similar in most relevant respects to the outcomes under a billing regulation approach with a relatively low level out-of-network charge limit. (Indeed, this contracting option can be thought of as a billing regulation approach with an out-of-network charge limit set to zero.) In either case, facilities would now play the primary role in compensating ED and ancillary physicians for their services.

Stark and Anti-Kickback Laws

Some of the policy solutions described above may expand or create new fund flows from hospitals to other clinicians, and so providers may raise concerns about their obligations under state and federal “referral fee” laws that govern financial arrangements between physicians and hospitals or other providers. In general, these laws, known federally as the Stark Law and the Anti-Kickback Statute, limit what payments can flow between physicians and facilities that refer patients to one another. If new legislation were to require certain specific forms of billing or contracting (like requiring all billing be conducted by the hospital), that should clearly override any conflicting implication from a more general law designed to proscribe inappropriate financial arrangements.

However, as noted previously, there could be legitimate concern about how these referral laws would apply to more indirect changes in contracting and payments between facilities and providers. Thus, if a low payment rate for emergency and ancillary physicians were to induce hospitals to compensate these physicians directly through stipends or other fund flows, careful legal counsel and documentation would be needed to ensure that the additional payments were legally structured. In particular, documenting that transactions are based on fair market value for the relevant services and avoiding payments that are based on the volume or value of services would be important. Policymakers may also wish to consider whether modifications to these federal laws are necessary.

Surprise Ambulance Bill Protections

Ambulance services are frequently overlooked in laws that address surprise billing, but increasingly they are a source of concern for out-of-network billing. Not too long ago, most ambulance service was provided either by local government or by hospitals for amounts close to what Medicare pays. Recent years, however, have seen a proliferation of for-profit ambulance companies that charge a good deal more than Medicare. Prices for government and hospital-

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based ambulance services also have increased substantially, to help cover cost deficits and to make up for volume lost to newer competitors.⁵¹

Because much ambulance transport is done on a scheduled basis (e.g., transferring patients), health plans usually include ambulance service in their contracted networks, but some ambulance companies, especially for-profit ones, are unwilling to agree to rates offered by insurers, preferring instead to remain out of network by relying on their ability to balance bill for emergency transport (mainly by responding to 911 dispatchers).

As described earlier, one analysis of 2014 commercial claims from primarily large employers reported that more than half of all ambulance cases involved an out-of-network ambulance.⁵² Anecdotal reports suggest that ambulance balance-billed amounts may be increasing.⁵³ Most egregious are air ambulance bills, which often amount to several tens of thousands of dollars. For ground ambulance service, balance bills in the past typically had been several hundred dollars, but the market developments just described have, more recently, resulted in balance bills of \$1,000 or substantially more, which is several times higher than amounts Medicare pays.⁵⁴⁻⁵⁵

Out-of-network ambulance bills should be addressed in the same manner as out-of-network emergency services, through a limit on out-of-network billed charges based on a multiple of Medicare rates combined with a hold harmless requirement on health plans to limit enrollee costs to in-network cost-sharing amounts.

Considerations for States

A number of states have enacted legislation that targets surprise out-of-network billing, generally using some version of the billing regulation approaches described above. Several specific considerations apply to state policymaking in this area.

First, preemption under ERISA—which bars states from regulating self-insured employer health plans—will be a major consideration for any state considering regulation of surprise out-of-network billing. Since the mid-1990s, the Supreme Court has been clear that states can engage in “general health care regulation” – even if the rules affect ERISA plans.⁵⁶ Thus, states are permitted to regulate the conduct of health care providers even when they treat patients covered

⁵¹ U.S. Government Accountability Office. 2012. “Ambulance Providers: Costs and Medicare Margins Varied Widely.” GAO-13-6, Oct 1, 2012. <https://www.gao.gov/products/GAO-13-6>.

⁵² Garmon and Chartock, 2017. See Supplemental Appendix Exhibit A1.

⁵³ Nation, George. 2017. “Taking Advantage of Patients in an Emergency: Addressing Exorbitant and Unexpected Ambulance Bills.” *Villanova Law Rev.* 62(4): 747-85 (2017).

<https://digitalcommons.law.villanova.edu/cgi/viewcontent.cgi?article=3357&context=vlr>.

⁵⁴ James, Sha’Ron. 2018. “Emergency Medical Transportation Costs in Florida.” *Florida Insurance Consumer Advocate*. <https://www.myfloridachief.com/Division/ICA/EMTWhitePaper.pdf>.

⁵⁵ Consumer Reports. 2016. “\$164 Per Mile: Surprise Ambulance Bills Are A Growing Problem & Difficult To Avoid.” Feb. 22, 2016. <https://www.consumerreports.org/consumerist/164-per-mile-surprise-ambulance-bills-are-a-growing-problem-difficult-to-avoid/>.

⁵⁶ *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

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by self-funded employer plans. For example, the Court has upheld a state law that directed hospitals to bill payers in a very specific way, including imposing a significant surcharge on most ERISA plans; the Court concluded that the state was regulating hospitals, not employer health plans, and that this was permissible “general health care regulation.”

Some regulations of surprise out-of-network billing can be constructed in ways that are clearly regulation of health care providers rather than payers. While regulation will certainly have effects on payers, including self-insured employer plans, rules about the practice of medicine and how providers interact with one another and bill for their services are the kinds of general health care regulations that the Court has allowed. However, to the extent a state wants to regulate what payers pay to providers or how payers treat consumer cost-sharing amounts, it must be careful to apply those standards only to fully-insured rather than self-insured plans.

State can take steps to limit the extent to which their regulation targets plans, rather than providers, and can thereby extend some meaningful protections to residents in self-insured plans. Specifically, billing regulation approaches that limit the amount a provider can charge (rather than establishing a minimum amount a plan must pay) are a particularly promising way for a state to design around ERISA preemption. To date states have not explored this option. State can also consider approaches that allow self-insured plans to opt in to a state regulatory scheme, and some enacted state laws contain this feature. That said, ERISA does still constrain state flexibility to enact comprehensive solutions.

A second consideration is the state’s own accumulated body of insurance law and standards regarding the practice of medicine. State limitations regarding the corporate practice of medicine and insurance “provider protections” that govern the relationship between health plans and physicians could frustrate the state’s surprise billing policy if not addressed. Finally, an evolving challenge for states is how to address situations where their residents receive care at an out-of-state facility, which can occur frequently in some regions.

Recommendations for Action

Solutions to surprise out-of-network billing should protect patients in a comprehensive manner and restore more normal market dynamics to contracting for emergency department and ancillary clinicians, which should in turn reduce health care spending. Below, are two approaches to achieving these objectives, which are likely to have similar effects in practice.

Option #1: Billing Regulation Only

The first option is a pure billing regulation approach. Under this approach, policymakers would:

- Set a limit on out-of-network charges equal to a multiple of the relevant Medicare rate in line with what non-emergency or ancillary specialists with similar training are paid by commercial payers. Given existing national data and the limited risks to setting the charge limit below “normal market” rates, 125 percent of the relevant Medicare rate could

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constitute a reasonable limit. Policymakers could modify the multiple, either nationwide or by state or market area, to reflect local market conditions.

- Require health plans to hold enrollees harmless for any cost-sharing beyond normal in-network cost-sharing amounts for these out-of-network services (and count such cost-sharing toward in-network deductibles and out-of-pocket limits).
- Apply these requirements to: (1) out-of-network emergency services (including ambulance transport but excluding services delivered after transfer to an in-network facility is offered); and (2) out-of-network ancillary clinician, hospitalist, and neonatology services delivered at an in-network facility (where a facility is defined as a hospital, ambulatory surgical center, or freestanding emergency department).

Option #2: Hybrid of Billing and Contracting Regulation

The second option is a hybrid billing regulation/contracting regulation approach. For out-of-network ambulance services and emergency services delivered at an out-of-network facility, policymakers would implement the billing regulation approach described under option #1. For the other services enumerated in the third bullet above—emergency, ancillary clinician, hospitalist, and neonatology services delivered at an in-network facility—the policy would bar independent billing, thereby implicitly requiring that insurers pay for these services entirely through payments to the facility at which they practice. (Facilities would then compensate clinicians delivering these services directly.)

By eliminating the lucrative out-of-network billing option for ED and ancillary physicians, these approaches could also reduce health care spending and insurance premiums (although for option #1, this reduction would likely only occur if policymakers set a charge limit sufficiently far below the inflated amounts currently paid for these services).

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Chairwoman WILSON. Thank you, Ms. Young. We will now recognize Ms. Schuman.

**STATEMENT OF ILYSE SCHUMAN, SENIOR VICE PRESIDENT,
HEALTH POLICY, AMERICAN BENEFITS COUNCIL**

Ms. SCHUMAN. Chairwoman Wilson, Ranking Member Walberg, and distinguished Subcommittee members, thank you for the opportunity to testify on behalf of the American Benefits Council about the growing problem of surprise medical billing. The Council applauds your willingness to examine and consider Federal solutions to protect patients from the financial pain of these surprise medical bills.

Collectively our members directly sponsor or administer health benefits for virtually all Americans covered by employer-sponsored plans. Employers are deeply concerned about the burden that unexpected medical bills from out-of-network providers place on employers and their families.

While a number of States have sought to address this problem, ERISA exempts self-insured plans from State insurance regulations to ensure that national employers can offer uniform health benefits to employees residing in different States.

Accordingly, the problem of surprise billing cannot be left to the States to solve. Indeed, we view the effort to protect patients from surprise bills within the broader context of efforts to lower health care costs.

A lack of meaningful patient choice between providers who participate in a plans network and those who don't is the key component of surprise balance billing.

In the case of emergency services provided at out-of-network facilities and air ambulance service, the patient simply needs the most expeditious stabilizing care.

Even when patients seek care at an in-network hospital from in-network providers, patients generally lack a role in choosing ancillary but necessary physician like an anesthesiologist. On the day of surgery, is the patient really going to question the network status of the anesthesiologist?

A study comparing physician charge to Medicare payment ratios across specialty sheds light on the drivers of surprise billing. Physician excess charge was higher for specialties in which patients have fewer opportunities to choose a physician or be informed of the physician's network status. For example, anesthesiologists were charging more than five times as high as the Medicare rate.

The ability of such specialties to set billing rates in this environment serves as a powerful incentive to remain out-of-network which in turn generates surprise balance bills. Clearly this constitutes market failure which necessitates legislative or regulatory intervention.

Health plan networks play a critical role in employer efforts to lower the costs and improve the quality of health care for employees and their families. They are the best tool employers have to drive better health care value.

Despite the efforts of employers to prevent unexpected balance billing or help employees faced with such a bill, the underlying problem continues. We urge Congress to develop legislation ad-

addressing surprise balance billing that protects patients without undermining access to high quality, high value networks.

One council member company with 130,000 covered lives estimates that without networks premiums would increase by approximately \$8,000, a 45 percent increase.

The council is also concerned that a requirement for payment by employer sponsored plans to providers in excess of in-network rates or by reference to build charges would discourage network participation and drive health care costs higher. Shifting the cost to payers merely masks the underlying problem of a distorted market.

We also have concerns with Federal legislation mandating finding arbitration. It would be costly, complex, and time consuming for nationwide employers. If Federal legislation does require the use of binding arbitration, policymakers should include sufficient protections to guard against increasing health care costs.

We offer the following recommendations for Federal legislation addressing the problem of surprise billing. At its root and at a nationally uniform manner. The message I'm delivering is reflected in a letter sent to you from over 30 trade associations.

No. 1, protect patient from surprise medical bills. No. 2, hospitals and physicians must provide up front information about out-of-network care and costs. No. 3, require certain reimbursement.

To ensure equitable payment for services provided without discouraging network participation, Federal legislation should establish a cap for emergency services at an out-of-network facility at 125 percent of the Medicare rate which would be clear and facilitate competition.

Legislation should also require all in-network providers, all at an—in-network facility to accept in-network rates. When a plan contracts with a hospital, it stands to reason that all essential service performed at the hospital would be included in the network.

Requiring in-network facilities to bundle medical services for covered procedures into a single payment could also help the problem if structured properly. Legislation must also address ambulance services. The council looks forward to working together on a solution that cures this problem not merely masks its symptoms.

[The statement of Ms. Schuman follows:]



TESTIMONY OF

**ILYSE SCHUMAN
SENIOR VICE PRESIDENT, HEALTH POLICY
AMERICAN BENEFITS COUNCIL**

BEFORE THE

**UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON EDUCATION AND LABOR,
SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR,
AND PENSIONS**

**HEARING ON "EXAMINING SURPRISE BILLING:
PROTECTING PATIENTS FROM FINANCIAL PAIN"**

APRIL 2, 2019

1501 M Street NW Suite 600 Washington, DC 20005 202-289-6700 Facsimile 202-289-4582 www.americanbenefitscouncil.org

Chairwoman Wilson, Ranking Member Walberg and distinguished subcommittee members:

Thank you for the opportunity to testify on behalf of the American Benefits Council about the growing problem of "surprise" medical billing. I am Ilyse Schuman, the Council's senior vice president, health policy. The Council applauds your willingness to examine and consider federal solutions to protect patients from the financial pain of these surprise medical bills.

The American Benefits Council is a Washington D.C.-based employee benefits public policy organization. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial well-being of their workers, retirees and families. Council members include over 220 of the world's largest corporations organizations serving employers of all sizes. Collectively our members directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans.

Employers are deeply concerned about the burden that unexpected medical bills from out-of-network providers place on employees and their families. Surprise balance bills arise in three scenarios:

- (1) emergency treatment at out-of-network facilities,
- (2) ambulance and air ambulance services provided by out-of-network providers and
- (3) treatments provided by out-of-network providers working at an in-network facility.

Importantly, in all cases, the patient lacks a meaningful choice between receiving treatment from a provider who is in their health plan's network, and thereby subject to contracted cost and quality requirements, or one who is outside of the network.

Surprise medical bills bring financial stress to patients and families already dealing with the challenges of a medical emergency or serious health condition. A patient receiving treatment at an in-network hospital should justifiably expect that ancillary, but necessary, services performed by facility-based physicians such as anesthesiologists, radiologists, emergency medicine physicians, and pathologists, would be covered by their health plans as in-network charges. However, when these facility-based physicians choose not to participate in a plan's network, an unexpected balance bill to a patient can threaten the financial security of working families.

Our member companies recognize the toll that surprise balance billing can take on working families. Although employers are not obligated to pick up the balance billing charges, many large employers currently do so in order to provide additional financial protection to their employees and families beyond the substantial cost the employers

already bear as sponsors of the health plan. As a result, the surprise balance billing practice is a financial burden on employer plan sponsors as well as individuals.

While a number of states have sought to address this problem through regulation of health insurance sold in the state, over 60 percent of employer-sponsored coverage is offered to employees through self-funded group health plans. ERISA exempts self-insured plans from state insurance regulations to ensure that national employers can offer uniform health benefits to employees residing in different states. Accordingly, the problem of surprise billing cannot be left to the states to solve. Adequately addressing this problem in a way that limits the financial burden on all consumers necessitates a federal solution.

It is important to recognize that, while the magnitude of the surprise billing problem may not be great relative to the plan's overall spend, for a patient receiving a surprise medical bill it could impose substantial financial hardship. Beyond the individual patients and families financially burdened with these unexpected balance bills from out-of-network providers, this issue has significant implications for the health care system as a whole. We view the effort to protect patients from surprise bills within the broader context of efforts to lower health care costs. As such, we urge the subcommittee to consider addressing surprise balance billing in a manner that protects patients without undermining access to high-quality, high-value networks or increasing health care costs for individuals and employers.

A LACK OF MEANINGFUL PATIENT CHOICE

A key component of surprise balance billing is the "surprise" – that is, the lack of information necessary for patients to make informed decisions about the health care services they receive and from whom. In all three of the situations mentioned above, this lack of information and subsequent lack of informed choice arise, albeit in slightly different ways. In the case of emergency services provided by out-of-network facilities and air ambulance services, the patient – simply put – has no choice. Assuming that the patient is conscious, the emergent nature of the condition requiring the medical treatment presents the dilemma of identifying an in-network facility or provider in lieu of receiving the most expeditious stabilizing care. Such a choice is, in fact, no choice at all.

In the third scenario, where patients seek care at in-network facilities from in-network providers, patients generally lack the information necessary at the time of scheduling to receive care from an in-network ancillary (but necessary) service provider like an anesthesiologist, radiologist, or pathologist. On the day of surgery, is the patient really going to question the network status of the anesthesiologist? Again, the patient is left with effectively no choice at all. While different solutions may be more aptly suited to these different issues, the common theme of all three is that patients lack the true

ability to avail themselves of a network provider, leaving the patient without knowledge or choice with respect to out-of-network providers.

A Kaiser Family Foundation analysis¹ of medical bills from large employer plans found that a significant share of inpatient hospital admissions includes bills from providers not in the health plans' networks. Nearly one in five inpatient admissions includes a claim from an out-of-network provider. The analysis found that almost 18% of inpatient admissions result in non-network claims for patients with large employer plan coverage.

Even when enrollees choose in-network facilities, 15% of admissions include a bill from an out-of-network provider, such as from a surgeon or an anesthesiologist. For inpatient admissions, those that include an emergency room claim are much more likely to include a claim from an out-of-network provider than admissions without an emergency room claim. This is the case whether or not enrollees use in-network facilities.

As with inpatient admissions, outpatient service days with a facility claim that include a visit to the emergency room are much more likely to include a claim from an out-of-network provider, whether or not enrollees use in-network facilities. The analysis also found that enrollees with anesthesia or pathology claims are more likely to have an out-of-network provider claim, even when using in-network facilities.

For out-of-network emergency services, Congress and the U.S. departments of Labor, Health and Human Services, and the Treasury ("the Departments") have recognized the need for robust out-of-network coverage of emergency services. Section 2719A of the Public Health Service Act, which applies to all insured plans and to self-funded plans through Section 715 of ERISA, limits the plan's ability to impose cost shares on these services that are not applicable to in-network emergency services. The Departments adopted a "Greater-of-Three" rule, which imposes a minimum reimbursement amount on plans but does nothing to prevent the provider from balance billing patients.

A lack of choice also defines the massive costs associated with non-participating ambulance and air ambulance services. According to GAO's analysis of the most complete data identified for air ambulance transports of privately-insured patients, 69 percent of about 20,700 transports in the data set were out-of-network in 2017.² This imbalance reflects the incentives that balance billing creates for providers to remain out-of-network. As with emergency services, ambulance and air ambulance services are essential to ensure that patients receive the care they need in the most urgent of

¹<https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-%20health-plans/>

²<https://www.gao.gov/assets/700/697684.pdf>

situations. By subjecting patients in these most dire of circumstances to balance billing, it exposes patients to material liabilities in order to receive the care they need.

Even in the case of the non-emergent surprise balance billing scenario at inpatient facilities, the patient often lacks a role in choosing an out-of-network provider and the necessary information to make an informed decision about provider network status. Despite the patient's efforts to select an in-network facility and in-network surgeon, patients are exposed to the threat of balance billing because necessary, but ancillary, providers who are engaged by the hospital without disclosure to the patient do not participate in the same networks as the patient. This is so because the out-of-network providers of ancillary services receive all the benefits of in-network status, *i.e.*, increased utilization, but are able to exact much larger reimbursements by remaining out-of-network.

A study by Ge Bai and Gerard F. Anderson, published in the Journal of the American Medical Association in 2017 comparing physician charge-to-Medicare payment ratio across specialties, sheds light on the drivers of surprise billing. Data from 429,273 individual physicians across 54 medical specialties were included. The physician charge-to-Medicare payment ratio ranged between 1.0 and 101.1 across individual physicians, with a median of 2.5. Among the 54 specialties studied, anesthesiology had the highest median (5.8), followed by interventional radiology (4.5), emergency medicine (4.0), and pathology (4.0). The ratio also varied across states. The study concluded that: "Physician excess charge was higher for specialties in which patients have fewer opportunities to choose a physician or be informed of the physician's network status (e.g. anesthesiology)."³

A study by Zack Cooper, Fiona Scott Morton and Nathan Shekita (the "Cooper study")⁴ similarly explains that a "fundamental problem" in emergency medicine in the United States is that emergency department physicians face inelastic demand from patients when they are practicing inside in-network hospital emergency departments. As a result, these hospital-based physicians need not set their prices in response to market forces, as noted in the study:

Because they are part of a wider bundle of hospital care and cannot be avoided once the hospital choice is made, emergency physicians (and other specialist physicians like radiologists, pathologists, and radiologists) face inelastic demand from patients and will not see a reduction in their patient volume if they fail to negotiate contracts with insurers.

³<https://jamanetwork.com/journals/jama/fullarticle/2598253>

⁴<https://www.nber.org/papers/w23623.pdf>

A recent report by the USC-Brookings Schaeffer Initiative for Health Policy drew a similar conclusion about why surprise out-of-network bills happen, stating that:

For most physicians in most geographic areas, it is not possible to maintain a practice without entering some insurer networks because few patients are willing to bear the higher costs associated with seeing an out-of-network physician. However, for some types of physicians, that basic dynamic does not apply. For ED physicians, patient volume is driven by patients' choice of hospital and is unlikely to be affected by whether the physician is in-network or not; hospitalists and neonatologists face a similar dynamic.⁵

The ability of such specialties to set billing rates in this environment serves as a powerful incentive to remain out-of-network, which, in turn, generates surprise balance bills. Clearly, this constitutes a market failure which necessitates legislative or regulatory intervention. In these situations where the consumer does not have a role in choosing their providers, the consumer is not the problem. The problem is that the consumer does not have a choice.

THE CHANGING LANDSCAPE FOR OUT-OF-NETWORK REIMBURSEMENT

The landscape for out-of-network reimbursement is changing. This is the message of a 2018 Milliman white paper (the "Milliman Report")⁶ and the experience of Council member companies. The paper reports that billed charge trends have consistently outpaced in-network reimbursement trends, and that "most billed charge trends are considered out of sync with costs and well above typical in-network reimbursement." The paper further notes that for some markets, it is common to see hospital billed charge levels many times those of typical commercial in-network reimbursement rates with Medicare and other government payer charge levels usually much lower.

Historically, many plans have reimbursed out-of-network providers as a percentage of billed charges. This reflected an economic assumption that billed charges would correlate with the financial cost to the provider with a premium imposed because the provider is not reaping the benefit of in-network status with the plan. The changing dynamics in the amounts billed by out-of-network providers, however, no longer accurately reflect that economic assumption.

The Cooper study, focusing on out-of-network billing for emergency care, found that physicians charge, on average, 637 percent of what the Medicare program would pay for identical services, which is 2.4 times higher than in-network payment rates.

⁵ https://www.brookings.edu/wp-content/uploads/2019/07/Adler_et-al_State-Approaches-to-Mitigating-Surprise-Billing-2019.pdf

⁶ <http://us.milliman.com/uploadedFiles/insight/2018/changing-landscape-on-reimbursement.pdf>

As the gulf between billed charges and in-network rates grows, the Milliman Report observes that many payers – including some Council member companies – are redefining out-of-network reimbursement as a multiple of Medicare rather than based on a percent of billed charges. The Milliman Report also describes another approach payers are taking to address out-of-network reimbursement – paying the in-network level for the market, determined as an average for providers in the market, or the standard base schedule, or even below the network level for non-emergency care.

Council members see the increasing disconnect between billed and network charges and the pressure it places on both patients and the benefit plans their employers sponsor. Reimbursing out-of-network providers by reference to billed charges is unsustainable and will result in even higher health care costs and fewer in-network providers. **As Congress seeks to address surprise balance billing as part of a broader goal of lowering health care costs and improving price transparency, the finding that most billed charge trends are “out of sync” with costs and “well above” typical in-network rates is alarming. We urge you to consider an approach that would narrow this gap, lower costs and enhance transparency – not widen this gap even further by creating incentives for providers to be out-of-network and increase billed charges in an effort to increase the final reimbursement they receive.**

THE IMPORTANCE OF HIGH-QUALITY, HIGH-VALUE NETWORKS

Health plan networks play a critical role in employer efforts to lower the cost and improve the quality of health care for employees and their families. Understanding the importance of networks in driving better health care value is at the foundation of understanding the surprise billing problem and developing an effective solution.

As plan sponsors, employers take great care to provide their employees and their families access to networks of providers that: (1) provide high quality health care services, (2) provide those services at reasonable and predictable costs to both plans and patients, and (3) control the aggregate cost of health care services. Patients generally face higher out-of-pocket costs under the terms of the health plan when using an out-of-network provider as an incentive to utilize network providers. However, because there is no contractual agreement in place between the out-of-network provider and the plan (or its third-party administrator), there is no ability for the plan to either predict patient costs or prevent any liability owed to the provider outside of the plan. The implications of this lack of a contractual agreement – and, critically, the reasons for it – are under examination by the subcommittee today.

It is essential that any legislative solution protects patients without undermining access to high-quality, high-value networks. The ability of certain specialists to set billing rates in an environment in which a patient chooses an in-network facility and the

ancillary provider receives the automatic referral serves as a powerful incentive to remain out-of-network and fuels the surprise medical bills patients are facing. Clearly, this constitutes a market failure that limits the benefit of networks in controlling costs for patients and plans.

A federal solution to surprise billing should serve to lower, not increase, premiums and lower costs for consumers and employer plan sponsors. Undermining high-quality, high-value networks removes the greatest leverage plans have to lower health care costs. Setting a federal requirement in a way that discourages network participation would result in higher costs for consumers. The resulting premium increase also makes plans more likely to trigger the looming "Cadillac Tax," the 40 percent excise tax on employer-sponsored health plans that cost above a certain level.

EMPLOYER RESPONSE TO SURPRISE MEDICAL BILLS

Council member companies are taking steps to limit the incidence of surprise billing in the first place through, for example, enhanced communications to employees about the potential for balance bills from out-of-network providers. Our members recognize the stress and financial devastation surprise medical bills can bring to working families and provide assistance to their employees in multiple ways. This assistance may take the form of contracting with other entities to negotiate the bill with the provider on the employee's behalf. Some employers provide balance bill legal defense services for employees to contest balance bills themselves.

Despite the efforts of plans to prevent unexpected balance billing or help employees faced with such a bill, the underlying problem continues. We are concerned that federal legislation enshrining a reimbursement rate for out-of-network providers in excess of in-network rates will eliminate what remains of plans' negotiating leverage to avoid or reduce the incidence and amount of surprise billing.

NEED FOR FEDERAL SOLUTION: EVALUATING POLICY APPROACHES

Understanding the problem is the key to finding a solution. Congress should develop legislation addressing surprise balance billing that protects patients without undermining access to high-quality, high-value networks or increasing health care costs for individuals and employer providers of health coverage. We urge Congress not to widen this gap even further by guaranteeing out-of-network providers a reimbursement rate that discourages network participation.

The Council is concerned that a requirement for payment by employer-sponsored plans to providers in excess of in-network rates would discourage network participation and drive health care costs higher. We are also concerned that using any

reference to billed charges, such as the 80th percentile of charges, as a payment benchmark would undermine participation in high-value networks and drastically increase costs for all consumers. Any attempt to characterize billed charges by facility-based physicians as reflective of market value is belied by the fact that the “market” itself is distorted. When patients have fewer opportunities to choose a physician or to be informed of the physician’s network status, the marketplace for these services is not functioning.

Shifting the cost of surprise balance billing from patients to payers merely masks the underlying drivers of charges from out-of-network providers for emergency treatment or at an in-network facility. Health plan networks promote better quality and lower cost for consumers. Moreover shifting the burden of balance billing from the patient to the plan or employer will no doubt result in higher premiums and increased costs for all consumers, and will do little to eliminate the underlying source of the issue. A federal solution to surprise balance billing should serve to lower, not increase, premiums and costs for consumers and employer plan sponsors, and the entire health economy as a whole.

Binding arbitration is an inefficient and ineffective approach to addressing surprise billing. We have serious procedural and substantive concerns with federal legislation mandating binding arbitration. For large companies with nationwide operations, a binding arbitration model would be administratively complex, costly and time-consuming. The experience of the mediation process in Texas is instructive. According to a recent report,⁷ the Texas Department of Insurance received just 43 requests from consumers for mediation in 2013. In 2014, the number of requests grew to more than 600 and have climbed steeply ever since. There were 4,519 requests in 2018, creating a significant backlog, and regulators expect 8,000 during the current fiscal year. The Texas experience is illustrative of the administrative challenges of a nationwide mandated dispute resolution process. If federal legislation requires the use of binding arbitration to resolve disputes between payers and providers, at a minimum, policymakers should include sufficient protections to guard against increasing health care costs and undermining value-based networks. For example, arbitrators should not be allowed to take billed charges into consideration.

POLICY RECOMMENDATIONS

We offer policy recommendations for federal legislation directed at addressing the problem of surprise balance billing at its root and in a nationally uniform manner.

⁷<https://www.texastribune.org/2019/02/12/texas-mediation-balance-billing-faces-massive-backlog/>

1. Protect patients from surprise medical bills.

Federal legislation to protect patients from surprise medical bills must begin with capping patient cost-sharing at in-network amounts. To protect consumers and families, federal legislation should prohibit balance billing of patients for emergency services provided at an out-of-network facility, for treatment by an out-of-network provider at an in-network facility, and out-of-network ambulance and air ambulance providers. Federal legislation should ensure patient cost-sharing is limited to in-network amounts for emergency services performed at an out-of-network facility, for treatment by out-of-network facility-based physicians performed at in-network facilities or for out-of-network ambulance or air ambulance providers.

2. Ensure disclosure and transparency.

Take the “surprise” out of surprise billing by requiring hospitals and other providers to disclose upfront information to patients about pricing and out-of-network care. Patients should be informed about out-of-network care and cost at the time of scheduling non-emergency care at an in-network facility and follow-up care from emergency treatment at an out-of-network facility.

3. Require certain reimbursement.

To ensure equitable payment for the services provided without discouraging network participation or resulting in higher costs for all consumers, federal legislation must set a reasonable federal reimbursement structure that:

- a. Establishes a federal cap for emergency services at an out-of-network facility at 125 percent of the Medicare rate. Using a Medicare rate eliminates problems inherent in relying upon a method based on billed charges. This approach is clear and would facilitate competitive, balanced negotiation.
- b. Requires all providers at an in-network facility to accept in-network rates. Federal legislation should require in-network facilities to accept in-network reimbursement rates for all care performed at the facility by all providers associated with the facility. When a plan contracts with a hospital, it stands to reason that essential services performed at the facility – emergency, anesthesiology, radiology and pathology – would be included in the network. No one would purchase a car without a steering wheel or tires. Yet, these are the very specialties that – by virtue of their necessity – are unhampered by competitive market forces in setting their rates or electing not to participate in a network. Requiring in-network facilities to bundle medical services for covered procedures into a single payment also could help address this problem if structured properly. In the case of bundled services performed by out-of-network providers, the costs of those services within the bundle cannot

exceed either the allowable in-network rate or 125% of Medicare. But, care must be taken to ensure that the contracted bundled payment is final and not merely a progress point toward further negotiation.

4. Address ambulance services.

Any legislative solution for surprise balance billing should also specify that ambulances and air ambulance services are considered emergency services for purposes of the statutory limitations on balance billing and reimbursement rates.

* * * * *

The Council shares your concern with surprise medical bills and the financial pain they inflict on patients. We look forward to working together on a solution that cures this problem, not merely masks its symptoms. With this goal in mind, relief can come to patients burdened by surprise medical bills and all consumers seeking lower cost and better quality health care.

I appreciate the opportunity to testify, and the Council looks forward to working with this subcommittee, and all the members of the Education and the Labor Committee, to advance these proposals.

Truth in Testimony Disclosure Form

In accordance with Rule XI, clause 2(g)(5)*, of the *Rules of the House of Representatives*, witnesses are asked to disclose the following information. Please complete this form electronically by filling in the provided blanks.

Committee: Education and Labor

Subcommittee: Health, Employment, Labor, and Pensions

Hearing Date: April 2, 2019

Hearing Title :

Examining Surprise Billing: Protecting Patients from Financial Pain

Witness Name: Ilyse Schuman

Position/Title: Senior Vice President, Health Policy

Witness Type: ☐ Governmental ☒ Non-governmental

Are you representing yourself or an organization? ☐ Self ☒ Organization

If you are representing an organization, please list what entity or entities you are representing:

American Benefits Council

If you are a non-governmental witness, please list any federal grants or contracts (including subgrants or subcontracts) related to the hearing's subject matter that you or the organization(s) you represent at this hearing received in the current calendar year and previous two calendar years. Include the source and amount of each grant or contract. *If necessary, attach additional sheet(s) to provide more information.*

N/A

If you are a non-governmental witness, please list any contracts or payments originating with a foreign government and related to the hearing's subject matter that you or the organization(s) you represent at this hearing received in the current year and previous two calendar years. Include the amount and country of origin of each contract or payment. *If necessary, attach additional sheet(s) to provide more information.*

N/A

False Statements Certification Knowingly providing material false information to this committee/subcommittee, or knowingly concealing material information from this committee/subcommittee, is a crime (18 U.S.C. § 1001). This form will be made part of the hearing record.	
 _____ Witness signature	3/28/19 _____ Date

If you are a non-governmental witness, please ensure that you attach the following documents to this disclosure. Check both boxes to acknowledge that you have done so.

- ☒ Written statement of proposed testimony
- ☒ Curriculum vitae

*Rule XI, clause 2(g)(5), of the U.S. House of Representatives provides:

(5)(A) Each committee shall, to the greatest extent practicable, require witnesses who appear before it to submit in advance written statements of proposed testimony and to limit their initial presentations to the committee to brief summaries thereof.

(B) In the case of a witness appearing in a nongovernmental capacity, a written statement of proposed testimony shall include a curriculum vitae and a disclosure of any Federal grants or contracts, or contracts or payments originating with a foreign government, received during the current calendar year or either of the two previous calendar years by the witness or by an entity represented by the witness and related to the subject matter of the hearing.

(C) The disclosure referred to in subdivision (B) shall include—

- (i) the amount and source of each Federal grant (or subgrant thereof) or contract (or subcontract thereof) related to the subject matter of the hearing; and
- (ii) the amount and country of origin of any payment or contract related to the subject matter of the hearing originating with a foreign government.

(D) Such statements, with appropriate redactions to protect the privacy or security of the witness, shall be made publicly available in electronic form not later than one day after the witness appears.

Ilyse Schuman

Senior Vice President, Health Policy

Ilyse Schuman is senior vice president, health policy, for the American Benefits Council. In this role, Ilyse directs the development and advocacy of the Council's health policy priorities. Before joining the Council staff, Ilyse was the Council's Policy Board of Directors Advisory Council representative from Littler Mendelson, P.C., where she was co-chair of the Workplace Policy Institute. In this role, Ilyse provided strategic counsel and representation to clients on a broad array of workplace issues and developments in Congress and executive branch federal agencies. She was also a member of the firm's ERISA/Employee Benefits practice and co-led the firm's Legislative and Regulatory practice.

A former top congressional staff member and policy advisor, Ilyse worked on the Senate Committee on Health, Education, Labor and Pensions from 2001 to 2008, culminating in her role as minority staff director and chief counsel. She began her work in the Senate as chief labor counsel for Senator Mike Enzi (R-WY) on the Subcommittee on Employment, Safety and Training. After leaving the Senate, Ilyse served as managing director of the Medical Imaging and Technology Alliance. Ilyse also has served as in-house counsel at a manufacturer and market and technology leader. She holds a bachelor's degree from Tufts University Jackson College and a law degree from Georgetown University.



Chairwoman WILSON. Thank you, Ms. Schuman.
 Ms. SCHUMAN. I am happy to answer any questions.
 Chairwoman WILSON. Thank you. We will now recognize Mr. Isasi.

**STATEMENT OF FREDERICK ISASI, J.D., MPH, EXECUTIVE
 DIRECTOR, FAMILIES USA**

Mr. ISASI. Thank you very much, Chairwoman Wilson and Ranking Member Walberg and members of the subcommittee. Thank you for the opportunity to speak with you today. I am Frederick Isasi, the Executive Director of Families USA. For nearly 40 years, we have served as one of the leading national voices for health care consumers both in Washington, DC. and on the State level.

Our mission is to ensure that every individual live to their greatest potential by ensuring that the best health care is equally accessible and affordable to all.

Surprise out-of-network medical bills are a truly egregious and all too frequent example of how distorted economic incentives in the health care sector are overwhelming the interests of patients and families.

A whopping 1 in 5 emergency department visits results in surprise medical bills. These bills can account—can amount to hundreds, thousands, and even tens-of-thousands of dollars. This is an utterly nonpartisan issue affecting people across the country in both rural and urban areas.

Given this committee's jurisdiction, it is critical to note that self-insured as we have heard today self-insured ERISA health plans are as likely to experience surprise billing as fully insured and individual plans.

So, what is most important to remember about this issue? We are talking about situations in which families despite enrolling in health insurance, paying their premiums, doing their homework, and trying to work within the system are being left with completely unanticipated and sometimes financially devastating health care bills.

And this is happening in part and I want to say this really clearly because hospitals, doctors, and insurers are washing their hands of their patients' interest.

Take for example one significant driver of this problem. The movement of hospitals to offload staffing requirements for their emergency departments to third party management companies. These hospitals very often make no requirements of these companies to ensure the staffing of the ED fit within the insurance networks that the hospitals have agreed to.

As a result, a patient who does their homework ahead of time and rightly thinks they're going to an in-network hospital receives services from an out-of-network physician and a surprise medical bill follows.

Let me give you one real world example. Nicole Briggs from Morrison, Colorado outside of Denver. Nicole woke up in the middle of the night with intense stomach pain. She went to a free-standing ER. She was told she needed an emergency appendectomy. She went to her local hospital.

She did her due diligence. Confirmed repeatedly that the hospital and its providers were in-network. However, months later she received a surprise bill from the surgeon who ended up was out-of-network. The bill to Nicole was \$5,000.

Nicole tried to work it out with her insurance company but within 2 years a collection agency representing the surgeon took her to court and won the full amount, including interest. As a result, a lien was placed on her home and the collection agency garnished her wages each month.

This came right before Nicole was about to deliver a baby and go on maternity leave.

And by the way, this investigation found that there were over 170 liens placed on people's homes in the Denver area by emergency department physicians. And this is just one example.

Consumers are exposed to surprise medical bills in other ways. Often as we have heard ground and air ambulances are out-of-network and many ancillary services like anesthesiology, laboratory services, imaging services can be out-of-network despite the fact the facility and the physician that is supervising are all in-network.

This is inexcusable behavior on the part of hospitals, doctors, and health insurers. They each know or should know that patients have no real way of understanding the financial trap they have just walked into.

In these surprise bill instances, it is the providers and insurers, not the patients who should bear the burden of settling on a fair payment.

Nicole and millions of families around this Nation need you to act. There are—they are paying their premiums trying to do their due diligence and to operate within the system, but the current system is leaving them financially vulnerable and destabilized.

To put the needs of families first, we built a coalition and developed 5 key principles for legislative action by Congress to address surprise medical bills.

The first, and we have heard this from, I think from the whole panel so far. Providers should be prohibited from billing for surprise out-of-network services and these protections should trigger automatically without consumers having to jump over hurdles.

Second, it should prevent surprise out-of-network payments from increasing health insurance premiums. That's really important. Consumers care about their premiums too.

Third, legislation should apply protections to all commercial health insurance plans, including ERISA plans that this committee has jurisdiction over.

Fourth, protection should apply to all care settings and care types where families can receive out-of-network bills due to no fault of their own.

And finally, we are very supportive of increased transparency in the health care sector. We fight for it all the time. But we underscore in this instance increased transparency cannot be the only or main strategy to deal with this problem.

So we are grateful for being able to testify to the subcommittee. I would be very happy to talk about these principles more or answer any questions.

[The statement of Mr. Isasi follows:]



Testimony of Frederick Isasi, JD, MPH
Executive Director
Families USA

The Impact of Surprise Out-of-Network Medical Bills on Consumers

Before the House Education and Labor Committee
Subcommittee on Health, Employment, Labor, and Pensions

April 2, 2019

Families USA
1225 New York Avenue, NW
Suite 800
Washington, DC 20005

Chairwoman Wilson, Ranking Member Walberg, and Members of the House Education and Labor Committee's Subcommittee on Health, Employment, Labor, and Pensions – thank you for the opportunity to speak with you today. I am Frederick Isasi, the Executive Director of Families USA. For nearly 40 years, we have served as one of the leading national voices for health care consumers both in Washington, D.C. and on the state-level. Our mission is to allow every individual to live to their greatest potential by ensuring that the best health care is equally accessible and affordable to all.

The Larger Context of Health Care Costs for Families

Unfortunately, while our country has made substantial progress in health care coverage over the last several decades,¹ health care costs continue to rise much faster than paychecks and erode the financial security of our nation.² The consequences of rapidly growing health care costs are real. Approximately 40 percent of our nation's families report not receiving needed medical care³ because the costs are unaffordable and 44 percent say they didn't go to a doctor when they were sick or injured in the past year because of cost.⁴ Additionally, a startling 30 percent of people in our nation report that health care costs are interfering with their ability to meet the most basic necessities of their life, like securing food, heating, or housing.⁵

We are one of the wealthiest nations in the world and we spend twice as much as other high-income nations to provide health care.⁶ People across this nation should not have to live in fear of getting sick and facing a sudden, crippling financial burden. And, yet, this what so many American families experience every day.⁷ In fact, a larger percentage of the population actually fear medical bills from a serious illness than the serious illness itself (40 percent vs. 33 percent).⁸ What's more, according to the American Psychological Association, the stress associated with medical bill anxiety can actually make them sicker.⁹

The Consequences of Surprise Medical Bills

Surprise out-of-network medical bills truly are an egregious example of how our health care system is allowing consumers' costs to spin out of control. Surprise bills can undermine and even destroy the financial security that families are attempting to build and maintain by purchasing comprehensive health insurance.¹⁰ Surprise medical bills are incredibly common. In fact, one-in-five emergency department visits that families make result in surprise medical bills.¹¹ These bills can result in hundreds, thousands, and even tens-of-thousands of completely unanticipated out-of-pocket costs.¹² They occur most often when families receive emergency care or, when families do their very best to go to an in-network provider and suddenly, after-the-fact, discover ancillary services like anesthesiology, radiology, lab,¹³ or ambulance¹⁴ fall outside of their provider network. Surprise out-of-network billing is an utterly non-partisan issue. It is occurring across the nation and in both rural and urban settings.¹⁵

Allow me to highlight the experience of Nicole Briggs, from Morrison, Colorado. Nicole woke up in the middle of the night with intense stomach pain. After first visiting a free-standing ER, she was told she needed an emergency appendectomy, and she went to

the local hospital. She did her due diligence to confirm repeatedly that the hospital and its providers accepted her insurance. However, months later, she received a surprise bill from the surgeon for \$4,727. While the hospital was in-network, the surgeon was an independent, out-of-network provider.

Nicole explained the situation to the insurer, but they continued to demand payment. She declined to pay the bill, and within two years, a credit agency representing the surgeon took her to court, and won the full amount, including interest. As a result, a lien was placed on her home, and the collection agency garnished her wages by 25 percent each month. This came right as she was pregnant and about to go on maternity leave.¹⁶

The Cause of Surprise Bills

Surprise out-of-network bills are a terrible example of how distorted economic incentives in the health care sector are overwhelming the interests of patients. They're an example of how easily providers and payers have washed their hands of caring for their patients and are sacrificing the financial security of our nation's families to generate revenue or turn a profit. Surprise out-of-network bills are the result of a systemic problem in our health care system that places consumers directly in the middle of a tug-of-war between health care providers and insurers over the price of services.¹⁷

Central to the business model of providers and insurers is the rate negotiated between them for services. Larger hospital systems have significant leverage, allowing them to command top dollar for in-network rates. Insurers are often forced to pay their high charges for in-network status, or insurers may simply walk away from the negotiation.¹⁸ On the other hand, when hospitals are smaller, insurers hold the leverage. Those hospitals must choose between accepting lower negotiated rates than they desire, or walking away from the negotiation and providing care out-of-network.¹⁹ These distorted market incentives lead to out-of-network provider status and ultimately, harmful surprise bills for families. In general, compared to in-network providers, out-of-network providers charge nearly three times as much for care.²⁰ This leaves families with balance bills that average over \$600, but can exceed \$20,000.²¹

One significant driver of this problem is the movement by hospitals to off-load staffing requirements for their emergency departments to third-party management companies that have no responsibility to ensure staffing fit with the provider networks otherwise agreed to by the hospital.²² In fact, two-thirds of hospitals in the US outsource the staffing of their emergency departments to third-party physician management firms.²³ Research shows that out-of-network claims are higher in hospitals that contract with common staffing companies.²⁴ All too often, these firms use a business model that leverages the higher prices that can be charged with an out-of-network status.²⁵ As a result, a patient with a medical emergency, who rightly thinks they are going to an in-network hospital, often receives professional services from an out-of-network physician. This is inexcusable behavior on the part of the hospital, doctor, and health insurer. They each know or should know that patients have no real way of understanding the financial

trap they have walked into. In these surprise bill instances, we and many believe it is the providers and payers who should bear the burden of settling on a fair payment.²⁶

The Intersection of Hospital Non-profit Status and Surprise Billing

Recent research has found that surprise billing, while widespread, is not evenly distributed among hospitals.²⁷ Specifically, nonprofit hospitals, teaching hospitals, and government-owned hospital have lower than average rates of out-of-network bills. For-profit hospitals have higher rates of surprise bills and higher out-of-network billing rates.²⁸ Finally, hospitals in areas with higher rates of economic inequality are more likely to have surprise bills.²⁹

However, there are countless exceptions to this overall trend. Sadly, many nonprofit and public hospitals with billions of dollars in favorable tax status and charitable donations are engaging in this egregious balance billing.³⁰ These hospitals receive a non-profit tax status because of the "community benefit" they purport to provide. In total this nonprofit tax status is worth at least \$25 billion to hospitals on an annual basis.³¹ What could be a more basic and fundamental community benefit than ensuring that patients who come to these nonprofit hospitals in need of critical care do not end-up experiencing a surprise, financial catastrophe?

For example, in January of this year, news reports revealed that Zuckerberg San Francisco General Hospital, the largest public hospital and only Level 1 trauma center in San Francisco, does not contract with any providers who are in-network whatsoever.³² While more than 90 percent of the hospital's patients are either uninsured or covered by Medicare or Medicaid, for the thousands of people with private insurance who seek emergency care at San Francisco General, or who *must* visit the hospital due to the severity of their medical need, there is no way to avoid surprise medical billing. Only after being exposed by Vox Media did the hospital decide to change its predatory billing practices.³³ It is unforgivable that facilities that are exempt from paying taxes and receive large sums of charitable contributions are saddling consumers with thousands of dollars of unexpected medical bills for the provision of critical care. And it is unacceptable that it takes an exposé by a national media outlet to shame hospitals to change their behavior.

Surprise Billing in Self-Insured, ERISA Plans

Given this committee's jurisdiction, it is critical to note that surprise medical bills are caused by systemic issues that pervade the health care system and can be found across health insurance plans. Consumers who receive coverage through self-insured, ERISA health insurance plans are *no less likely* to receive a surprise bill than those in fully insured group or individual plans.³⁴

As you know, ERISA pre-empts state law, and thus, only Congress can enact protections that comprehensively reach into ERISA plans.³⁵ A large majority of working families across the nation— 61 percent-- are enrolled in ERISA health insurance products and are looking to this Committee and Congress for action.³⁶ Among people with large

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employer coverage, nearly one in five (17.6 percent) inpatient admissions includes a claim from an out-of-network provider. And 15.4 percent of inpatient admissions with only in-network facility claims include a claim from a non-network provider. When the inpatient admission includes an emergency room claim, the share of claims that include non-network providers jumps to 24.7 percent (for in-network facilities).³⁷

Take, for example, the experience of Stacey Shapiro, a first-grade teacher in the public school system in Austin, Texas. Stacey woke up one morning not feeling well. A short while later, she passed out on the bathroom floor and her boyfriend took her to the nearest hospital. After a few hours of tests, IV fluids, and anti-nausea medications, doctors diagnosed her with hypoglycemia, or low blood sugar. For this relatively simple visit, Stacey received a surprise bill of \$6,720. Stacey says she received instruction from her Austin Independent School District insurer to just pay the deductible of \$1,275. However, the hospital continued to send her bills for the remaining \$5,000. Stacy eventually contacted a local press outlet to tell her story. Only after the local outlet contacted the hospital did the hospital tell Stacy that she had fulfilled her financial obligations.³⁸

While it is reasonable to expect consumers to “shop around” for in-network providers when they have the luxury of time, in an emergency situation, no one should have to worry about the financial consequence of taking a loved one to the nearest emergency room.

The Range of Care that Results in Surprise Bills

Although the frequency of surprise bills is high in emergency departments and among select physician providers that are involved in facility-based care, consumers are exposed to surprise medical bills in other care settings and from other provider types.³⁹ Often, ground⁴⁰ or air ambulance providers that transport patients for emergency care are out of network.⁴¹ Moreover, new research shows laboratory services also can be a common source of surprise medical bills.⁴² For example, the Health Care Cost Institute examined how often a professional claim for various specialties and care types was out-of-network when associated with an in-network admission. Their research found that more than one out five lab claims (22.1 percent) for inpatient hospital care in an in-network hospital were billed as out-of-network.⁴³ State regulators also report consumer complaints of surprise bills from out-of-network lab work. For example, Pennsylvania Insurance Commissioner Jessica Altman has described multiple consumers in her state receiving surprise bills after visiting their in-network OB/GYN’s office because their mammograms were sent to out-of-network labs for review.⁴⁴

Addressing the Problem of Surprise Bills

The ubiquity of surprise medical bills in all types of health plans and in all states warrants immediate federal action. Current federal law enacted as part of the Affordable Care Act (ACA) provides limited protections that apply to families who receive out-of-network care in emergency situations.⁴⁵ Specifically, the ACA limits copayments and coinsurance charged *by the insurer* to in-network rates, when families receive services

from an out-of-network emergency provider.⁴⁶ Despite these protections, however, providers may still balance bill families for additional out-of-network costs. Furthermore, insurers are not required to count copayments or coinsurance paid by a family toward in-network deductibles and out-of-pocket caps.⁴⁷ Thus, current federal law leaves families with considerable financial exposure for surprise out-of-network bills for emergency services and no protections for other categories of surprise, out-of-network bills.

Principles for Surprise Bill Legislation

To ensure that surprise bill protections truly put the needs of families first, Families USA and our consumer partners recommend that Congress consider the following principles in crafting legislation:

- **Hold Consumers Harmless:** Most importantly, legislation must ensure that families are held harmless from surprise out-of-network balance bills, which they receive due to no fault of their own. Importantly, families should not have to take any action to trigger such protections and providers should be prohibited from sending such bills. Furthermore, in a surprise billing situation, insured families should never have to pay more than their standard, in-network cost-sharing requirements. Legislation also should be explicit that these capped cost-sharing payments accrue to in-network deductibles and out-of-pocket caps.
- **Protect against surprise bills increasing health insurance premiums:** It is critical that Congress not only consider the immediate impact of surprise bills on families' out-of-pocket costs, but also the impact of these bills on the overall health insurance premiums paid by families, employers, and the government. Thus, some reasonable standard should be established for what insurers must pay providers for surprise out-of-network care. Such safeguards should take into account the importance of protecting the ability of the health insurance market to operate and for healthy negotiations between providers and payers. This payment cap should be limited to instances of true, surprise billing that occur by no fault of the consumer and is out of families' control. Families USA is open to various mechanisms to determine payment limits, including benchmark rates based on Medicare payment or a binding arbitration process with appropriate guardrails. Other approaches could require hospitals to negotiate a bundled payment for all services rendered, including the costs of providers and/or ancillary care.⁴⁸
- **Protect consumers in all health plans:** Legislation should apply protections to all commercial health insurance plans. This includes self-insured plans, as well as fully insured individual, small group, and large group plans. This is important because consumers receive surprise bills indiscriminately across all plan types.⁴⁹
- **Protect consumers in all care settings and from all providers:** While surprise medical bills occur at high frequency in emergency situations and from a specific set of provider types involved in facility-based care, consumers are also exposed to surprise medical bills in other care settings and from other providers.⁵⁰

Surprise bill protections should apply to all care settings and care types from which a consumer could receive an out-of-network bill due to no fault of their own. This will ensure, for example, that if a consumer visits an in-network doctor who sends their labs out-of-network to be read, the consumer will not be responsible for a surprise balance bill from the lab.

- **Transparency alone does not solve this problem:** In discussions of surprise billing, often the question arises of whether increased transparency for families could be a sufficient way for Congress to address the problem. We and many experts believe that transparency is not enough.⁵¹ For example, in many surprise billing cases, the affected patient has little-to-no ability to seek an alternative in-network provider due to the medical urgency of their situation, even if more information were provided. Furthermore, there is strong evidence that the health care sector does not have the ability to provide to consumers actionable, real-time information about provider networks or the true cost of services, including ancillary services.⁵² While we support greater transparency requirements for plans and providers, proposing transparency as the solution to surprise medical bills is insufficient and would continue to leave families helpless against this pervasive problem.

A Call to Action

Families USA is grateful to the committee for holding this important hearing today. Families have been trapped for too long in the tug-of-war between providers and payers that leads to surprise medical billing, and without your action it will only get worse.⁵³ The public has identified health care costs as a top priority for action this Congress,⁵⁴ and addressing surprise billing is a chance to demonstrate real leadership to our nation. Families USA urges Congress to swiftly take advantage of this opportunity and to pass legislation to protect consumers from surprise medical bills this year.

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³ NORC at the University of Chicago and West Health Institute. "Americans' Views of Healthcare Costs, Coverage, and Policy." NORC at the University of Chicago. 2018. <https://www.westhealth.org/wp-content/uploads/2018/03/WHI-Healthcare-Costs-Coverage-and-Policy-Issue-Brief.pdf>.

⁴ Ibid.

⁵ Ibid.

⁶ Papanicolas, Irene, Leana Woskie, and Ashish Jha. "Health Care Spending in the United States and Other High-Income Countries." Journal of the American Medical Association. 2018. <https://jamanetwork.com/journals/jama/article-abstract/2674671>.

⁷ American Psychological Association. "Stress in America: Uncertainty about Health Care." APA, 2018. <https://www.apa.org/news/press/releases/stress/2017/uncertainty-health-care.pdf>.

⁸ NORC at the University of Chicago and West Health Institute, op. cit.

⁹ American Psychological Association, op. cit.

¹⁰ Jonathan Berr, "How unexpected medical bills can ruin your finances." CBS News. 2016. <https://www.cbsnews.com/news/how-unexpected-medical-bills-can-ruin-your-finances/>.

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Chairwoman WILSON. Thank you, Mr. Isasi. We will now recognize Dr. Hoadley.

PROFESSOR JACK HOADLEY, PH.D., RESEARCH PROFESSOR EMERITUS, GEORGETOWN UNIVERSITY, HEALTH POLICY INSTITUTE, MCCOURT SCHOOL OF PUBLIC POLICY

Dr. HOADLEY. Thank you, Chairwoman Wilson, Ranking Member Walberg, and members of the subcommittee. I do appreciate the opportunity to share my perspectives about surprise medical bills.

I'm Jack Hoadley on the research faculty at Georgetown University and I'm going to draw today on a 50-State study of State laws and regulatory activity that I have conducted along with my colleagues at Georgetown. We have also taken a more in-depth look at some of these particular State protections. As you have heard already today, patients often receive surprise medical bills when they have reason to assume they are being treated by network providers or when they have no real ability to select a network provider.

Many Americans are worried that they may confront a surprise bill of this type and it happens all too often. And you have heard the examples already.

Our research shows that to date, 25 States have acted to protect consumers from surprise bills in at least some circumstances. Nine of these 25 meet our standards as offering what we consider to be comprehensive protection.

For protections to be comprehensive, we look to No. 1, whether they apply in both emergency situations, and in-network hospital settings such as electing an in-network surgeon but being treated by another clinician who is out-of-network. Second, that these laws apply to both HMOs, PPOs and all other types of insurance.

Third, that the laws address both insurers by requiring them to hold consumers harmless from balance bills and providers by barring them from sending balance bills.

And fourth, that the laws adopt some kind of a payment standard, either a rule to determine payment from insurer to provider or an arbitration process to resolve payment disputes.

Although these four conditions don't guarantee complete protection for consumers, they combine to protect consumers in most emergency in-network hospital settings that the States can address. But as you have already heard, State protections are limited by Federal law and ERISA which exempts State from State regulations, self-insured employers sponsored plans. Although many of the State laws have been in effect only a short time, we can learn some key lesson from the State experiences.

First, it is critical to consider whether consumers are protected regardless of the type of provider. Some State laws limit their protections to hospital-based physicians such as anesthesiologists or emergency department physicians. But consumers may also face surprise bills when treated by other specialists who are called in for their particular health needs such as a neonatologist, a cardiologist or a gastroenterologist.

And some State laws do not offer protections when services are delivered in out-of-network hospitals but only cover situations

where you're in the in-network hospital but are treated by an out-of-network provider.

In addition, most State laws have not addressed ground ambulance transportation and States are prevented by the Federal Airline Deregulation Act from addressing air ambulance providers. So those are also gaps.

Second, some State laws apply only to HMO enrollees and not to PPO enrollees and this limits the scope of consumers protected, but of course the larger gap as I have already mentioned is the ERISA plans.

New Jersey and New York have explored voluntary approaches for ERISA plans but it is too early to tell if these will have any impact and they are only voluntary steps.

Third, some States have considered making protections contingent on whether consumers receive a disclosure about the possibility of surprise bills, and although disclosure is helpful for consumers, making protection contingent on those disclosures seems inadequate given the challenge that consumers already face in understanding the many disclosures they see in a medical encounter.

In going to the medical system, you get a whole clipboard full of pieces of paper you are supposed to read and sign and this is just one more of those it doesn't really help.

Fourth, determining how to set a payment rate for the services delivered by a non-network provider may be the most challenging issue as we have already heard some comments on. Some States set a payment standard for what the insurer must pay, but States differ in whether to base a standard on Medicare rates, on average network rates, or on provider charges. And there are advantages and disadvantages to each of these. For example, basing payment on provider charges will tend to drive up costs.

Other States have elected an arbitration process to determine the reasonable reimbursement for a particular case. Arbitration is typically designed in a way that encourages providers and insurers to reach a voluntary agreement and leave the arbitration as a last resort.

And the last lesson is the challenge of enforcement. States have more ability to regulate insurers than providers and that can be an issue. But the key is to avoid placing the onus on the consumer to protest a surprise bill.

Although States are making progress in protecting consumers from surprise medical bills, they are looking to the Federal Government to address the self-insured ERISA arrangements they cannot regulate. Federal legislation would also help consumers in the many State that have not yet acted.

In addition, State officials have noted that a Federal law could help when a State resident receives care across the board or in another State.

But questions remain on what role States should continue to play if there is a Federal law. For example, does that Federal law defer to existing State laws or leave a role for States to adapt rules to local market environments?

The key unifying principle for States has been that consumers should not be liable for surprise medical bills in these circumstances we are talking about. Protecting consumers in these

situations will offer them some relief from worry about health costs. Thank you.

[The statement of Dr. Hoadley follows:]

State Approaches to Protecting Consumers from Surprise Medical Bills

Statement of
Jack Hoadley, Ph.D.

Research Professor Emeritus
Health Policy Institute, McCourt School of Public Policy
Georgetown University

Before the
House Committee on Education on Labor
Subcommittee on Health, Education, Labor, and Pensions
Examining Surprise Billing: Protecting Patients from Financial Pain

April 2, 2019

Good morning, Madam Chairwoman, Ranking Member, and Members of the Subcommittee. My name is Jack Hoadley, and I am a Research Professor Emeritus at Georgetown University's McCourt School of Public Policy. Together with Kevin Lucia and other Georgetown colleagues, I have been studying for ten years the ways states address surprise medical bills. Our most recent analysis of state legislation was conducted with the support of the Commonwealth Fund, resulting in a June 2017 report¹ and an update published in the "To the Point" blog in January of this year.² I am pleased to have the opportunity to share the findings of this research and my perspectives on this policy issue with the Subcommittee.

What Are Surprise Medical Bills?

A surprise medical bill is any bill sent by a medical provider to a patient for an amount larger than expected. A surprise bill can happen when you did not expect that a medical procedure would be so expensive or when you did not understand the consequences of a cost-sharing requirement, such as a deductible, included in your insurance policy. These are unfortunate circumstances, but they are not the type of surprise billing that are the current focus for your Committee. Our concern today is about those surprise medical bills that result from interactions with the medical system in situations where patients reasonably assumed that they were being treated by providers in their health plan's insurance network or where patients had no real ability to select their medical provider.

¹ K. Lucia, J. Hoadley, and A. Williams, Balance Billing by Health Care Providers: Assessing Consumer Protections Across States, Issue Brief, The Commonwealth Fund, June 2017. <https://www.commonwealthfund.org/publications/issue-briefs/2017/jun/balance-billing-health-care-providers-assessing-consumer>.

² J. Hoadley, K. Lucia, and M. Kona, State Efforts to Protect Consumers from Balance Billing, To the Point, The Commonwealth Fund, January 18, 2019. <https://www.commonwealthfund.org/blog/2019/state-efforts-protect-consumers-balance-billing>.

In these situations, surprise bills arise when insurance makes a payment for out-of-network care based on in-network rates, but the provider bills the consumer for the balance of their charges beyond what the insurer pays and beyond the consumer's cost sharing.

These surprise bills, sometimes referred to as balance bills, may occur in emergency situations where a consumer has no effective way to choose their provider. The bill may come from an air or ground ambulance service, from an emergency department physician, or from any physician or other clinician who provides treatment in the case of this emergency. It may also be a bill from the facility in cases where the closest emergency facility is out of network.

Surprise bills also occur for consumers who do their due diligence by selecting an in-network facility and an in-network surgeon for an elective procedure such as a joint replacement. But on the day of surgery, the anesthesiologist assigned by the hospital to provide care or the radiologist who reads an MRI or CT scan is out of network. This is another situation where consumers typically assume these health care professionals are in network or have no forewarning that an out-of-network clinician will be providing care. The balance bill is therefore unexpected. Unexpected bills may also occur when a consumer relies in good faith on an inaccurate provider directory or misinformation from a doctor's office.

All these situations are different from those where consumers make an informed and voluntary choice to receive services from an out-of-network obstetrician or oncologist and understands and accepts that their costs will be greater than if they chose an in-network physician.

We lack good data on how often unanticipated surprise medical bills from out-of-network providers occur, but insurance claims data suggest that about 20 percent of inpatient emergency department encounters have the potential for a surprise out-of-network bill. This is twice the rate of out-of-network encounters for elective inpatient care.³

These unexpected medical bills are a major concern for Americans, with two-thirds saying they are "very worried" or "somewhat worried" that they or a family member will receive a surprise bill. In fact, these bills are the most-cited concern related to health care costs and other household expenses.⁴

Most public-sector insurance programs—including Medicare, Medicaid, Tricare, and VA care—protect their beneficiaries fully or in large part from balance bills. But the same protections do not exist for most private insurance. The Affordable Care Act requires that insurers under its jurisdiction make payments for emergency services that are out of network comparable to what they would pay for those services when they are in network. But the ACA does not restrict health care providers from asking patients to pay the balance of the bill.⁵

³ C. Garman and B. Chartock, One in Five Inpatient Emergency Department Cases May Lead to Surprise Billing, *Health Affairs* 36(1): 177-181, January 2017

⁴ A. Kirzinger, B. Wu, C. Muñana, and M. Brodie, Kaiser Health Tracking Poll – Late Summer 2018: The Election, Pre-Existing Conditions, and Surprises on Medical Bills, Kaiser Family Foundation, September 5, 2018. <https://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-late-summer-2018-the-election-pre-existing-conditions-and-surprises-on-medical-bills/>

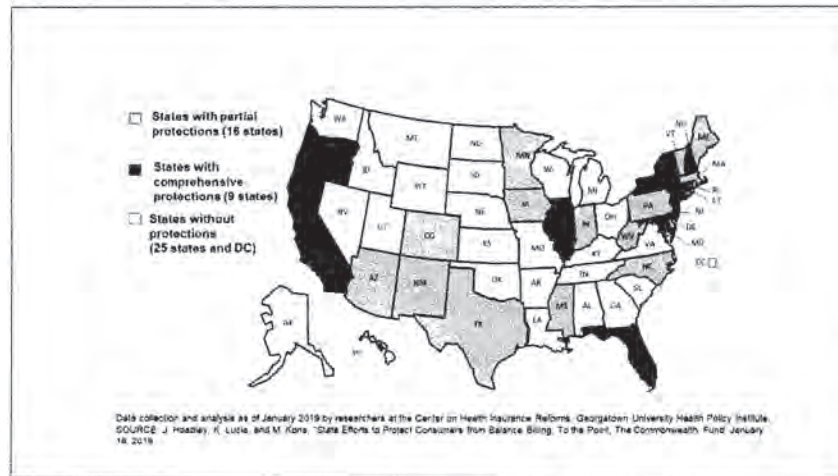
⁵ K. Keith, New Regulation Justifies Previous Position On Emergency Room Balance Billing, *Health Affairs Blog*, May 9, 2018. <https://www.healthaffairs.org/doi/10.1377/hlblog.20180509.247998/fall/>.

Employers and insurers may voluntarily protect their employees or enrollees from these balance bills in some situations. And as I will describe here, some states have acted to protect consumers from surprise bills in some circumstances. However, state protections are limited by federal law (ERISA), which exempts self-insured employer-sponsored plans, covering 61 percent of privately insured employees, from state regulation.⁶ As a result, state laws do not apply to the majority of Americans covered under employer-sponsored health plans.

The Scope of State Protections

At Georgetown, we conducted a study, most recently updated in January 2019, that found that 25 states today have laws offering consumers at least some protections in a balance billing situation (Figure).⁷ The key element in all these state laws is that they take the consumer out of the equation and make sure that they are only obligated to pay normal cost sharing.

Figure. State Laws Protecting Consumers Against Balance Billing



Although 25 states have created some protections, only nine—California, Connecticut, Florida, Illinois, Maryland, and New Hampshire, New Jersey, New York, and Oregon—have laws meeting our standard for “comprehensive” protections.

To qualify as offering comprehensive protection for consumers, we look for a state to meet four conditions:

- Extend protections to both emergency department and in-network hospital settings;

⁶ 2018 Employer Health Benefits Survey (Section 10), Kaiser Family Foundation, October 3, 2018, <https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-10-plan-funding/>.
⁷ J. Hoadley, K. Lucia, and M. Kona, State Efforts to Protect Consumers from Balance Billing.

- Apply balance billing laws to all types of insurance that are subject to state regulation, including both HMOs and PPOs;
- Protect consumers both by requiring that insurers hold them harmless from extra provider charges—meaning they are not responsible for the charges—and by prohibiting providers from balance billing; and
- Adopt an adequate payment standard—a rule to determine how much the insurer pays the provider—or an arbitration process to resolve payment disputes between providers and insurers.

Collectively, these conditions do not necessarily constitute total protection for consumers with no gaps. But they combine to protect consumers in most emergency room and network hospital settings.

We have seen considerable state activity in recent years. In 2017 and 2018, four states—Arizona, Maine, Minnesota, and Oregon—created balance-billing consumer protections for the first time, and two—New Hampshire and New Jersey—substantially expanded existing protections. Many states in their current legislative sessions are considering new bills. Several states—Colorado, Georgia, New Mexico, Oklahoma and Washington—have seen action in at least one chamber of their legislatures. It remains to be seen what new laws will be enacted or which ones will meet our standard for comprehensive protections.

The approaches taken by states in recent years has varied. For example, New Jersey has met our criteria for comprehensive protection by creating a dispute-resolution process to establish a payment amount for the out-of-network service. Other states have recently acted to protect consumers from balance billing in a more limited way. For example, Missouri's new protections apply only if the provider and insurer voluntarily agree to participate in the process. Such laws mark a starting point; many states have built up their protections over several years.

Lessons from the States

In many cases, state laws have been in effect only a short time so it is premature to understand fully how effective they may be. But we can still take away some key lessons from the state experiences.

Scope of State Protections

One issue has been the scope of laws passed in different states. Some states apply protections only to bills coming from certain types of providers. For example, a state may otherwise have a comprehensive approach to balance billing, but only applies the protection to certain hospital-based physicians—radiologists, anesthesiologists, pathologists, neonatologists, or emergency department physicians when those services are provided in a network hospital or ambulatory surgical treatment center. Thus, the law would not apply to surprise bills for services by a consulting cardiologist or orthopedist called in to treat the patient. This law also fails to protect patients who are taken in an emergency to a non-network hospital.

In addition, most state laws do not apply to ground ambulance services. Furthermore, states are prohibited by federal law from addressing bills arising from air ambulance services.⁸

Types of Insurance to Which Laws Apply

A second issue is the range of insurance products to which state laws apply. Laws in several states apply balance billing protections only apply to HMO enrollees and not to PPO enrollees.

Furthermore, as I pointed out earlier, states are prohibited by ERISA from applying protections to self-funded arrangements. New Jersey has included in its law a provision allowing self-funded plans to participate in the state protections on a voluntary basis. Because this law was just enacted in 2018, it is too early to know whether any ERISA plans will opt to participate.

Gaps in State Protections

A third issue is whether there are gaps in how well consumers are protected. Some states have made protections contingent on disclosure to the consumer that they may be subject to balance bills if they are treated by out-of-network providers. Protections, at least in nonemergency situations, only apply if the required disclosure does not occur. Disclosure can be helpful to consumers but making protection contingent on this disclosure seems inadequate given the challenges that consumers face in understanding the many disclosures handed to them when receiving medical services.

California's law goes a step beyond most other states in one regard. It explicitly forbids providers from sending their patients balance bills. It further requires providers to refund any amounts consumers pay that should not have been paid.

Determining a Payment Amount for Non-Network Services

A fourth issue is how to set a payment amount for the services delivered by a non-network provider. For in-network services, insurers pay based on the contracts established for network participation. In the absence of a contract, it is important to have a mechanism to establish a payment amount. Without any such mechanism, insurers and providers may be at odds over the payment, and payment disputes can leave the patient at risk.

Some states—for example, California, Maryland, and Oregon—have opted to set a payment standard in law to determine what the insurer must pay, while also requiring that the provider accept this amount as payment in full. Payments vary in how they are structured and in the level of payment. Standards can be structured as a percentage of Medicare rates, or they can be based on a percentage of average network payments or based on a percentage of provider charges. The different approaches matter; for example, a charge-based standard is more likely to be inflationary. Political and market considerations in a state have led to setting standards in different ways and at different levels.

Other states—for example, Florida, New Jersey, and New York—have opted instead for an arbitration process to determine a reasonable reimbursement rate for a particular case. The expectation is that in most cases, providers and insurers will agree on an appropriate amount

⁸ S. Corlette and M. Kona, *Lawmakers had a Chance to Provide Relief from Surprise Medical Bills – and Whiffed It*, CHIRBlog, September 27, 2018, <http://chirblog.org/lawmakers-blow-chance-to-curb-surprise-medical-billing/>.

voluntarily. But where no agreement can be reached within a reasonable time, the parties go to binding arbitration. New Jersey and New York use “final offer” or “baseball-style” arbitration, where each party elects a payment amount. The arbitrator then selects one amount or the other but cannot select any other amount. This system is designed to create an incentive for the sides to submit reasonable amounts, thus making it easier to reach a voluntary settlement. One consideration is whether to provide the arbitrator any sort of guidance; if this is done, it raises similar considerations to those in setting a payment standard.

States have typically found designing a payment standard or arbitration process to be the most challenging issue in gaining consensus among all stakeholders. When all stakeholders come to the table, it often proves possible to reach agreement on a solution that fits the particular needs and market conditions of that state.

Enforcement

A final consideration raised by the states that have acted on balance billing is how to enforce the protections they write into their laws. State insurance departments have jurisdiction over insurers, so enforcing rules on their insurers is a normal part of doing business. But they generally have no jurisdiction over providers. Prohibitions against balance billing by providers are sometimes defined as an unfair business practice, an established area for state regulation. But enforcement remains a challenge. A critical consideration is to avoid placing the onus on the consumer to protest a surprise bill.

The Role for Federal Legislation

Although states continue to make considerable progress in protecting consumers from surprise medical bills, they are looking to the federal government to address the self-insured ERISA arrangements they have no jurisdiction to regulate. In addition, protections are still lacking in half the states, meaning that federal legislation could make these consumer protections universal.

Federal policymakers also face decisions on the degree to which they allow a continuing state role in these protections. Federal policy could defer to state laws that meet a standard for adequate consumer protection. Federal policy could also leave a role for states in adapting payment standards or arbitration processes to their market environments.

Throughout the state actions to date, the unifying principle has been that consumers should not be liable for surprise medical bills in circumstances where they have little or no control over whether their medical providers are in network. Protecting consumers in these situations will offer some relief from worry about their health costs.

Chairwoman WILSON. Thank you. Thank you, Dr. Hoadley. We will now proceed to member questions. Under committee rule 8(a) we will now question witnesses under the 5-minute rule. I will now yield myself 5 minutes. First of all, let me thank you for the very interesting testimony.

When we talk about surprise billing, it seems that a fundamental problem facing consumers is that they often have no way of knowing whether their provider is in the plan's network. And it is unclear to me who has the burden of making sure that the consumers have the information they need in order to make an informed decision.

So I'm going to ask Mr. Isasi under current law, who is responsible for making sure that a doctor or hospital is in-network? Is it the doctor, the insurance company, or the patient themselves?

Mr. ISASI. Chairwoman Wilson, thank you for the question. To be very clear, it is the patient themselves that has a responsibility and these negotiations are very complex. These are some of the most important and intense negotiations in the health care sector between a payer and a provider. There is absolutely no visibility for a consumer to understand what is going on there.

And so the notion that a consumer wouldn't walk into an emergency department and know for example that their doctor was out-of-network, because that hospital could not reach agreement on an in-network provider for the ED, is absurd. Right. There is no way they would ever know that.

And similarly, if you walk in and you receive surgery and it turns out your anesthesiologist isn't in-network, there is no way for the consumer to know that.

And I would, I would like to say there is some discussion about transparency and creating, you know, sort of provider directories. We have tried to do that in many instances and what we know is that right now the health care sector has no real way to provide real actual insight to consumers about who is in-network, who is out-of-network.

I would posit probably everybody in this room has tried at some point to figure out if a doctor is in-network or out-of-network and as we know that system doesn't work.

So this idea that consumers can do research and find out what has happened behind the scenes in these very intensive negotiations is absurd and it doesn't work.

Chairwoman WILSON. Okay. Let me followup. The burden in non-emergency situations is also significant. Would any of the witnesses like to comment on this issue and elective procedures?

Do patients always know the name of all of the doctors who could potentially be sending them a bill later? Anyone.

Ms. SCHUMAN. I would be happy to talk about that. And the answer again is no. And there is no obligation on the part of those providers to provide that kind of notice to a patient about the kind of care they are going to be getting, whose it from and whether they are in-network or out-of-network and what the cost associated with that is.

Therefore I do think that rules requiring some disclosure up front at the time of scheduling when you can actually make a dif-

ference would be helpful. But as the other witnesses pointed out here, increased notice and transparency is only part of the problem.

Chairwoman WILSON. But even if a patient is able to determine the name of every doctor that will see them, I worry that not all of the information they are given about the network is accurate.

Dr. Hoadley, or Mr. Isasi, would you comment on the accuracy of provider directories? What happens if a consumer relies in good faith on accurate, on inaccurate information about their plan's network. The changes.

Dr. HOADLEY. Yes, that's a really good point. You know, directory, provider directories can be notoriously inaccurate. One of the things that even if they are accurate, that I have seen in my own family is you may be enrolled in Blue Cross. You ask your physician are they in the—participating in Blue Cross? They say yes. But it turns out Blue Cross has a variety of different networks. This would be true of any insurance company.

And so, you know, you may be in this one particular flavor of the Blue Cross plan and your provider may not participate in that particular network. So it's a very complex issue and some of the States have tried to link protections for balance billing with some of the issues around adequate networks and adequate provider directors.

Chairwoman WILSON. Okay. Ms. Young, why is it important for providing an appropriate Federal payment standard, whether by establishing a benchmark or creating a dispute resolution process? Why is that necessary to address this problem of surprise billing?

Ms. YOUNG. Absolutely. So as my co-panelists have talked about, notice isn't enough here. Even if a consumer had perfect information which is not a reasonable expectation, but even if they did have perfect information, they can't do anything with that information. They can't go across town to get their anesthesia and then come back to the hospital.

There, even with perfect information, they may be treated by out-of-network providers and so we need to set a standard that limits how much providers can be paid in these out-of-network scenarios that makes it sort of less attractive for providers to remain out-of-network. And so instead, they are subject to more normal market conditions.

Chairwoman WILSON. Thank you so much. I now recognize Ranking Member Walberg for his round of questions.

Mr. WALBERG. Thank you, Madame Chairwoman, and thank you to the panel for being here. Ms. Schuman, we have had this hearing specifically because of the rise, at least the ability to see the number of surprise billings that have taken place, the balance billings that are going on and the escalation there and the problems.

What factors could you suggest that have led to the rise in occurrence of these surprise billings and do you think the trend will continue if action isn't taken?

Ms. SCHUMAN. Well, thank you for the question. And all of these cases of surprise billing have a common theme. The patient lacks a meaningful role in choosing between a provider who is in the network or outside of the network. And the provider is not bound by competitive market forces to join or not join that network.

So the real problem fueling surprise billing is that for example hospital-based specialists like anesthesiologists, or radiologists, or emergency physicians don't have to lower their prices to draw patients. They can charge higher rates and the patients will still come.

So with these automatic referral of patients, the typical price-volume tradeoff for joining a network does not apply. Again, this is a fundamental market failure that I believe will only worsen if action is not taken to restore competition and choice.

Mr. WALBERG. We have talked about already in the initial questioning about transparency, adequacy of information just isn't there. Even if it were, are patients and their loved ones capable of navigating these types of decisions about their health care under difficult circumstances.

Ms. SCHUMAN. Well, I think any one of us who have been in this situation either ourselves or with our family members know how challenging that is. And patients and loved ones should not be put in the position or expected in a stressful emergency circumstance to be able to understand and navigate all the complexities of our health care system.

In these instances, our laws should go beyond just the mere notice of a provider's network status to protect individuals against costly surprises when they are in no position to direct their care themselves.

Mr. WALBERG. List a few mechanisms or approaches for patients, I guess we could say rate payers, insurance rate payers as well to protect themselves against that surprise billing experience.

Ms. SCHUMAN. Well, I laid out some of the recommendations. And to reiterate, I think it has to start again with protection of the patients and a ban on the practice.

But beyond that, we really do need to address this in a uniform way to make sure that we capture the 60 percent of ERISA self-funded plans and also one that is directed at the root of the problem which I just described.

And so therefore we need to remove those incentives that encourage these—out-of-network providers to stay out-of-network while at the same time ensure that they are equitably compensated for our services.

So in the case of an out-of-network hospital or facility, performing emergency services, I suggest that a Medicare rate of 125 percent it's clear and a way to restore competition and negotiation with respect to that out-of-network facility for emergency services.

For—in-network hospitals, when a plan has contracted with that in-network hospital, all of the providers practicing at that hospital should be paid no more than an in-network rate.

When you buy a car, you assume that the steering wheel and the tires are going to be attached. And I think it is somewhat similar to that.

I think there has also been a discussion about a bundled payment model whereby the hospital submits one single bill. And that might have some merit. Again but if there is appropriate safeguards on there to prevent against price escalation or undermining employer plan networks which are the greatest tool that employers

have to both reduce the cost of health care and increase the quality.

Mr. WALBERG. Just for the—I'm going to run out of time so I won't do this to you.

Chairwoman WILSON. Go ahead.

Mr. WALBERG. If you could just briefly discuss the price difference between—in-network rates and—out-of-network rates.

Ms. SCHUMAN. Sure. Happy to. And I think what we have seen is—in-network rates or—out-of-network rates more than two or three times—in-network rates depending upon again certain specialties.

And I think we have also seen a trend, a recent report about the fact that gap is growing and that it's alarming. It's not a comparison to cost and it's not in comparison to networks.

And I think as that trend continues and that gap continues to grow, we want to address the situation in a way that narrows that gap, not only makes it wider.

Mr. WALBERG. Thank you. And thanks for the grace period.

Chairwoman WILSON. Thank you.

Mr. WALBERG. I yield back.

Chairwoman WILSON. We will now hear from the distinguished chairman of the Education and Labor Committee, Mr. Scott. Welcome.

Mr. SCOTT. Thank you. Thank you, Madam Chair. Ms. Young, Section 1311(e)(3) of the Affordable Care Act helped improve transparency by requiring plans to provide public and timely disclosure of certain information. Why is this section important and what is the status of the implementation?

Ms. YOUNG. Thank you for the question. I think as we have talked about transparency, it is important, it is not a comprehensive solution to this problem. But it is important to give consumers information about their health care services.

The Federal Department of Health and Human Services has taken some steps to require disclosure of basic information about health plan information for qualified health plans under 1311(e) of the Affordable Care Act so those rules have been in place for a couple of years and I think we have those sort of first year data has become publicly available just over the last 6 months or so.

Mr. SCOTT. How useful is that information and is the Department of Labor doing its job under the provisions of the act?

Ms. YOUNG. So we don't think the information in—under section 1311(e) is particularly useful for consumers that are trying to navigate the out-of-network situation, though it does provide us some insight about what is going on in health plan networks and I think researchers would certainly welcome that transparency.

For the Department of Labor, so there is a parallel requirement on that group health plans make information available. My understanding is that the Department of Labor proposed some standards about updating sort of the tax form that ERISA plans file to include better information about health plans but that those policies have not been implemented and are not in effect.

Mr. SCOTT. And we have had a lot of back and forth about what doctors can charge. Why doesn't normal contract law apply? That a doctor can't charge what he or she wants? When you go into the

hospital and receive the services, you have under contract law agreed to pay a reasonable fee, not whatever the doctor thinks he can get out of you.

Why isn't what they accept under Medicare, what other physicians similarly situated accept? Why isn't there some more reasonable calculation of what a physician is owed? Not just what he wants, two, three, four five times what Medicare pays? I mean, it's a contract law.

Ms. YOUNG. Yes, so this is a, I think an interesting area of the law. Right now when patients are seen out-of-network, the providers are sending them balance bills at a rate that as you suggest, the provider has sort of largely made up. It's not determined by market forces.

There are some legal scholars who have been advancing this idea that there is no contract between the patient and the anesthesiologists in this circumstance and so as a result, the—there hasn't been a meeting of the minds and so we fall back on background contract law principles that would limit how much the anesthesiologist gets paid.

And there have been a couple of cases across the country that try to test this theory. I'm not an expert in these cases. I don't think any of them have been successful yet, but it is an interesting area of legal inquiry.

Mr. SCOTT. I don't know who this should be aimed at, but there is another surprise bill when you go in for a screening and which is supposed to be free under the Affordable Care Act and they do some little procedure in the middle of it.

It converts the whole thing into a treatment which is not free under the Affordable Care Act. Is that not a surprise in addition to the other surprises we are getting?

Ms. YOUNG. So I can talk a little bit about that issue. As you noted, it's not the same problem as the surprise balance billing that we have been talking about but consumers who are receiving free preventive care under the Affordable Care Act may—an example is a colonoscopy where the individual sort of starts with a screening colonoscopy and ends up getting a biopsy or a polyp removal.

Mr. SCOTT. And then you have to pay for the whole thing.

Ms. YOUNG. And that can generate charges. My understanding—

Mr. SCOTT. What about what kind of charge are we talking about?

Ms. YOUNG. It will depend on the procedure, but it can be fairly expensive or, I mean, it's an invasive outpatient procedure so it can be expensive.

The Department of Labor, HHS and Treasury have issued guidance that tries to limit that practice for colonoscopies performed in employer coverage, but my understanding is this is still a problem in the Medicare context.

Mr. SCOTT. Anybody else want to comment on that?

Dr. HOADLEY. I would simply note that, you know, it's an example of a broader issue that is what we are talking about here which is a lot of situations you go in for one particular procedure, you are doing an elective procedure but something else arises.

So you might be going in for your knee replacement but something happens while you are in the middle of that surgery. And your heart is not doing the right thing so they bring in a consulting cardiologist. And that could turn out to be one of these out-of-network situations.

So, you know, health care is not so predictable. We can't assume that simply because you went in to do X, a screening colonoscopy, a knee replacement, that isn't going to trigger some other problem and then that's part of what we are I think trying to address in these issues.

Chairwoman WILSON. Thank you, Mr. Scott. Dr. Roe.

Mr. ROE. I thank the Chair and I want to thank the Chair for having this very important hearing and all the members for being here.

And, Dr. Hoadley, I note, I was reading your what is a surprise medical bill that is any bill sent by a medical provider to a patient for an amount larger than expected.

I think all the bills I ever sent to patients thought they were larger than they expected. So probably applies to everything.

I really appreciate you being here and, Ms. Schuman, you make a point about a car. The difference in health care though is you go down to your car dealer and you buy a car. He doesn't have you sent you out without a car unless you pay for it. There is a law passed and as it should have been in 1986 called MTALA. You are very familiar with it and we have to cover anyone who comes into an emergency room and sees a Medicare patient as we should.

I'm an obstetrician by training and I have done that many, many times before. And so what happens to us in, on the provider side is that we have to provide those services as we should, regardless of your ability to pay. So we have that restriction on us as we should in the hospital.

I have been negotiated out of health care networks. Our group which was a large group so there are no innocents in this when you look at the insurers, the hospitals, the providers. Everybody is culpable here.

And I could not agree more about transparency. I have had a surprise bill after a surgery I had a year and a half ago so I'm very much aware of that and I could negotiate it because I knew the nuances of this. Many people cannot. It is complicated.

And even, Dr. Hoadley, as you said, even having—I have been—had my name in-networks that I wasn't in. That you use and many of those unscrupulous networks will use that to get people to sign up because this doctor, my doctor is in there when you are really not. And you get surprised bills.

So another couple things I want to mention is that we have to look at when you look at Medicare for instance as a benchmark, and most of us don't have a problem with that except if you look at the Medicare Wage Index.

Where I live in rural Tennessee, we have the lowest—second lowest Medicare Wage Index in the United States. We get .73 cents for what someone else gets \$1 for. Now in California for instance they have a very, very generous Medicare Wage Index.

So we have to, we pay our providers less and we can keep less than 10 percent of the nurses that we actually train in our area

because we can't pay them enough. So when you benchmark off Medicare, you are just again where we live you're discriminating against us. And so we need to work that out and it is a very unfair system that needs to be fixed.

And one other buzz I have got up my—a burr up my saddle is in Medicare if I saw an elderly patient that had a very limited income and I wanted to waive her copay, it is illegal for me to do that. And yet in California it is illegal for a doctor to balance bill. You have got two very—it's a dichotomy.

So how do we do all this and put this together where it is fair to the patients and it is also fair to the providers? And one other thing and anybody can comment on this. We have one hospital system where I live now. They've merged so there is no competition. There is one.

And when you have a bundle payment where that goes just to the hospital what leverage does a provider have to be treated fairly?

Ms. SCHUMAN. Can I just comment on that and thank you so much for saying that. I think that we all stakeholders have to be part of this solution without a doubt. And you know, and I think that, you know, to that point, I think it is very important that all stakeholders again are part of the solution. And we are looking at this in the broader context of the effort to increase transparency and lower health care costs.

And I think one of the big drivers behind rising health care costs is that lack of competition that you talked about. So we really do have a unique opportunity to try to address the root of this problem and the lack of competition that is driving it more.

Mr. ROE. And to the Chairman's point a minute ago, let me tell you how frustrating it is as a provider. I am doing a procedure, let's say a colonoscopy on a patient. And you're doing a Medicare patient and you see the polyp that is there. If you take it out that's a second bill. I mean, are you going to stop and bring that patient back? I think that's awful to have a patient go through all of that again.

And so as I said there are no innocents here. I really appreciate just the start of having this discussion. We need to stop surprise billing, no question about that and do it fairly for everyone. I yield back.

Chairwoman WILSON. Thank you, Dr. Roe. And now Ms. Wild from Pennsylvania.

Ms. WILD. Thank you, Madam Chairwoman. Thank you all for being here. I am somewhat gratified by the fact that it seems that we have bipartisan consensus that surprise billing really is a genuine problem and that patients are the ones who really are the losers in this system.

I am, you know, I am struck by the fact that we all seem to be wanting a solution to this problem. But the solutions that I'm hearing don't really sound very workable in the context of our present medical system. And that's, you know, that's where I really struggle to understand how we are going to fix this.

Ms. Schuman made the comment that all stakeholders have to be a part of this and I agree with you. The problem is the ultimate stakeholder is the patient. And the patient has no part in this in

terms of negotiation or even understanding the complexity of the insurance market and who may be in-network or out-of-network.

I will tell you as somebody with a post-graduate degree who has worked in as a lawyer in the insurance field for many, many years, I never understand a hospital bill without calling and seeking answers. And that's somebody—coming from somebody who's educated, literate, and knows the field and I still have a tremendous problem with it.

Ms. Schuman, you also used the phrase and I think what you said was that we need more competition in choice. Was that your statement?

Ms. SCHUMAN. Yes, that was.

Ms. WILD. And what does that mean?

Ms. SCHUMAN. What that means I think that what Dr. Roe was talking about the fact that there was only one hospital in town and when you only have one hospital in town its sort of difficult to negotiate.

And I think that again was what I was getting to both specifically with respect to having more than one hospital in an area but also more specifically when we are talking about surprise billing and the fact that some of these specialties have this free flow of patients that are coming to them without having to compete on prices and quality to attract them.

Ms. WILD. I'm sorry, I have just never found that competition causes any sort of clarity when it comes to medical charges. If I develop a relationship with a physician, I continue to go see that physician because I have a level of comfort with him or her, if I—it—I happen to be in a district with two excellent regional medical centers. There is plenty of competition in my district but that hasn't done anything to drive the prices down.

And I guess my question to you is isn't the real problem that we have turned over our medical system to private market forces?

Ms. SCHUMAN. Well, I think that indeed those private market forces are the best lever to drive health care value, drive down costs and increase quality. And that's why I cited an example of an employer member of ours, one of our member companies who networks because of networks basically they're saving their employees and their families 45 percent than without networks.

So I think that networks and the high-value, high-quality lower-cost networks are the key to innovation and to be able to get better value, better cost, and better quality.

Ms. WILD. But using your reasoning, a patient in New York City which has a wealth of hospitals and physicians and insurance plans, should result in no patients having surprise billing.

And yet I am quite certain that there are plenty of New Yorkers who have surprise billing every single day. So, I come back to my question of, you know, I am really not convinced that private market forces and competition in choice is the solution here.

Ms. SCHUMAN. Well, I think I also said that there is a fundamental market failure right now. And I think that that's what we are looking for, some sort of national response to this that restores those fundamental—so the market can work because when the market can work it works best. But there needs to be assistance and intervention to make that market work.

Ms. WILD. Well, I, you know, Mr. Roe used the expression there are no innocents here and I would agree with him except to say that I think the patients are the innocents. And so, there is an innocent party here.

Mr. Isasi, you seem to want to say something so please.

Mr. ISASI. I was going to say I think there are so many observations that we would agree with, but in particular, you're saying, you know, what is the workable solution here? What—I can't see the constructive, what—how do we move the ball forward? And what I would say is there is a concept here which is what does in-network mean? Right.

When you sit down with your husband or your partner and decide what kind of insurance do we want for our kids? Right? We want to make sure that they can go to the ED if they're playing soccer they get hurt, all those sorts of things.

The question is when you make that decision and you say oh look this hospital is in-network. Right. But what does that mean? If you can go to that hospital and all the services they're providing are out-of-network, right?

And I think as you've said and as we have heard from other folks, the patient is not the person who should be responsible for that. It's the folks who are negotiating. It's the hospital, it's the docs and the payers that should bear that responsibility.

So, let's start by clarifying what does in-network mean so that we have some way of making educated decisions about the insurance that we are purchasing and putting our trust in.

Chairwoman WILSON. Thank you. Thank you so much. And now we will hear from Mr. Meuser.

Mr. MEUSER. Thank you, Madam Chair, for holding this hearing and for allowing members and staff to learn more about the issues of surprise billing and thank you certainly to our witnesses for sharing your expertise. I have and I would venture to guess many of my colleagues if not all have heard stories from distraught constituents about what is very appropriately named surprise billing where they go for an emergency visit or often, a scheduled planned medical procedure or surgery which goes according to plan and then receives a surprise bill often in the tens of thousands of dollars.

So, Ms. Schuman, let's walk through a scenario please. And I have heard from individuals have experienced similar scenarios firsthand. At the advice of a doctor, an individual schedules a surgery and confirms that the hospital is—in-network. The surgery is scheduled 8 weeks in advance and the individual assumes that there will be no issues with undergoing surgery in an—in-network hospital.

Only after the surgery does the individual learn that the surgeon was out-of-network. The primary surgeon mind you and receives a bill for \$25,000. Had the individual known the surgeon was out-of-network, they would have very likely found an—in-network surgeon. Doesn't that sound reasonable?

Ms. SCHUMAN. Absolutely.

Mr. MEUSER. Okay.

Ms. SCHUMAN. And I think that that—I think that exactly the situation with the patient is doing their homework, they're doing

their research. How are they to expect that some of those other services would be out-of-network?

Mr. MEUSER. Okay. Well, what would the patient—what do you recommend that the patient do differently? Ask further questions?

Ms. SCHUMAN. Well, I think in this kind of situation, the patient did everything that they could be doing. And the problem is not the patient. The problem is not the consumer. The problem is that the consumer didn't have knowledge and didn't have a choice.

And again, in some situations even when they have knowledge upfront and they are informed of that, they still may not have choices. So, I think it's knowledge and choice that the consumer needs.

Mr. MEUSER. Choice would be understandable. Knowledge not so much. What about the hospital? Do you feel they have any responsibility here in this scenario?

Ms. SCHUMAN. Absolutely. Hospitals play a critical role in this. When you go to a hospital, again, they have the ones, they have the leverage, they have the ability to negotiate with those physicians that are practicing in their hospital.

Getting back to something from my testimony, it stands to reason that when you contract with a hospital all of those essential services that are performed in the hospital under that roof like anesthesiology or radiologists, would be in-network. How can you go to a hospital? How can you have surgery without anesthesiology or a hospital operate without radiologists?

Mr. MEUSER. So you also feel the surgeon in that scenario would have responsibility or would it be the hospital?

Ms. SCHUMAN. Absolutely. And I think getting back to this point, everyone has a stake in this. All of the stakeholders have a role to play.

Mr. MEUSER. Okay. So what would you offer that could be done during that 8 week period leading up to the surgery to help assure that the patient would not receive a surprise bill?

Ms. SCHUMAN. Well, I think we have to look at this in a comprehensive way. And I think again we had talked about transparency, upfront disclosure. So at the time of scheduling, not when they get into the emergency—not when they get into the surgery room, to be able to make a decision based upon their action.

But even that alone is not enough. And I think what we have to talk about is getting behind the reason why the patients might not have a meaningful choice or might not even know. And that's why I think a Federal standard, a Federal solution that does not discourage these out-of-network specialists to stay out-of-network and generate these surprise bills in the first place is the core of the solution.

Mr. MEUSER. Okay, thank you. Madam Chair, I yield back the remainder of my time.

Chairwoman WILSON. Thank you, Mr. Meuser. And now McBath? Okay. Ms. McBath. Welcome.

Ms. MCBATH. Thank you, Madam Chairman, Chairwoman, excuse me, for holding this important hearing today. And I have been hearing about surprise medical bills from constituents in my district and from many stories in the news and like I'm sure that we all have.

The recent statistics have been alarming to say the least. I will tell you I'm a two-time breast cancer survivor. I have had many surgeries in my time and I can tell you the number of times that I was surprised myself by these surprise bills that came in unexpectedly.

A recent Kaiser Health survey showed that two-thirds of American are very worried or somewhat worried that they or a family member will receive a surprise medical bill.

In another survey, we see that 57 percent of American adults have been surprised by a medical bill for something that they expected to be covered by their health insurance.

Now I have here a whole number of individuals just within Georgia alone, and I'm sure there will be millions more that represent just these very things that have happened, these surprise bills.

These Americans, they are our friends, they are our neighbors and our family members. And I brought these stories from individuals in my district who have been affected by these surprise bills.

There is Michelle from Alpharetta and then also there is Tom from John's Creek, Elaine from Roswell and countless others. And like other Americans across the country, they were taken by surprise by a medical bill.

These men and women are worried about the financial impact that these bills have on themselves and their families. Some are able to get their bills reduced but most aren't and most aren't that lucky.

Now for me these stories make it clear that we have got to do something at the Federal level to address the financial impacts and emotional distress these surprise medical bills have on patients.

Mr. Isasi, I would like to ask you and thank you for your testimony. As Sarah Kliff of Vox and others have extensively documented, surprise medical bills lead to devastating consequences for consumers throughout our country. Now I really like evidence and data and could you talk about what data exists that could help us here in this room and in Congress understand just how large these expenses can be for consumers?

Mr. ISASI. Absolutely. So, as we have heard today there are a few facts. One, almost a fifth of all emergency department visits involve surprise bills. Right. So, for all of us, you know, as I was saying earlier, if your kid gets hurt playing soccer and you go to an ED, there is a really good chance you are going to get a surprise bill.

As you mentioned, we know that right now almost half of Americans' health care costs are top of mind and they are—they report they cannot meet basic, their basic health care needs with—because the costs are too high.

They won't go see a doctor, they won't get their meds, because they can't afford it and a third of people in this country right now are saying that their basic needs of life, their rent, their heat, their food, they cannot pay for those things because of health care costs.

So, this question of surprise billing is falling into much largest context which is that American families are overwhelmed by health care costs. And surprise bills are just that moment where despite trying everything, paying your premiums, checking to see if you're in-network, right, you find out now I owe \$5,000, \$10,000.

And what we know as we have heard is those bills typically are about three times more than they would be paying in-network but they can be tens of thousands of dollars more. Because as we have heard, there isn't a structured contract between that patient and that doctor. And therefore, they can charge whatever they can get away with. Right. So, I would say that to your question one of the most important concepts here is and we have heard this and I actually in a previous life saw this happening, right.

The negotiations between an insurer, a hospital, and a physician group are some of the most intense and sophisticated negotiations occurring in markets in this country. And the notion that you or I as a patient, as a person in need of health care services has to be able to track all of that and then be responsible because my hospital could not negotiate an in-network contract with an ED doctor so now I'm going to get stuck with the bill.

Is the tail wagging the dog? Right. That hospital should have the responsibility of saying if I am an in-network provider for you, you can come to my ED and not get stuck with a hospital bill that is three times larger and my cost-sharing is much larger, right. That is the tail wagging the dog.

Ms. MCBATH. Thank you. So how prepared are Americans for these unexpected expenses and could you speak on the impact that these expenses also have on individuals' overall wellbeing?

Mr. ISASI. You bet. Absolutely. And as I noticed in my testimony that right now what we know is that more people are scared of hospital bills and health care bills than getting sick. I mean, that's where we are as a Nation.

So we are—there is more harm right now happening in this country in some way psychologically around the cost of health care than actually being scared about their health. Okay. And in terms of the—what was the, I'm sorry, I missed the first part of your question.

Ms. MCBATH. Oh, I was just saying how prepared are Americans for these unexpected.

Mr. ISASI. Oh. Well, this is another thing we know is that almost half of Americans, they don't—they have less than \$400 in savings, right. And so, a surprise medical bill for \$2,000 means I'm going to have to miss my car payment, miss my mortgage payment. I'm going to have to take out of my retirement account. Right.

These are—when people pay for health insurance, what they are trying to pay for is financial security. To know I am doing my part, I am paying into a system, now I get sick and now that system takes care of me and makes sure that I don't lose everything I worked for in my whole life because I got sick.

Ms. MCBATH. Right.

Mr. ISASI. And what we know is a surprise medical bill is a, can be a devastating blow on a family that is trying to live that life and be self-actualized.

Chairwoman WILSON. Thank you. Thank you. And now, Mr. Allen. Thank you.

Mr. ALLEN. Thank you, Chairwoman and thank you, panel for giving us some insight onto just how magnified this problem is and of course, you know, I hear from constituents that surprise medical billing has become a significant concern for Georgia families.

You know, the problem is this whole process of health care is so complex that you have a, if you are—out-of-network, or in-network, you know, deductibles, and, you know, is your doctor in-network? I mean, you were supposed to be able to keep your doctor, it's just a total mess. And it needs to be fixed sooner than later.

But you know, 2/3 of Americans say they are somewhat worried about being able to afford their own family members unexpected medical bills and as we said, these surprises, how does a family deal with it?

Ms. Schuman, 22 States have passed legislation on surprise billing. What are the different models that States have enacted and are there any lessons learned from their approach to this problem?

Ms. SCHUMAN. Thank you. Yes, a number of States have acted to address surprise billing in a number of circumstances, some of which we have discussed here ranging from purely protecting the patient to requiring for example binding arbitration between the payer and provider to resolve that dispute.

Or in some cases California for example requiring setting a reimbursement that's the greater of 125 percent of Medicare or the average in-network rate. There are some lessons to be learned from that, but they are limited. They're limited by time and scope.

By time, because for example the California law just became effective at the beginning of this year so we really don't know the impact it's having.

But I think more critically they're limited in terms of scope because they don't cover ERISA self-funded plans 60 percent of employer sponsored coverage. So we don't necessarily know if those some lessons would apply on a national level.

And I do want to say just with respect to Texas, there could be some important lessons there with respect to a binding arbitration or dispute resolution process. In terms of a backlog of cases in the Texas system to try to address this through managed through dispute resolution.

They have changed the law but again, I think we need to be careful of that if we are thinking about employing that on a nationwide level.

Mr. ALLEN. Well, certainly we need to look at these models and see what we need to do at the Federal level because health and the other problem is healthcare costs are just accelerating like nobody has ever seen in the country.

We have heard a lot about the role of patients and providers and employers and finding a solution through surprise billing. Should hospitals also have a role in addressing surprise billing? In other words, should the hospital know that hey, you know, you are going to get a bill from, you know, this group or that group? I mean, it looks like full disclosure should be on the agenda here.

Ms. SCHUMAN. Absolutely. Hospitals play a critical role in this. The hospitals are the one with these hospital-based physicians. Often times those specialties that are integral to being able to operate that hospital and treat patients are not employed by the hospital. They're not in that hospital network.

And that leverage, that relationship between the hospital and the physicians that are practicing at that hospital is key and I think fundamental to addressing this problem in a way that works.

Mr. ALLEN. We have got about a minute. Many of the patients that receive surprise bills are covered through employer sponsored plans. What are employers doing and of course, you know, the business community is trying their best to address this accelerating cost of health care.

What are they doing to provide more information and transparency for their employees to help avoid these situations?

Ms. SCHUMAN. Well, thank you so much for that question. And this is a deep concern for employers. And council member companies are taking steps to limit the incidents of surprise billing in the first place, through for example enhanced communications to their employees about the potential for balance bills. And also, provide assistance to their employees who do receive a balance bill in the form of contracting with other entities to try to negotiate that down or providing some sort of legal defense funds. But despite these efforts of employer, the problems still persist.

Mr. ALLEN. Yes. Well, thank you so much and I yield back

Chairwoman WILSON. Thank you. Ms. Underwood.

Ms. UNDERWOOD. Thank you, Madam Chair.

Chairwoman WILSON. You're welcome.

Ms. UNDERWOOD. Thank you for holding this really important hearing today and I would like to thank our panelists for being here and for your really comprehensive written testimony. I have enjoyed reading through your comments.

Like many of us, people in my community in Illinois have experienced surprise billing and I frequently hear from constituents about their struggles to afford health care even health care more broadly when I'm home.

And so according to the Health Care Cost Institute, in my home State of Illinois, about 15 percent of in-network hospital admissions resulted in at least one out-of-network claim in 2016. And so, my questions are for you, Dr. Hoadley.

I'm proud that Illinois has taken a leading role in addressing this issue by enacting consumer protections that you have described as comprehensive in your research. Given your expertise on these State approaches, I was interested in getting your perspective on how effectively Illinois has addressed this issue.

So first, what are some of the strengths of the Illinois law in terms of its scope and protections for consumers?

Dr. HOADLEY. Well, certainly one of the strengths of its law is that it does apply to a broad variety of circumstances. They regulate both the HMO environment, the PPO environments regardless to the type of insurance.

They address both situations that arise in emergencies as well as those that arise in more elective procedures as we have heard talked about, some of the circumstances where you go in to get a particular elective surgical procedure but might encounter an out-of-network anesthesiologist. So, Illinois does have a good law in place.

Ms. UNDERWOOD. Great. And so how does the Illinois law resolve disputes between the providers and insurers?

Dr. HOADLEY. So, what they really look to is to try to get the provider and the insurer to negotiate a private amount. There is a dispute resolution option in Illinois. When we last talked to the

folks in Illinois, they said that had not actually been invoked. So, it was there perhaps as a backup, a backstop but for the most part things got resolved privately.

They did have some concern when we talked to the Illinois officials that there may be instances where consumers get bills sent to them, aren't aware that they don't need to pay them, so don't start the process. And that goes to this sort of point of how do you really make sure it's not the consumers responsibility to figure out that oh, I don't—by law I don't actually have to pay this bill. Now what do I do to make sure that happens? If you don't know that, that doesn't really help you.

And so, what some other States like California has done is to include a provision that says the provider really can't send a bill and if they do end up sending a bill and the consumer pays it, there is an obligation on that provider to refund the amount that was paid back to the consumer. And that's something we haven't seen in some of the other States.

Ms. UNDERWOOD. That is interesting, thank you. As we look to develop this comprehensive Federal solution, what lessons do you think we can learn from how Illinois has tackled the issue?

Dr. HOADLEY. So certainly, you know, trying to do something that is comprehensive is an important part. I think one thing that is also a somewhat of a limitation in the Illinois law is that in the non-emergency situations, it limits the protections to a certain specified list of provider types.

So, you know, it does cover the emergency room doctor, the most common ones that come up. The anesthesiologists, the radiologists and so forth. But it doesn't necessarily address an issue of when there is a consulting cardiologist that's called into your case or where maybe an orthopedist is called in because you came in with some situation that involved a bone injury.

And so, you know, one of the things that other States have done is to make sure that the law applies comprehensive to all types of providers rather than specifying the list of the ones. And yes, they do list the ones that are most commonly come up. But that doesn't mean it necessarily works in your particular case.

Ms. UNDERWOOD. Thank you. Speaking of the providers, I was reading in Christen Linke Young's testimony about the neonatologists and some specific surprise bills that often arise upon the likely early birth of a child and some unexpected out-of-network claims. I just was wondering if you wanted to expand a little bit on that.

Ms. YOUNG. Absolutely. Thank you for the question. So, we have talked a lot about the, this issue from the patient's perspective which I think is extremely important. But it is also helpful to think about the issue from the perspective of one of these providers.

Once a provider like an anesthesiologist or a neonatologist is in the hospital practicing, they will receive a flow of patients regardless of whether or not they join insurance company networks and regardless of what price they set.

So, for that neonatologist, once they're in the hospital, they're going to be the neonatologist taking care of those babies and they

have a very limited incentive to join insurance company networks and accept a negotiated contract rate from an insurance company.

It's the same dynamic that all of these provider types face. And the key to a solution is to get rid of that set of incentives and instead encourage those folks to come back in-network or work with hospitals for their payment.

Ms. UNDERWOOD. Well, I would like to thank you all so much—

Chairwoman WILSON. Thank you.

Ms. UNDERWOOD [continuing]. for your expertise and I yield back my time.

Chairwoman WILSON. Thank you Ms. Underwood. Now Dr. Foxx, our distinguished ranking member of the Education and Labor Committee.

Ms. FOXX. Thank you.

Chairwoman WILSON. For 5 minutes.

Ms. FOXX. Thank you, Madam Chairman, and thank you for organizing this hearing and I want to thank all of our witnesses for being here today. They've been very, very informative.

Ms. Schuman, I know that surprise billing impacts patients on a personal level. On a larger scale, how often do patients receive surprise bills? Do we have information on that?

Ms. SCHUMAN. Sure. Kaiser Family Foundation of medical debt found that among individuals who faced—out-of-network bills that they could not afford, nearly seven in 10 of those didn't even know the provider was—out-of-network at the time they received care hence the surprise—the surprise. Another analysis of medical bills from large employer plans found that nearly one in five inpatient admissions included a claim from an out-of-network provider that could result in a surprise bill.

Even when enrollees choose in-network facilities, 15 percent of inpatient admissions include a bill from an out-of-network provider such as an anesthesiologist.

Ms. FOXX. So does the percentage change based on whether the patient is receiving emergency care? Do we have information about that?

Ms. SCHUMAN. Yes. And for inpatient admissions that include an emergency claim, they're much more likely, 27 percent to include a claim from an—out-of-network provider that admissions without an emergency room claim 15 percent. That's the case whether or not employees, enrollees use an in-network or—out-of-network facility.

Ms. FOXX. All right. What about when ambulances are provided.

Ms. SCHUMAN. Well, for ambulance services, the figures are even more alarming for patients in the most dire of circumstances.

As Ms. Young's testimony notes, among people with employer sponsored health plans, 51 percent of all ambulance cases involved out-of-network ambulances. And according to a recent GAO analysis of air ambulance transports of privately insured patients, 69 percent were out-of-network.

Ms. FOXX. Okay. So let's talk a little bit about what happens after a patient receives a surprise bill. What—are patients able to successfully negotiate down the amount? Professor Hoadley alluded

to this in his comments recently but are they able to negotiate down the amount or are they forced to pay the entire bill?

Ms. SCHUMAN. Well, generally a patient does not have much recourse after he or she receives a balance bill. And that's because State laws generally hold individuals liable for the cost of goods and services received not just with consumer's goods but for medical care as well.

And to that end, providers generally have individuals sign a contract prior to service indicating that they agree to be responsible for all billed charges. And it's these contracts and the related State laws the providers use as the basis for balance billings.

Now in some instances, employers do try to protect their patients from receiving or otherwise having to pay these balance bills by negotiating with the—out-of-network provider but these employer actions themselves are not without costs because employers that voluntarily try to protect their employees from balance bills have increased plan costs because in most cases they end up having to pay more to settle the balance bill and this gets reflected into higher premiums for all consumers.

Ms. FOXX. Lets pursue that a little bit more. Determining whether providers are in or—out-of-network can be confusing and obviously it sounds like for plan providers as well as patients.

So what influences a provider's decision to participate or not participate in insurance network and are there incentives or tradeoffs for participating?

Ms. SCHUMAN. This is the key question. And the incentive for providers to participate in the network is to have access to a volume of plan enrollees whose plans are trying to drive patients to a high value network.

The tradeoff for a lower—in-network reimbursement rate is a provider is going to more than make up for that in volume. But for some of these hospital based specialists that we have been talking about, they have inelastic demand. The patients are going to come to them anyway so that incentive is not there and the market is therefore supported and surprise medical bills ensure.

Chairwoman WILSON. Thank you.

Ms. FOXX. Thank you, Madam Chairman, I yield back.

Chairwoman WILSON. Thank you, Dr. Foxx. Mr. Courtney.

Mr. COURTNEY. Thank you, Madam Chairwoman, and thank you for your leadership on this issue which is definitely sweeping the country. It is partly because of some great reporting.

Sarah Kliff from Vox has done a great service in terms of a series of articles on this as well as National Public Radio. Congressman Doggett from Texas has a bill that's pending in Congress that again would take the patient out of the cross fire.

And as we have heard, a number of States have actually moved forward with legislation like the State of Connecticut which in 2016 passed a bill on a bipartisan basis by the way that again at least focused on the question of emergency room billing which again took the patient out, set up a standard in terms of reimbursement and also limited the out-of-pocket loss that would be credited against people both for out-of-network bills in terms of their overall deductibles.

You know, again, this committee which has jurisdiction over ERISA is exactly where this issue belongs. As I think we have heard, the Employment Retirement Income Security Act preempts State regulations. So, the fact that Connecticut or Illinois or other States have done good work in terms of moving forward, again, there is a huge number of employment-based plans that again are unaffected by this.

And again, I think it's just so important to foot-stomp that and I guess I would just ask Ms. Schuman again that again ERISA really has to be dealt with if we are going to really have a comprehensive solution for America's patients, is that correct?

Ms. SCHUMAN. That's exactly right. For the self-funded plans at 60 percent of employer-based plans that are not subject to these State laws like in Connecticut or other States, we have to have a Federal solution that addresses ERISA so that we deal with this problem in a uniform, nationwide way.

Mr. COURTNEY. And when we passed patient protections with the Affordable Care Act in 2009, again it was this committee that really crafted the language regarding preexisting conditions, lifetime limits, essential benefits which again removed the ERISA preemption and again set a standard that was universal in terms of all health plans.

So again, I think it's unfortunately the President has declared war again on the Affordable Care Act but again, our mission is just to keep again using the best information possible because health care is such a dynamic issue and this surprise billing issue obviously has really popped up that really escaped the Affordable Care Act's scope of patient protections.

So, again, I would like to ask Professor Hoadley about the Connecticut law which again as far as emergency rooms, used a different approach than the negotiated process of resolving some of these bills and again, established a standard which would appear at least in some respects to have the salutary effect of having a pretty sort of standard process that can be dealt with—can be implemented in a timely fashion versus a negotiated arbitrated. I am just sort of wondering if you could kind of tease out the pluses and the minuses from those two approaches.

Dr. HOADLEY. Yes, there are definitely pluses and minuses to the two approaches and, you know, we haven't had enough time on a lot of the laws like Connecticut's and New Jersey's to really gain a longer, richer experience to draw from.

But we can look at some of the differences, I mean, what the payment standard that Connecticut and other States use. One of its advantages is that it sets a clear number. It's there for everybody to see. There is sort of no ambiguity. Now if you don't like the number that it sets, or you think the number that it sets has consequences so States will vary between using a Medicare-based rate, a rate based on network charges or sorry, network allowed amounts or a standard based on charges.

And it makes a lot of difference which of those because the numbers involved are quite different. In any of those cases, it's a percentage of that standard so, I mean, it's not necessarily at the Medicare level. It might be as others have suggested 125 percent of Medicare.

The advantage of the arbitration process is it allows the individual circumstances of a particular case to be dealt with. Most States that have used an arbitration process have set it up in a way that really views it as something as kind of a last resort. Not something that is going to be used on case after case.

And so a combination of when they do adjudicate cases and make a decision, those amounts become a part of public information and so they can be a lesson to others. But simply the fact that there is a potential way to solve a number if you can't get to a resolution actually does create the incentive for the parties to get together and resolve it on their own.

They want to avoid the cost of going through that process. So there really are some merits and disadvantages on both of those approaches.

Mr. COURTNEY. Hopefully we will move swiftly and make a choice because again, this is an issue that can't wait. With that I yield back, Madam Chairwoman.

Chairwoman WILSON. Thank you, Mr. Courtney. Mr. Taylor?

Mr. TAYLOR. Thank you, Madam Chair. And I will just, you know, particularly for the chairwoman that, you know, I consistently voted in the State legislature to address this particular issue on a bipartisan basis in my time in Texas. And it certainly is an issue that we as State legislatures in Texas saw as a problem and addressed of course, you know, most Americans, you know, over half of Americans are on ERISA plans. So we are talking about the big plan, right.

This is really where the show is from a policy point of view. And so one of the questions I had, Ms. Schuman, is just what is—and let me just reiterate. It is so important that we solve this problem. This is a real problem and it is affecting people every single day. And I hope that we craft a bipartisan solution in this committee because only a bipartisan solution can actually go be signed by the President—can be passed the Senate and go be signed by the President.

Otherwise, we are just sending another messaging bill which will have no impact and not really solve the problem. So I would rather have something that is going to go all the way to the President's desk than something that is going to not get anything done.

But, Ms. Schuman, in your mind, looking at the State solutions, I know we have had some discussion about different State solutions. What have they done that in your mind is a model for us that you think could be supported by Republicans and Democrats, get through the Senate and be signed by the President?

Ms. SCHUMAN. Well, thank you so much and I think there are some lessons to be learned and maybe drawing from different States and taking pieces of different State legislation.

The California State legislation that we have talked about does include a component of capping reimbursement at 125 percent of Medicare or the—in-network rate as a way to again cap reimbursement so as not to undermine network participation. Other States that have adopted an arbitration model—

Mr. TAYLOR. So you're—that's an acceptable solution for you? 125 percent?

Ms. SCHUMAN. Well, I think—

Mr. TAYLOR. Because your original testimony I thought you were saying we shouldn't set prices but it sounds like you are—

Ms. SCHUMAN. Well—

Mr. TAYLOR [continuing]. saying set prices.

Ms. SCHUMAN. I think there is two—I think our recommendation is twofold and deals with a situation of an—out-of-network emergency service facility for emergency services different than for an in-network hospital.

Mr. TAYLOR. Okay.

Ms. SCHUMAN. For emergency services at an—out-of-network facility, that means a hospital didn't even contract with the plan emergency services, that's what I would suggest that capping it at 125 percent of Medicare is a reasonable way of approaching that and to foster some sort of equitable competition.

With respect to an—in-network hospital, that—in-network hospital should ensure that providers practicing at that hospital would pay an—in-network rate.

So the Medicare reimbursement structure is only with that I recommended is only with respect to the—out-of-network emergency. Otherwise, you go to a hospital, an—in-network hospital,—in-network rate, contracted rate. And that would remove the disincentive for these specialties, these hospital-based specialties not to join the network.

Mr. TAYLOR. Have you seen the legislative support for those two solutions in other States on a bipartisan basis the way that we been able to do it—we have not approached it the way that you are suggesting. But what we did in Texas was bipartisan. I mean—

Ms. SCHUMAN. Yes.

Mr. TAYLOR [continuing]. everybody voted for it. It was or pretty much everybody voted for it. So it was something that we can all agree on. And again, I want to solve this problem here.

Ms. SCHUMAN. Yes.

Mr. TAYLOR. At this level. So my question to you is that something that you have seen yes, there is a lot of bipartisan support for or did that get kind of caught up in a lot of partisan politics?

Ms. SCHUMAN. We are crafting solutions right here. We are looking at the problem. We are looking at States like Texas, California, no one has come up yet with a comprehensive solution that gets it right and gets it right for everyone and I think that is what this committee has an opportunity to do.

Mr. TAYLOR. Okay. And, Madam Chair, I will just reiterate, you know, I voted for every effort in Texas to try to address this issue because this is a real issue as you point out. I think we all know this is a real issue and I just want to entreat you as the chair of this subcommittee that you reach out and let's get something done on a bipartisan basis so that it can go through the Senate and be signed into law by the President and we can address some of this problem.

I know we are not going to probably get a perfect solution if it is a bipartisan solution unlike I am sure you could draft a perfect solution over on your side. But the problem is a perfect solution that doesn't go anywhere is of no help to the people that we are trying to help.

So I am with you and I look forward to working with you on this. With that I yield back.

Chairwoman WILSON. You got a deal. You have got a deal. All right. Thank you, Mr. Taylor. And now, Dr. Shalala.

Ms. SHALALA. Yes, thank you very much, Madam Chair. I have always been interested in building on when States have taken on an issue building on their experience and it looks to me like it is the payment standard and the dispute resolution standard that differ between the States.

Some of the other elements there seems to be consensus on, so it sounds like this committee has to focus on those two things. And I am with Mr. Taylor. If we can figure out how to get a compromise somehow but here is my question because you have been answering questions about individual States. Has there really been a decrease in the number of out-of-network bills since States have adapted, particularly the comprehensive States?

Have these—I haven't seen the answer to the question on whether it is actually worked, particularly in the comprehensive States. I think Texas is sort of a moderate, somewhere in between, but I am particularly interested in the comprehensive States.

My own State, Florida, which is for the most part represented by my colleagues on the other side, has had a comprehensive approach. California has had a comprehensive approach. So, could you talk a little about how effective these approaches have been?

Dr. HOADLEY. Yes, I can talk about that. It's a really good question. One of the challenges we have is that a lot of these have only been in effect a relatively short time and it is noteworthy that many of these solutions, I think really all of the States have done this in a very bipartisan way. And have brought together—and the ones that have been most successful is when they have really brought both parties and all the different stakeholders to the table.

Now there has been some look at the track in New York because it is one of the ones that has been in effect a few years now and I think we are finding, I have colleagues at Georgetown that are taking a closer look at sort of what's worked and what hasn't in New York and they'll have that report done soon.

But what I understand they're finding so far is a general degree of satisfaction. That stakeholders across the spectrum do think that things have worked out pretty well and there is some research evidence that there has been no particular inflationary effect coming out of the process they've used in New York and so that's an encouraging sign.

You know, Florida has had a different approach in for a few years and then they revised the approach just a couple of years ago. I have not heard any particular feedback yet from Florida on how well that's played out. California's is relatively new. New Jersey is quite new and so that's the—that's really the challenge in trying to learn the lessons.

But I think the overall impression at least qualitatively, when we interview stakeholders and insurance department officials and others that are involved in this is that they feel like the solutions they've had have been pretty successful and then they go back and make adjustments where they find gaps and maybe that's a little easier to do in a State legislative context than it is in Federal legis-

lation, but they have been able to go back in many of these States and make adjustment and try to improve their law.

Ms. SHALALA. But it sounds to me like we have to learn from the adjustments.

Dr. HOADLEY. Yes.

Ms. SHALALA. As we are crafting national legislation, I have one other quick question and that's about air ambulances. I live in Florida. Air ambulances are often out-of-network. And I think the GAO recently said that 69 percent of the air ambulances were out-of-network. Have any of you thought about that in particular? Yes, Ms. Young.

Ms. YOUNG. Yes. So, as you know, this is an acute problem in the air ambulance context for exactly the same reason it's a problem in the other areas of the market that we have been talking about.

Because there is no incentive for these providers to go in-network because when somebody needs an air ambulance, they're going to be picked up by a particular air ambulance and a patient just doesn't have a choice about the network status. So, the solution here is the same as we have been talking about for all other provider types.

You need to sort of create conditions that diminish the attractiveness of remaining out-of-network and encourage these folks to come in-network at a reasonable price or to otherwise sort of get paid an appropriate amount, so by setting a payment standard or otherwise establishing a mechanism by which these folks can get paid an appropriate amount.

The other complication with air ambulances which I think is important for this committee to consider is that States are generally preempted from regulating air ambulance conduct and so it's a place where in particular you need Federal activity. The one other thought that I think is important as we think about evaluating State solutions is and what States have done so far is not just whether or not the State law has decreased surprise bills or out-of-network bills but also what effect it has had on overall health care costs. Because you can have a law that sort of makes a lot of people happy by paying more money to these specialties and we also need to be considering the effect we are having on premiums and overall spending.

Ms. SHALALA. Thank you.

Chairwoman WILSON. Thank you, Ms. Young.

Ms. SHALALA. I yield back.

Chairwoman WILSON. Thank you, Dr. Shalala. Mr. Banks.

Mr. BANKS. Thank you, Madam Chair. Consolidation of the health care sector is something that we need to consider when looking at some of the high hospital costs faced by our constituents. A number of government policies discourage a thriving and competitive hospital market including lack of site neutral payments at the Federal level and certificate of need regulations at the State level.

While I agree that surprise billing is a problem that we need to address, it is important that we not pursue policies that encourage even more consolidation in the hospital market which countless studies have shown drives prices up to unaffordable levels.

Ms. Schuman, your testimony mentions bundled payments as a possible remedy for surprise billing. First, can you explain to the committee how bundled payments would look different from the system that we currently have?

Ms. SCHUMAN. Sure. You'd get one payment from the hospital for all of the services that were provided at that hospital. So instead of getting one bill from an—in-network facility and the anesthesiologist that was out-of-network and you get a different bill from their practice and the radiologist that did an MRI on you and they're out-of-network. You get a different bill from them. A balance bill by the way that oh, it was a surprise, you didn't know about.

The idea of a bundled service is its one stop shopping at an—in-network hospital, an in-network facility. So they make sure that when they contract with the plan you're contracting for a bundled of service, that continuum of care that the patient is going to receiving.

And I do think that there is some promise in looking at that and it certainly does bring hospitals into the equation and they're a necessary partner. But we do have to have some guardrails around there to make sure that doesn't further escalate and increase costs and just become a bundled payment of a much higher billed charges. And that it's also indeed a final payment, not a starting point.

Mr. BANKS. I have another question to followup with it you had a quick—

Mr. ISASI. I was just going to say, Congressman, it's such an important question you are asking which are the unintended consequences in trying to solve this problem. And this idea that by trying to get providers to coordinate and work in networks, you can create consolidation and then you can really damage competition and price goes up. And it's a very valid concern.

In this instance, however, we are dealing with these, what folks refer to as auto-referrals or inelastic demand where these providers' are—this isn't a situation in which you have two competitive providers who are operating. And then you are bringing them together and you're killing competition.

It's an instance where you have these providers who are protected from competition because they get these auto-referrals, right. And it could be because when I come in for a service in this facility the lab service goes here and there is no competition, right.

So, I think it is a really important question. We are doing a lot of thinking about that at Families. It's a central part of a focus of our work in the coming year, but in this instance, because you are in this auto-referral environment with inelastic demand, it's actually the opposite problem. These guys never compete because they can just count on this volume no matter what.

Mr. BANKS. And thank you for that. Let me move on really quick. Because Medicare pays hospital owned outpatient departments more than independent practices, hospitals have a strong incentive to purchase outpatient departments in clinics. Not only does this results in higher copays and out-of-pocket expenses for patients, it pushes overall costs higher through increased consolidation.

Ms. Schuman and Mrs. Young, or the other of you who want to weigh in on this too if we have time left, is it fair to worry that a bundled services model of payment could encourage even more vertical consolidation in the hospital market and further drive up costs just like the lack of site neutral payments? Ms. Young?

Ms. YOUNG. Sure, I can start. So I think that in this arena, these are already providers that are sort of by definition practicing in the hospital. Your anesthesiologists, your radiologists, they are already delivering the services in the context of a hospital inpatient stay or an emergency department visit. So, I think there is less reason to be worried about it in this context of others.

I would also add that these provider groups and hospitals typically have, already have sort of linked financial relationships so there is—you're not creating a new dynamic or a new set of incentives here.

Mr. BANKS. Ms. Schuman, I got 20 seconds left.

Ms. SCHUMAN. Yes, so I would just reiterate those same comments and want to do—and also the importance and advocacy for site neutral payment reform as a way to remove some of the disincentives to a lack of competition and consolidation. And as I said before, I think the bundled payment model could have some promise here but we need to include the appropriate guardrails.

Mr. BANKS. I wish I had my—

Chairwoman WILSON. Thank you.

Mr. BANKS [continuing]. more time for the rest of you but my time has expired.

Chairwoman WILSON. Thank you, Mr. Banks. Mr. Morelle.

Mr. MORELLE. Thank you, Madam Chair, for holding this very important hearing. I just want to note that during my time in the New York State Assembly tackling the issue of surprise billing was priority for me when I serve as chair of the insurance committee. And then as majority leader, I am very proud that our work culminated in the bipartisan passage of New York's groundbreaking out-of-network consumer protection law.

And I just want to take a moment or two to just describe what we did and then to get some feedback from the panel. This law took effect in 2015, so it has been on the books now for several years.

And the law created transparency and a simple system for resolving out-of-network medical bills which we believe makes life easier for every New Yorker that would otherwise be hit with costly bills that would devastate their families.

In addition—and this was really important to us as we were drafting—that the law did not in my view create a perverse incentive for people, providers to move out-of-network because they would get a benefit financially from doing so, and we avoided that.

In New York, hospitals, clinics, physicians, provide patients with public information regarding standard charges for medical services and insurance plan participation, and the law allows patients to be smart consumers of medical care, reducing the possibility of the first place of being hit with an out-of-network charge.

But even more importantly, the law provides a mechanism for providers and insurers to come together to resolve out-of-network charges without stress or additional costs to the patient.

In cases where patients received emergency services at an out-of-network facility, the patient is held harmless paying the same exact copay or deductible as they would as an in-network emergency department.

And even patients without insurance or those with non-State regulated health insurance are eligible to file a dispute for an emergency services bill so those self-insured and other plans covered by ERISA not regulated by the State.

In addition to surprise emergency room bills, New York patients are protected when a non-emergency provider sends them an unexpected bill and rather than being forced to cover out-of-network costs from their own pocket, patients do an assignment of benefit to their provider who then has to negotiate a reimbursement amount with their health plan. So again, the consumer is taken out of it.

In the rare cases that negotiation is unsuccessful, an independent arbitrator is able to make the determination to set a reimbursement rate within 30 days.

I think it says a lot that in most cases arbitration is not necessary. I heard yesterday, and I have got to verify this, but roughly 800 arbitrations out of 7 million claims information. Instead insurers and providers can reach an acceptable deal without the consumer having to pay any—devote any more time, money or any more headaches.

The law has helped settle about 2,000 billing disputes and protecting those New Yorkers from potential harmful medical debt.

To my colleague, Ms. Shalala, I just want to note my data shows that out-of-network bills in New York has declined 34 percent since the law took effect in January or I think January 2015.

In addition, prices charged by in-network emergency room doctors have dropped by 9 percent. So, it is rare but in New York and I have talked within the last several days in advance of this hearing to insurance plans, consumers, and health care providers and they all agree that the system has changed for the better and frankly there is not much that those three groups necessarily agree on.

So to any of our panelists and I apologize, that was sort of a long intro to this, but I would be curious as to your observation of New York's law which has been in place now three plus years and whether or not there are things that New York has done that could be done better in your view and what barriers there would be to putting those protections at the Federal level? And I would ask each of you to quickly just—

Ms. YOUNG. So, I'll be quick. I think the strengths of the New York law are that it is very comprehensive and it's clear to stakeholders what the process looks like.

The potential reason for concern is that I think that because the New York law gives guidance to arbiters that's based on charges for services, it has the potential to be inflationary over time. It is a concern that a lot of observers have about how the New York law may evolve and I would encourage folks to think carefully about that.

Mr. MORELLE. And the direction we use is that 80 percent of the usual and customary charge is determined by the Fair Health Plan.

Ms. YOUNG. Right. So, it is 80 percent of charges. The problem with charges is they're not market-determined. So, it's a bit like saying sort of, you know, the 80th percentile of your wish list to Santa. Over time there is no constraint on what you ask Santa for, so it can be inflationary over time in ways that we should think carefully about.

Mr. MORELLE. Got you. Any others?

Ms. SCHUMAN. Yes, I want to just raise that same sentiment and the concern that an arbitration model that in any way uses a reference to billed charges is just going to billed in those same perverse incentives that we're trying to address.

Mr. MORELLE. I do note—

Chairwoman WILSON. Thank you.

Mr. MORELLE [continuing]. the end response.

Chairwoman WILSON. Thank you.

Mr. MORELLE. I'm sorry. Let me just do this, Madam Chair. I would ask unanimous consent to submit the following letter from the Heath Association of New York State which highlights the success of comprehensive legislation in New York to eliminate surprise billings and the benefits it's created for New Yorkers.

Chairwoman WILSON. Without objection.

Mr. MORELLE. Thank you.

Chairwoman WILSON. Thank you so much, Mr. Morelle. Mr. Watkins.

Mr. WATKINS. Thank you, Madam Chairwoman. Nobody likes going home, opening the envelope and finding a surprise medical bill. Lack of network and cost transparency seems to be a problem. As Congress members, where should we start looking to find a solution to this? Are there State law or State law models that we could adapt at the national level? Ms. Schuman?

Ms. SCHUMAN. Sure. Sure, happy to talk about that. and I think your—we can look to the State models as examples. As we talked about before, they have limited application in the sense that they don't include ERISA plans so that's a large swath of people that aren't going to be protected by State laws.

So and also some of them are rather new. So we don't really know what their application over time is and just the discussion we were just having for example with respect to New York and the arbitration model there, I think we can, we need to guard against any sort of structure in an arbitration model that would use billed rates as direction to the arbitrator. Because that would I think just fuel and further incentivize out-of-network providers to stay out-of-network and raise their bill charges.

So we have got certainly lessons that we look to the States but recognizing again that to get at the problem and its root and in a uniform matter we need Congress to act.

Mr. WATKINS. Thank you, Ms. Schuman. Mrs. Chairwoman, I yield my time.

Chairwoman WILSON. Ms. Trahan.

Ms. TRAHAN. Thank you, Madam Chairwoman. Thank you all for your testimony today, it has been very helpful.

My father was an ironworker before he was diagnosed with multiple sclerosis. MS as you all know is an unpredictable and disabling disease of the central nervous system. And for those living with a chronic and progressive disease like MS, surprise billing adds undue stress and financial uncertainty.

For instance, an individual living with MS might go to an in-work facility—an in-network facility but be seen by an out-of-network neurologist.

So, Ms. Young, we all have heard stories from family members and from our constituents who have received surprise medical bills even after carefully researching their provider networks. How can we best protect these individuals who suffer from chronic diseases like MS from surprise medical bills in all settings of care, including those non-emergency situations?

Ms. YOUNG. Thanks for that question. So, there are two key principles in designing a solution. The first is to take patients out of the middle as we have talked about. It's essential that patients not be responsible for these balance bills and not have the burden placed on them to navigate the system.

And the second principle in designing a solution is to create a system that doesn't drive up overall health care spending. And with the group of scholars at the Brookings Institution, we have recommended two potential policy solutions.

One we call billing regulation. It's something that we have talked a lot about this morning where we would use policy to set a cap on what providers can get paid out-of-network. Again, our goal here isn't to determine the ultimately correct commercial payment rate, it's just to end the lucrative out-of-network billing option and instead restore sort of a more normal set of market incentives for these folks. So that's one option.

And that's what we see in all States or the vast majority of States that have tackled this problem. They use a model that looks like that.

The other potential approach is something that we have called contracting regulation, you have heard from others under the name of bundling but the idea is simply to get this group of providers out-of-the business of billing patients directly at all. That's a big step, it's a big change from the way these services are billed today but it does have analogs in other parts of our health care system. It is how nurses and nursing services are paid and billed today. So, I think it is an area worthy of exploration.

Ms. TRAHAN. Great, thank you. Thank you for that. Mr. Isasi, I—the workplace is a single, is the single largest source of health coverage in the United States. According to the Kaiser Family Foundation about 152 million Americans, which is about half of our non-elderly population, are enrolled in employer-sponsor health insurance.

So, I think it is critical for us to highlight how surprise billing impacts employer-sponsored insurance specifically. How common are surprise bills among enrollees in employer-sponsored plans?

Mr. ISASI. Yes. Well, what we know is the research is very clear. They are as common in employer-sponsored coverage as they are in insured or individual plans. There is no difference. It happens just as often.

Ms. TRAHAN. So same—no difference between individual and group market?

Mr. ISASI. Exactly. Exactly.

Ms. TRAHAN. How should the committee proceed then in order to fully protect workers in terms—from your view?

Mr. ISASI. Yes. Well, I think the principles we are hearing, there's such broad agreement on the panel and amongst all the members. This is really clear. As we talked about earlier, this is a situation in which the tail is wagging the dog, right.

When you enroll in health insurance and your hospital says this is our network, you get to go to that hospital and get services and be in-network. Right. You don't get to be surprised because your hospital decided, you know what, we are not going to negotiate with the ER docs, they will be out-of-network. Or we are not going to negotiate for laboratory services, right.

So, this principle that the entity that should bear the risk of building the network and paying for it and making sure those services are part of the contract is the hospital, the payer and the provider. Not the consumer. So, the consumer is taken out-of-the equation is a really important one.

The second one is the idea that transparency is not nearly enough. We all know this, we know this from our experience, we know this from the research that the health care sector cannot provide real, actual information to consumers at point of service about what their network looks like, what their costs are. There is lots and lots of data about this.

And so you can't put the onus on the consumer to just simply figure out what the price is or whether or not they are in-network.

I think the third is this idea that patients—this is not just about emergency services. Right. It's about ancillary services that can occur without your even knowing. So, if you go get surgery, your surgeon is in-network, your hospital is in-network, but your anesthesiologist is not. That can't happen either.

Ms. TRAHAN. Well, great.

Chairwoman WILSON. Thank you.

Ms. TRAHAN. Thank you so much. I yield back.

Chairwoman WILSON. Thank you, ma'am. There are no more members here. Anyone else—questions? Wow. Okay.

I want to remind my colleagues that pursuant to committee practice, materials for submission for the hearing record must be submitted to the committee clerk within 14 days following the last day of the hearing. Preferably in Microsoft Word format.

The materials submitted must address the subject matter of the hearing. Only a member of the committee or an invited witness may submit materials for inclusion in the hearing record. Documents are limited to 50 pages each. Documents longer than 50 pages will be incorporated into the record via an internet link that you must provide to the committee clerk within the required time-frame. But please recognize that years from now that link may no longer work.

Again, I want to thank the witnesses for their participation today. Thank you so, so much. This was fabulous. What we have heard is very valuable.

Members of the committee may have some additional questions for you and we ask the witnesses to please respond to those questions in writing. The hearing record will be held open for 14 days in order to receive those response. And I will guarantee you, you will have lots of questions. Everyone seemed to have run out of time.

I remind my colleagues that pursuant to committee practice, witness questions for the hearing record must be submitted to the majority committee staff or committee clerk within 7 days. The questions submitted must address the subject matter of the hearing.

I am now going to ask the ranking member, our distinguished Mr. Walberg for his closing statement.

Mr. WALBERG. Thank you, Madam Chairwoman, and thank you for leading this hearing today. It is something that I think a lot of us have looked forward to as we have begun to hear more and more of the problem and it is not just my situation. Or yours. It's running rampant at this point in time.

It's impacting our employees, its impacting our employers. It's impacting our health care providers, our insurance industry.

But I think what came out today to me most importantly was that No. 1 concern we need to address and I think in unanimity here on this panel as well. We believe it is the patient. The patient who has the need at the moment, seeking the care from probably the best health care opportunity in the world, and yet some of the highest costs that continue to be there because a system is literally confused if not broken. And so as I have listened today, Madam Chairwoman, I think we can come to an agreement and I think the fact that we have people here on this panel, this committee, who have done yeoman effort in their own States to come up with solutions, I think we have had a head start in understanding some of the pitfalls we can stay away from.

Some of the benefits we can go directly toward and ultimately a solution that will indeed be a compromise, but a compromise that is a long way ahead of where it could have been had we not had the expertise or the experience involved.

In the end, with a society that is not only intent on having health care available, and we do our effort, our research to find our physician that is in-network, our hospital that is in-network and we think we have it all done for ourselves. We need to make sure that is the case.

But I think also let's not forget the fact that we are a mobile society. We travel all over. And one of my passions, indeed maybe my only advice—only vice that I will admit to, other than fly fishing is motorcycling.

When I travel around the country on my motorcycle, if something perchance would happen, I want to make sure I am taken to a hospital, hopefully not by a helicopter but hopefully not by even an ambulance, but if I am, that I am cared for.

And ultimately in this great country, I am not put into a situation that's financially impossible as a result of taking the care that is good care but in a place that happens to be out-of-network.

So I am, I commit myself for working with you, Madam Chairwoman, and appreciate your efforts on this behalf and hopefully we will come to a conclusion sooner rather than later. I yield back.

Chairwoman WILSON. Thank you, Mr. Walberg. We are going to work toward that goal together. Yes. Okay. I now recognize myself for the purpose of making my closing statement.

Again and again I would like to thank the witnesses for providing their testimony today. This has been fabulous. This hearing is the first step in what I hope can be a bipartisan conversation as we work to develop a solution to the challenge of surprise medical billing.

As the committee of jurisdiction over employer-sponsored health coverage, we have a crucial role to play in developing comprehensive legislation to address this problem. Our witnesses' testimony will prove invaluable as we move forward. We heard from Ms. Young about the prevalence and impact of surprise bills as well as some potential ideas for solutions to this problem.

We heard from Ms. Schuman about the perspective of large employers regarding surprise bills.

We heard from Mr. Isasi about the devastating impact these bills have on consumers, as well as some key principles that should guide us as we look forward toward reform.

And we heard from Dr. Hoadley about the innovative solutions that States have taken to protect consumers from surprise bills.

As our witnesses have made it clear, it is up to Congress to move forward to comprehensively address this issue on behalf of our constituents.

I look forward to continuing this process in the weeks and months ahead.

I thank my colleagues for an informative and productive discussion, and I yield back my time.

If there is no further business, without objection, the committee stands adjourned. Thank you.

[Additional submissions by Mrs. Foxx follow:]

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Statement for the Record
of the
American Medical Association
for the record

U.S. House of Representatives Committee on Education and Labor
Subcommittee on Health, Employment, Labor and Pensions

Re: Examining Surprise Billing: Protecting Patients
from Financial Pain

April 2, 2019

Division of Legislative Counsel
(202) 789-7426

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STATEMENT

of the

American Medical Association

to the

**U.S. House of Representatives Committee on Education and Labor
Subcommittee on Health, Employment, Labor and Pensions**

Re: Examining Surprise Billing: Protecting Patients from Financial Pain

April 2, 2019

The American Medical Association (AMA) appreciates the opportunity to present our views to the U.S. House of Representatives Committee on Education and Labor, Subcommittee on Health, Employment, Labor and Pensions concerning unanticipated medical bills. As health insurance plans increasingly rely on narrow and often inadequate networks of contracted physicians, hospitals and pharmacies to control costs, even patients who are diligent about seeking care from in-network physicians may face unanticipated medical bills from out-of-network providers that participate in their care. Physicians are limited in their ability to help patients avoid these unanticipated costs because like patients, they may not know in advance who will be involved in an episode of care, let alone other providers' contract status with all the insurance plans in their communities. Health insurers must be incentivized to negotiate fair contracts with physicians to ensure that networks are sufficiently robust.

The problem of unanticipated out-of-network bills is complex and requires a balanced approach to resolve. The AMA agrees that any solution must keep patients out of the middle of payment rate negotiations and ensure that when patients seek emergency care or otherwise do not have the opportunity to select their provider, they should not be responsible for cost sharing beyond what they would face if they had seen an in-network provider. Any proposed solutions should also require both providers and insurers to be transparent about anticipated charges and the amount of those charges that insurance will cover. We also agree that if balance billing is banned, there must be a process in place to ensure that providers receive fair reimbursement for their services.

The AMA encourages Congress to look to states that have already acted to address unanticipated medical bills, specifically those state laws that have functioned well such as New York and Connecticut. The AMA is committed to working with Congress to find a workable solution for all stakeholders that protects patients from unanticipated out-of-network bills.

Key Principles in Addressing Unanticipated Medical Bills

There are several key principles that must be a part of any solution proposed to address unanticipated out-of-network medical bills. First, oversight and enforcement of network adequacy is needed. Robust network adequacy standards include, but are not limited to, an adequate

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ratio of emergency physicians, hospital-based physicians, and on-call specialists and subspecialists to patients, as well as geographic and driving distance standards and maximum wait times. Provider directories must also be accurate and updated regularly to be useful to patients seeking care from in-network providers. In addition, insurers should be held to complying with the prudent layperson standard in existing law for determining coverage for emergency care, so that insured patients are not liable for unexpected costs simply because they were unable to accurately self-diagnose ahead of time whether their symptoms were, in fact, due to an emergency medical condition.

Any solution to address unanticipated medical bills must also require transparency so that all patients who choose in advance to obtain scheduled care from out-of-network physicians, hospitals or other providers are informed prior to receiving care about their anticipated out-of-pocket costs. When scheduling services for patients, providers should be transparent about their own anticipated charges, and insurers should be transparent about the amount of those charges they will cover.

In general, the AMA urges Congress to avoid any solutions that arbitrarily cap payment for physicians treating out-of-network patients. If pursued, guidelines on what out-of-network providers are paid should reflect actual charge data for the same service in the same geographic area and should not be based on a percentage of Medicare rates, which have become increasingly inadequate in covering overhead costs or be based on in-network rates, as either standard would eliminate the need for insurers to negotiate contracts in good faith.

The AMA could support a legislative solution that provides for a mediation or sequential alternative dispute resolution (ADR) process for those circumstances where the minimum payment standard is insufficient due to factors such as the complexity of the patient's medical condition, the special expertise required, comorbidities, and other extraordinary factors. Arbiters should not be required to consult in-network or Medicare rates when making final determinations regarding appropriate reimbursements.

Finally, as noted previously, the AMA strongly supports solutions that keep patients out of the middle of payment rate negotiations. Patients should only be responsible for in-network cost-sharing amounts when experiencing unanticipated medical bills.

Successful State Models

Many states have acted to address unanticipated out-of-network billing and there are several existing state models that have worked well to protect patients from surprise medical billing. The AMA points to New York's balance billing law as a well-functioning model for several reasons including:

- The law protects patients from unanticipated out-of-network bills.
- The law emphasizes the role of network adequacy in solving the "surprise" billing problem and puts in place new requirements to regulate networks and affords patients the right to an independent external appeal to be treated by a non-network provider if the network is inadequate.
- The law establishes a strong independent dispute resolution (IDR) process made by a reviewer with training and experience in health care billing, reimbursement, and usual and customary charges in consultation with a licensed physician in active practice in the same or similar specialty as the physician providing the service that is the subject of the dispute.

- The IDR process requires consideration of factors, including the rate that non-participating physicians charge for the service in the area based on independent data, usual and customary charge for the service based on independent data, the complexity of the case, and the physician's experience, training and education.
- There are no data that we know of that suggest that the law has resulted in either premium increases or a dramatic narrowing of networks.

The AMA also views the Connecticut law on unanticipated out-of-network care for emergency services as a potential model for all unanticipated out-of-network care situations because:

- The law protects patients from unanticipated out-of-network bills for care received at an in-network hospital.
- The law creates a solution by establishing a payment standard that incorporates charge data from an independent data source.
- There is no evidence that we know of that suggest law has resulted in premium increases, dramatic narrowing of networks, or higher rates of out-of-network physicians.

Facilitating In-Network Contracting

It is important to recognize that most physicians want to be included in payers' networks, if fair contracts are offered. However many physicians are in a weak bargaining position relative to commercial health insurers. Therefore, Congress must incentivize insurers to come to the negotiating table with physicians and offer fair contracts. The most promising way for policymakers to facilitate contracting between providers and health plans is to ensure regulation of provider networks. Strong network adequacy requirements create a more balanced environment for all stakeholders where: insurers are incented to maintain meaningful access to in-network providers by offering providers competitive contracts; providers are incented to come to the table knowing that it will be a fairer process; and patients will have access to in-network care and get greater value for their premiums paid.

While there has been a great deal of discussion about the growth of narrower provider networks, relatively little has been done to create or enforce network adequacy requirements, especially as they relate to hospital-based providers. Ensuring that, at a minimum, in-network providers are available at in-network hospitals should be the first step for legislators and regulators in addressing unanticipated out-of-network care at in-network hospitals. Moreover, ensuring that patients have appropriate access to primary and specialty care will go a long way in preventing emergency department visits and other hospitalizations that may lead to unanticipated out-of-network bills.

The basis of network adequacy standards should be quantitative, measurable requirements on the front-end, before insurance products are brought to market. The quantitative standards should include minimum time and distance requirements, maximum patients-to-provider ratios, and maximum wait times. In addition, and specific for hospital-based specialties, it is critical that standards also measure access to in-network physicians at in-network hospitals.

Meaningful regulation of provider networks must also be ongoing. Consistent monitoring of the network's ability to provide in-network hospital-based care is particularly important, given that patients may not evaluate access to these providers simply through a directory or other tool, as is normally the case when choosing a provider.

Finally, it is important to recognize the connection between accurate provider directories and meaningful access to in-network providers for patients. The AMA encourages greater oversight of provider directories and stronger requirements that they be transparent and up-to-date. Patients need access to robust, up-to-date provider directories to enable them to determine which providers are in-network as they purchase their plans, and which providers continue to be in-network as their medical needs change. Additionally, providers need accurate information from health plans to allow for in-network referrals when further treatment is needed.

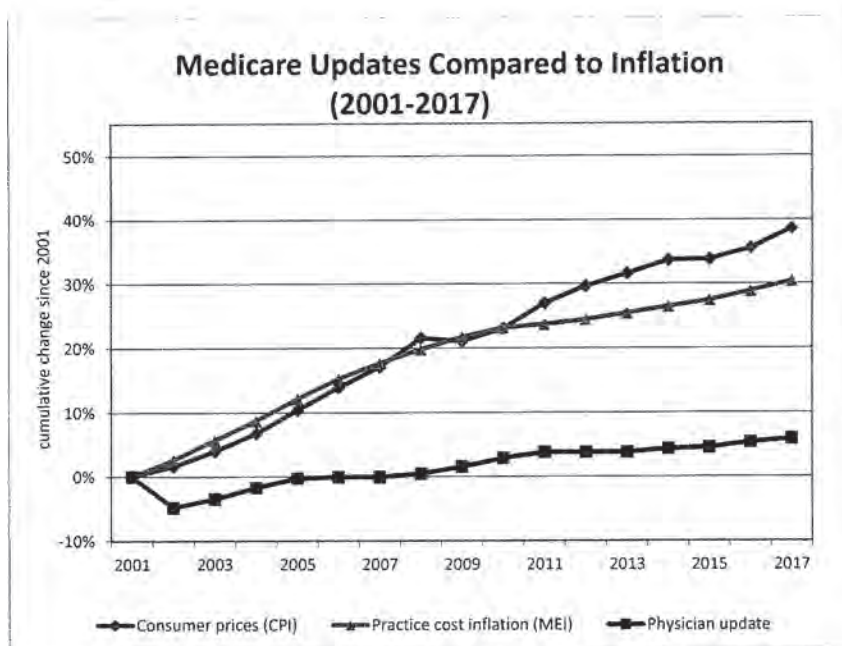
Payment Standards

As AMA has repeatedly pointed out, Medicare payment rates do not reflect the costs of providing care, especially in the commercial market where the population varies greatly. Medicare uses the resource-based relative value scale (RBRVS) system to establish physician payments, determined by the resource costs associated with the total amount of physician resources required to provide a specific service. However, before Medicare rates are finalized, they go through adjustment and conversion processes to meet federal budgetary requirements. Adjustments are done in a budget neutral manner, meaning that if an adjustment increases the payment for one service, it must account for this increase by decreasing payment in another. This establishes artificial decreases in payment for many physician services every year. And before the final Medicare payment is set, geographically adjusted values are multiplied by a conversion factor - a monetary payment determined by Medicare each year that changes based on the Medicare economic index, adjustments pertaining to budget neutrality and other adjustments stipulated by legislation. After everything is complete, the resulting payment rates are not reflective of markets rates for physician services.

As illustrated by the chart below, Medicare physician payments have not kept up with inflation over the past decade. According to data from the Medicare Trustees, Medicare physician payment rates have barely changed over the last decade and a half, increasing just six percent from 2001 to 2017, or just 0.4 percent per year on average. And, under the Medicare Access and CHIP Reauthorization Act (MACRA), physician payment rates will be frozen for calendar years 2020 through 2025.

In comparison:

- The cost of running a medical practice has increased 30 percent between 2001 and 2017, or 1.7 percent per year. Inflation in the cost of running a medical practice, including increases in physician office rent, employee wages, and professional liability insurance premiums, is measured by the Medicare Economic Index, or MEI.
- Economy-wide inflation, as measured by the Consumer Price Index, has increased 39 percent over this time period (or 2.1 percent per year, on average).



Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics

Over time, the adequacy of Medicare physician payment rates has eroded significantly. Adjusted for inflation in practice costs, Medicare physician payment rates have declined 19 percent from 2001 to 2017, or by 1.3 percent per year on average. As such, the AMA opposes efforts to cap or benchmark out-of-network physician payments on a percentage of Medicare. Linking out-of-network rates to Medicare would eliminate any incentive for insurers to build adequate networks or offer physicians fair contracts.

Thank you for the opportunity to offer our input. We look forward to working with you and your colleagues to help determine the best way to protect patients from costly surprise medical bills.



Statement for Hearing on

“Examining Surprise Billing: Protecting Patients from Financial Pain”

**Submitted to the
House Education and Labor Committee
Subcommittee on Health, Employment, Labor, and Pensions**

April 2, 2019

America’s Health Insurance Plans (AHIP) and our members are committed to finding solutions to alleviate the financial burdens imposed on patients by surprise medical bills. Everyone in America deserves affordable, high-quality coverage and care, and control over their health care choices. Surprise medical bills undermine these values, putting the health and financial stability of millions of patients at risk every year.

Surprise medical bills are a major national problem affecting at least one in five Americans annually. These bills—for unjustifiably high prices for medical treatment—create tremendous financial burdens for families and can even lead to bankruptcy. In addition, the inflated prices typically lead to health insurance providers and employers paying far more than negotiated rates for care, which increases premiums for everyone. Federal legislation is needed to end this practice and protect patients, particularly for the more than 100 million Americans who have coverage through an ERISA plan not covered by state reform efforts.

Our statement focuses on the following:

- Why people receive surprise medical bills and how this impacts hardworking Americans;

America’s Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

- Principles and legislative recommendations for protecting patients from surprise medical bills; and
- The importance of developing and maintaining strong provider networks to achieve lower costs and high quality care for patients.

Surprise Medical Bills Harm Americans

When consumers are enrolled in health care coverage and receive services through their plan's provider network, the health insurance provider typically covers the cost of medical care beyond the required copayment, coinsurance, or deductible. However, when patients receive care from out-of-network providers—either voluntarily or involuntarily—the provider often will send patients a bill for charges for which they are responsible. This can be particularly challenging for patients who go to a hospital that is in their health plan's provider network, but see a doctor at that hospital who is not in the network.

When it comes to paying for services in a hospital, patients often don't realize that many physicians are independent contractors who work *at* the hospital, but not *for* the hospital. That means that hospitals can have "in network" status as part of a health plan's provider network, but the doctors delivering care to patients at the hospital might not.

Under current law and practice, most states allow a doctor to bill a patient for any balance that may be outstanding after the health insurance provider pays the costs for which it is responsible. But those charges become truly problematic for patients when out-of-network providers—who are not bound by contractual, in-network rate agreements with an insurance provider—bill patients for the entire remaining balance.

Surprise medical bills mean that patients are often burdened with thousands of dollars of costs—or even tens of thousands of dollars—for the care they received in an emergency room or at the hospital, often without even knowing the doctor who treated them. This can be financially devastating for most American families. Forty percent of American families cannot afford an unexpected \$400 expense.²

² Board of Governors of the Federal Reserve System. (May 2018). "Report on the Economic Well-Being of U.S. Households in 2017"

The problem of surprise medical bills tends to be concentrated among certain medical specialties where providers are likely to charge substantially more than their peers in other specialties and not accept private insurance. Studies have found that surprise medical bills are most likely to come from emergency medicine physicians, anesthesiologists, radiologists, and pathologists.

For example, one study found that:

- Anesthesiologists charge, on average, 5.8 times the Medicare reimbursement rate;
- Radiologists charge, on average, 4.5 times the Medicare rate; and
- Emergency medicine physicians and pathologists charge, on average, 4 times the Medicare rate.³

Research also shows that 14 percent of all patients treated in an emergency room were likely to receive a surprise medical bill in 2014, as well as 9 percent of all admitted hospital patients.⁴ The figure more than doubles to 20 percent for hospital inpatient admissions that originated in the emergency room. In addition, 51 percent of ambulance rides nationwide were likely to result in a surprise bill in 2014.⁵

There is substantial geographic variance in the likelihood of receiving a surprise medical bill, largely because specialists and emergency rooms in some parts of the country are noticeably less likely to accept private insurance. In these instances, the market power obtained through aggressive provider consolidation prevents contractual network agreements. For example, patients treated in McAllen, Texas and St. Petersburg, Florida had an 89 percent and 62 percent chance, respectively, of receiving surprise medical bills. In Boulder, Colorado and South Bend, Indiana, researchers found the rate of surprise bills to be nearly zero.⁶

Finally, even for those who never receive a surprise medical bill, this practice translates into higher premiums. A 2015 analysis of out-of-network charges in New Jersey highlights the

³ Bai, G., & Anderson, G. F. (2017). Variation in the Ratio of Physician Charges to Medicare Payments by Specialty and Region. *JAMA*, 317(3), 315

⁴ Garmon, C., & Chartock, B. (2017). One In Five Inpatient Emergency Department Cases May Lead To Surprise Bills. *Health Affairs*, 36(1), 177-181. [jun_lucia_balance_billing_ib.pdf](#)

⁵ Garmon and Chartock (2017)

⁶ Cooper and Morton (2016)

impact of these charges on consumer premiums.⁷ For the largest health insurance provider in the state, out-of-network claims comprised 8 percent of their total commercial spending in 2013. If the insurer had paid these out-of-network claims at 150 percent of Medicare rates, rather than the billed charges, the insurer would have paid 52 percent less for out-of-network services, amounting to savings of \$497 million, which could result in a reduction of 4.3 percent in total commercial claims and consumers paying 9.5 percent less out-of-pocket.

The bottom line is that surprise medical bills create financial hardship for millions of Americans, and legislative action is needed to address this problem.

Patients Should Be Protected From Surprise Medical Bills

Health insurance providers act as the consumers' advocate and bargaining power, ensuring that they have affordable choices for coverage so they can get the care they need. We believe every American deserves affordable, high-quality coverage and care, as well as control over their own health care choices.

In December 2018, AHIP joined other leading organizations representing consumers, businesses, and health insurance providers, voicing our support of a set of core, guiding principles to protect patients from receiving surprise medical bills after getting the care they need.⁸

By signing onto these guiding principles, we agree that:

- **Patients Should Be Protected from Surprise Medical Bills Through Federal Legislation.** We support federal legislative action to end surprise medical bills.
- **Patients Should Be Informed When Care Is Out of Network.** Patients have a right to know about the costs of their treatment and options.
- **Federal Policy Should Protect Consumers from Surprise Medical Bills While Restraining Costs and Ensuring Quality Networks.** Putting patients first means enacting

⁷ Avalere Health (2015). "An Analysis of Policy Options for Involuntary Out-of-Network Charges in New Jersey." http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1427291367_AH_Analysis_of_Policy_Options_WP_v3b2.pdf

⁸ <https://www.ahip.org/wp-content/uploads/ Surprise-Billing-Consensus-Statement-12.10.18.pdf>

policies that protect consumers from surprise medical bills, while ensuring that those policies do not simultaneously increase premiums or other costs for consumers.

- **Payments to Out-of-Network Doctors Should be Based on a Federal Standard.** More than 100 million Americans are enrolled in a self-funded health plan. Protecting them requires a federal standard that reduces complexity while ensuring they cannot be surprise-billed for emergency or involuntary care.

We also recently joined 16 other organizations representing employees, large and small businesses, health insurance providers, and brokers in sending a letter to congressional leaders, calling for meaningful steps to address surprise medical bills.⁹ Our letter urged Congress to “take action this year to pass legislation that will protect patients from surprise medical bills and rein in out-of-control health care costs.”

Building on the principles we endorsed and our work with other health care leaders, AHIP is advocating for federal legislation that would protect patients from egregious out-of-network surprise medical bills. We have four recommendations for legislative action on this issue.

First, hospitals and other health care providers should be prohibited from sending a surprise medical bill for: (1) emergency health care services provided at any hospital; (2) ambulatory transportation (either ground or air) to any health care facility in an emergency; or (3) any involuntary health care services or treatment performed at an in-network facility by a non-participating (out-of-network) provider. In situations involving emergency or involuntary care, patient cost-sharing should be limited to the amount that would apply if the patient had been treated by a participating network provider.

Second, hospitals and other health care providers should be required to provide an advance notice to patients, which informs them of their providers’ network status and possible options for seeking care from a different provider. Patients have a right to know about the costs of their treatment and options. They should receive complete information about whether facilities or providers do not participate in their health plan and what that could mean for their financial obligations. This notice should be for informational purposes only and not constitute a waiver of patient rights or a release of obligations imposed upon facilities or providers.

⁹ <https://www.ahip.org/wp-content/uploads/Hill-Sign-on-Letter-Surprise-Medical-Bills-031819-2.pdf>

Third, in situations involving emergency or involuntary care, criteria should be established—based on market rates determined by reasonable, contracted amounts paid by private health insurance providers or Medicare—to determine the reimbursement paid to non-participating health care providers. Without reasonable reimbursement criteria, arbitrary and excessive payments to out-of-network providers will continue to increase premiums for everyone and undermine both health plans' provider networks and care coordination—leading to higher costs and decreased value for patients. In setting reimbursement criteria, Congress should take an approach that does not lead to increased health costs for either individual consumers or the overall health care system.

Fourth, these protections should apply nationwide to all self-funded plans governed by the Employee Retirement Income Security Act (ERISA) with the option for states to establish standards for reimbursement through enacted legislation. While states have taken varying approaches to addressing surprise medical bills, they lack the authority to protect the more than 100 million Americans enrolled in employer-provided coverage that is self-funded by their employer and regulated under ERISA (which specifically precludes states from regulating these plans). For this reason, federal legislation is necessary. ERISA has been amended in the past to require mental health parity, establish out-of-network emergency room payment amounts, cover clinical trials, and prohibit annual and lifetime dollar caps. However, we recognize that ending surprise billing would place new requirements on health plans, hospitals, and health care providers.

Improving Affordability by Reining in Out-of-Network Costs

Egregious surprise medical bills are not only a financial burden on the patients billed, but a cost-driver for the entire health care system. Certain provider groups recognize they have market leverage heavily weighted in their favor and therefore are empowered to bill in amounts that do not reflect the actual costs of care or good faith negotiations. These bills are a key part of the reason health costs are so high – the prices demanded by certain physicians inflate costs for everyone. The prices are too high, and not based on any market force.

Benchmarking rates to market-based negotiations will help address these high prices. We noted above the detailed inflation for certain specialty providers compared to other provider groups and the amounts reimbursed by Medicare. Researchers from the University of Southern California and the Brookings Institution note that “ED and ancillary physicians, as well as hospitalists,

neonatologists, and ambulance companies...have a potentially lucrative out-of-network billing option that is unavailable to most providers. The amount charged to out-of-network patients face few market constraints..."¹⁰ Given the lack of a free market and a clear leverage imbalance, the problem will not be fully solved without addressing the root cause. Doing so will help reduce costs for all, if properly regulated through a payment benchmark that drives rates to result from negotiations between payors and providers.

With a level-playing field, out-of-network billing becomes less lucrative and consumers will pay less. It is worth noting that requiring out-of-network bills to be reimbursed based on negotiated in-network rates brings the rates back to a place where they are set by the market, rather than one-sided demand. Health insurance providers and doctors routinely negotiate rates based on the cost of care, demand for services, expertise of the provider, and other factors that ensure fair compensation at costs that reflect competitive market realities. This process gives leverage to both the health care provider and the payor, resulting in a rate set not by the health insurance provider, but rather mutually agreed upon by both parties.

Some proposals would rely not on negotiated rates, but on billed charges. Reimbursements based on billed charges do not address the root cause of surprise medical bills and will not meaningfully reduce health care costs. Indeed, researchers reached the same conclusion, finding that "basing an out-of-network charge limit on billed charges would likely lead to too high a limit and drive up health costs and insurance premiums. Charges (or list prices) face little constraint from market forces and tend to be extremely high relative to objectively reasonable prices."¹¹ These proposals include those that create an independent dispute resolution process, such as "baseball style" arbitration, that gives billed charges equal consideration as negotiated rates. When the process relies on inflated charges to begin with, the end result will similarly be inflated payments.

The problem of highly inflated billed charges is one that has increased exponentially in recent years and driven not by greed on the part of doctors who are focused on practicing medicine, but rather by for-profit staffing firms that have driven provider consolidation and raised prices as the central component of their business strategy. Researchers at the American Enterprise Institute (AEI) looked into this and reached a similar conclusion as Brookings researchers: that provider

¹⁰ Adler, L., Fieldler, M. et. al., (February 2019) *State Approaches to Mitigating Surprise Out-of-Network Billing* USC-Brookings Schaffer Initiative for Health Policy White Paper: https://www.brookings.edu/wp-content/uploads/2019/02/Adler_et-al_State-Approaches-to-Mitigating-Surprise-Billing-2019.pdf

¹¹ *Id.*

consolidation and staffing companies' profit strategies have escalated this problem. Indeed, that is why AEI notes that "surprise out-of-network billing does not appear to be a problem for most hospitals" but rather where provider consolidation has made high out-of-network bills an attractive business strategy, finding that "some providers actively take advantage of this fact."¹² AEI singled out one of the largest physician staffing companies in the U.S., EmCare, and pointed to research finding that "EmCare raises list prices by 96 percent on average, which dramatically increases the size of potential balance bills."¹³ The same researchers found that "at many facilities, 100 percent of ED patients receive an out-of-network physician bill from their otherwise in-network ED when EmCare enters." When providers consolidate and going out-of-network becomes the business model, patients suffer financially and we all pay more.

By requiring providers to accept market-based benchmark rates rather than continuing to allow their staffing firms to derive profit from inflated charges, we can address the problem of surprise medical bills at the source and rein in health care costs that increase premiums for everyone.

Health Plans' Provider Networks Drive Affordability and Access

Health plans' provider networks are an essential part of health care coverage. They help ensure that enrollees have access to the best doctors and health care settings, and that these providers are held accountable to high standards for care quality at reasonable, market-driven rates.

Health insurance providers rely on networks to ensure patients have access to the care they need from doctors they choose and trust. They negotiate payment rates that fairly and reasonably compensate providers for their services and expertise, increasingly with models that reward doctors for delivering higher value care at lower costs. As a result, when doctors and hospitals join a network, patients have greater confidence that they will be protected from high costs when they get sick or injured, particularly in emergency situations.

Many, if not most, health insurance providers cover a portion of the costs for services performed by an out-of-network provider. However, because out-of-network providers are not in a contractual agreement with the health insurance provider, there is nothing to stop the provider

¹² Hyman, D. and Ippolito, B. (March 2019) *Solving Surprise Medical Billing*. American Enterprise Institute: <https://www.aei.org/wp-content/uploads/2019/03/Solving-Surprise-Medical-Billing.pdf>

¹³ *Id.*

from sending bills to patients when a plan does not pay the full amount they charge. Our legislative recommendations directly address this concern.

Health plans' provider networks also help to ensure that consumers have access to high-quality and effective care. Health insurance providers evaluate doctors and hospitals for quality and safety performance before including them in a network. This involves ensuring that facilities and providers meet patient safety goals and credentialing standards.

In fact, performance on quality measures is a key part of the criteria used by health insurance providers when selecting and including providers in their networks—including high-value network plans. In developing their networks, health insurance providers also make sure they have the variety of primary care doctors, specialists, hospitals, and other providers that consumers need and can access in a variety of locations. Health insurance providers periodically reevaluate the qualifications of the health care providers and their performance within their networks to make sure the consumers' needs are met.

Developing strong provider networks that ensure patients have access to the care they need from providers they choose is not only a top priority for health insurance providers, it's also the law. Most health insurance providers are required by law to meet either federal or state standards for network adequacy; many state standards are based on the National Association of Insurance Commissioners' Managed Care Plan Network Adequacy Model Act. Although the standards vary between different states, they reflect the common theme that plans must provide options that minimize the distance a patient would have to travel for care. In other words, the law requires that private health plans have robust provider networks and also requires regular verification of their continued compliance.

Health insurance providers have incentives to work closely with doctors and hospitals. Similarly, doctors and hospitals have incentives to contract with health insurance providers. We know that health plans, providers, and hospitals are committed to promoting the best outcomes for patients, and quality provider networks are an essential part of this. Federal legislation should create a market environment where payors and providers can continue to actively collaborate on offering affordable, high quality care that puts patients first. Legislation should not just end balance billing and turn over out-of-network claims to an arbitration process. This would increase costs and not provide needed certainty for consumers.

Our recommendations would help level the playing field for patients when receiving treatment in a hospital while promoting strong provider networks that reward the best care at rates consumers can afford.

Conclusion

Health insurance providers develop networks to negotiate better value and lower costs for the consumers they serve. When doctors, hospitals, or care specialists choose not to participate in health plans' provider networks—or if they do not meet the standards for inclusion in a network—they charge whatever rates they like. The consequence is millions of consumers receiving surprise, unexpected medical bills that can often break the bank. By working together, we can take consumers and patients out of the middle, and solve the surprise medical bill problem. We look forward to working with you on legislative solutions to alleviate the financial burdens imposed on the American people by surprise medical bills and improve affordability of health care for millions of Americans.



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April 2, 2019

The Honorable Bobby Scott
Chairman, Education & Labor Committee
2176 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Virginia Foxx
Ranking Member, Education & Labor Committee
2101 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Scott and Ranking Member Foxx,

The American Heart Association (AHA) appreciates your interest in addressing balance billing. The rising cost of healthcare continues to be a barrier to treatment and recovery for millions of Americans, including many with cardiovascular diseases and stroke. The expansion and prevalence of balance billing practices in the U.S. exacerbates an already untenable situation and places additional unnecessary strain on the health and financial wellbeing of patients. We therefore urge you and your colleagues to take swift action to limit surprise billing to protect consumers and patients.

AHA is the nation's oldest and largest voluntary organization dedicated to building healthier lives free from heart disease and stroke. Our nonprofit and nonpartisan organization represents over 100 million patients with cardiovascular disease (CVD) and includes over 40 million volunteers and supporters committed to our goal of improving the cardiovascular health of all Americans.

For many Americans, an unexpected or surprise medical bill is an expense they cannot afford. Most insured consumers expect their plan will provide protection from unexpected medical bills; however, 57% of insured Americans have been caught off guard by a bill for care they thought would be paid for by their insurance plan. For thousands of CVD and stroke patients, bills that result from emergency or routine care, including emergency air or ground transportation, can be life-altering. Frequently, surprise bills arise from emergency situations when the patient is unable to select an in-network physician or treatment facility. However, balance billing practices extend far beyond emergency situations. Surprise bills can also arise from medical care unknowingly provided to the patient by an out-of-network physician or in an out-of-network facility. For example, this can happen if a patient's lab results are processed at an out-of-network facility, or if an out-of-network

Advocacy Department | 1150 Connecticut Ave., NW | Suite 300 | Washington, DC | 20036

anesthesiologist assists during a covered surgical procedure, even in an in-network hospital.

While 21 states have already passed laws or issued regulations aimed at protecting patients from balance bills, the protection and comprehensiveness offered by these proposals vary significantly from state to state and none are comprehensive enough to protect all consumers. The need for a comprehensive, uniform policy to protect all Americans from balanced bills as a result of medical transport or treatment necessitates action from federal policymakers. We recognize that differences in the regulation of emergency transportation will require lawmakers to re-examine authorities currently assigned to the Department of Transportation in order to adequately protect patients.

Access to quality, affordable health care is a priority for AHA and represents a key concern for the patients we represent. We implore policymakers to take a multi-faceted approach to comprehensively address balance billing:

- **Patients should be protected from balance billing.** In instances when a patient unknowingly receives care from an out-of-network provider or in emergency situations, patients should not be held responsible for resulting balance bills. In these circumstances, the maximum financial liability should be no greater than the in-network cost-sharing amount would be for the same services. This protection should exist regardless of the health insurance plan the patient holds.
- **Actionable and meaningful transparency.** Timely, actionable, and easily understood information should be provided to patients to help them avoid out-of-network services for non-emergency care. Resources should be up-to-date and easily available so consumers can make informed choices and not be held responsible for bills that result from inaccurate or outdated information. Individuals who live in areas with limited provider networks should be protected from balance bills if an in-network provider is inaccessible.
- **Adequate consumer rights and communications.** Prior to receiving non-emergency care, patients should receive prior notification that they will be receiving care from an out-of-network source. This notification should provide concrete information on estimated costs and the opportunity to seek in-network care. Prior notification should not preclude the dispute of a balance bill if there is not a reasonable opportunity to seek alternative in-network care.
- **Acknowledge existing state statutes.** Federal action to address balance billing should take into consideration potential interactions with current state law. Policymakers should be careful to not undermine any existing state laws that provide consumer protections. Instead, federal remedies must ensure a minimum standard of patient protections which states can further build upon.

AHA is ready to work with Congress, the Administration, and other stakeholders to ensure all Americans are protected from financial hardships as a result of balance bills. As patient and consumer advocates, we look forward to working with the Committee to ensure patients and consumers are not saddled with additional medical bills through no fault of their own.

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Thank you for the opportunity to share our thoughts with you as you work to address balance bills. If you have any questions or would like to discuss these comments further, please contact Katie Berge, Federal Government Relations Manager for the American Heart Association at katie.berge@heart.org or (202) 785-7909.

Sincerely,



Mark Schoeberl
Executive Vice President for Advocacy

Cc:

The Honorable Chuck Grassley
The Honorable Ron Wyden

The Honorable Frank Pallone
The Honorable Greg Walden

The Honorable Lamar Alexander
The Honorable Patty Murray

The Honorable Richard Neal
The Honorable Kevin Brady

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April 2, 2019

The Honorable Robert Scott
Chairman
Committee on Education and Labor
United States House of Representatives
2176 Rayburn House Office Building
Washington, DC 20515

The Honorable Virginia Foxx
Ranking Member
Committee on Education and Labor
United States House of Representatives
2101 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Scott and Ranking Member Foxx:

America's physicians, hospitals and health systems are fully committed to protecting patients from surprise medical bills. No patient should have the added stress and financial burden of receiving a bill for out-of-network emergency care that they could not avoid or out-of-network care that they reasonably could have expected to be in-network. Our organizations support a federal legislative solution to protect patients in these scenarios that limits patients' cost-sharing obligations to the in-network amount, and prohibits balance billing when the opportunity for health plans and providers to arrive at a fair payment rate is ensured.

The simplicity of the solution outlined above is in stark contrast to the complexity of another, untested idea that has been raised as part of the important dialogue about solving this issue: hospital bundled billing. This concept may seem simple and straightforward in theory; in reality however, this approach would be administratively complex, fundamentally change the relationship between hospitals and their physician partners, and alone, does nothing to protect patients from surprise bills. We strongly oppose such a model.

Bundled billing is not appropriate for many types of medical services. For example, the unique nature of emergency care – namely uncertainty and the potential for high variation – makes it a poor candidate for bundled payments. Several variations of bundled payments for episodes of care have been implemented over the past decade with mixed success. Developing such an arrangement involves a complex array of clinicians, statisticians, lawyers and others to define the services and duration of the bundle, to appropriately price it, and to ensure that any financial relationships between the various providers adhere to state and federal law, including the Stark law and the Anti-Kickback Statute. To-date, bundling has been tested by the Center for Medicare & Medicaid Innovation and some commercial payers in limited circumstances and, in general, early results indicate it could work for services for which the clinical care pathway is well defined and little variation is expected, such as for certain planned joint replacements. Even so, for the vast majority of these bundles, physicians and hospitals continue to negotiate their own rates with insurers. Any individual visit to an emergency department can involve countless possible services – from initial diagnosis and confirmatory tests to complicated trauma and surgical procedures involving multiple physicians and other providers, depending on an array of factors. Simply put: bundled payments are not appropriate for emergency care and have not been sufficiently tested for widespread adoption for other types of care.

Surprise bills are a direct result of a lack of negotiated contract between the patient's insurer and the hospital and/or physicians that provided their care. We support solutions that focus on arriving at a fair

payment from an insurer to a provider while protecting patients from the consequences that can arise when an insurer lacks adequate contracted providers. In contrast, bundling facility and physician payments in these situations simply allows insurers to transfer to hospitals their responsibility for establishing comprehensive physician networks and managing the associated financial risk.

We should remain focused on taking patients out of the middle of standard negotiations between insurers and providers and protecting them from "surprise bills" when they have not had the opportunity to choose who provides their care, while rejecting unproven proposals that would up-end the foundation of relationships that hold the health care system together.

Sincerely,

American Hospital Association
American Medical Association
Federation of American Hospitals

[Additional submissions by Mr. Morelle follow:]

April 2, 2019

The Honorable Joseph Morelle
U.S. House of Representatives
1317 Longworth House Office Building
Washington, D.C. 20515

Dear Congressman Morelle:

The Healthcare Association of New York State, on behalf of our member nonprofit and public hospitals, nursing homes, home health agencies and other healthcare providers, is pleased to have the opportunity to comment on the success of the Out-of-Network Consumer Protection Law in New York state.

As HANYS and our members worked with lawmakers in New York to address the challenge of surprise billing, HANYS remained committed to one core principle: protect patients and insulate them from any negotiation between insurers and providers. This principle was a key to the successful passage and implementation of New York's groundbreaking Out-of-Network Consumer Protection Law, which took effect on March 31, 2015.

The Out-of-Network Consumer Protection Law protects New Yorkers from financial exposure from surprise bills and emergency services. It requires hospitals, clinics and other practitioners to post information relating to plan participation and fees, and it mandates that managed care organizations and other network plans disclose details of their networks and out-of-network payment policies. The law applies to all New York state-regulated insurance products, including health maintenance organizations, preferred provider organizations, exclusive provider organizations, municipal health benefit plans, student health plans and Medicaid managed care plans. However, it does not apply to Employee Retirement Income Security Act preempted, Medicare Advantage and self-insured health plans.

Among the provisions of the law that have been successfully implemented in New York is an independent dispute resolution process for charges for services that would be considered a surprise bill under the law, and for emergency services.

During the debate on the Out-of-Network Consumer Protection Law, HANYS supported a dispute resolution process rather than setting a flat rate for services for several reasons. Among the concerns with setting a rate for payment in these circumstances is that it would encourage the expansion of narrow networks throughout the state and would strip the hospital of any ability to negotiate contracts with insurers in the long term. In a sense, it puts The Honorable Joseph all control of payment back in the hands of private insurance companies, at the expense of New York's nonprofit hospitals.

The result of this policy has been that very few cases of surprise bills and emergency bills even get to the arbitration stage. According to the New York State Department of Finance, in 2017, only 645 claims for emergency services were arbitrated by an Independent Dispute Resolution

Entity. Of those 645 cases, 203 disputed claims were ruled in favor of the health plan, 61 were ruled in favor of the provider, 102 were a split decision and 170 were considered ineligible. In the case of non-emergency surprise bills, only 451 claims were considered by an Independent Dispute Resolution Entity. Of those claims, 141 were ruled in favor of the provider, 49 for the health plan, 75 were a split decision and 119 claims were ineligible.

The data demonstrate that the dispute resolution process is rarely used and more importantly, that New Yorkers are not burdened with overwhelming out-of-network surprise bills. As Congress looks to curb the financial and emotional stress caused by surprise bills at the national level, HANYS urges lawmakers to reject any proposal that would set base payments as a means to resolve payment disputes between insurers and providers. Based on the New York experience, it is clear that this policy is not necessary and that it could only lead to severe unintended consequences.

HANYS also urges Congress to ensure that any national framework does not impede the great strides made in New York.

Sincerely,

Marie B. Grause, RN, JD
President



Monica B. Brown, RN, BS • President
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April 2, 2019

The Honorable Joseph Morelle
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 Washington, D.C. 20515

Dear Congressman Morelle:

The Healthcare Association of New York State, on behalf of our member nonprofit and public hospitals, nursing homes, home health agencies and other healthcare providers, is pleased to have the opportunity to comment on the success of the Out-of-Network Consumer Protection Law in New York state.

As HANYS and our members worked with lawmakers in New York to address the challenge of surprise billing, HANYS remained committed to one core principle: protect patients and insulate them from any negotiation between insurers and providers. This principle was a key to the successful passage and implementation of New York's groundbreaking Out-of-Network Consumer Protection Law, which took effect on March 31, 2015.

The Out-of-Network Consumer Protection Law protects New Yorkers from financial exposure from surprise bills and emergency services. It requires hospitals, clinics and other practitioners to post information relating to plan participation and fees, and it mandates that managed care organizations and other network plans disclose details of their networks and out-of-network payment policies. The law applies to all New York state-regulated insurance products, including health maintenance organizations, preferred provider organizations, exclusive provider organizations, municipal health benefit plans, student health plans and Medicaid managed care plans. However, it does not apply to Employee Retirement Income Security Act preempted, Medicare Advantage and self-insured health plans.

Among the provisions of the law that have been successfully implemented in New York is an independent dispute resolution process for charges for services that would be considered a surprise bill under the law, and for emergency services.

During the debate on the Out-of-Network Consumer Protection Law, HANYS supported a dispute resolution process rather than setting a flat rate for services for several reasons. Among the concerns with setting a rate for payment in these circumstances is that it would encourage the expansion of narrow networks throughout the state and would strip the hospital of any ability to negotiate contracts with insurers in the long term. In a sense, it puts

The Honorable Joseph Morelle
April 2, 2019

Page 2

all control of payment back in the hands of private insurance companies, at the expense of New York's nonprofit hospitals.

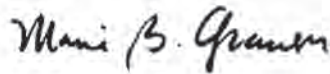
The result of this policy has been that very few cases of surprise bills and emergency bills even get to the arbitration stage. According to the New York State Department of Finance, in 2017, only 645 claims for emergency services were arbitrated by an Independent Dispute Resolution Entity. Of those 645 cases, 203 disputed claims were ruled in favor of the health plan, 61 were ruled in favor of the provider, 102 were a split decision and 170 were considered ineligible.

In the case of non-emergency surprise bills, only 451 claims were considered by an Independent Dispute Resolution Entity. Of those claims, 141 were ruled in favor of the provider, 49 for the health plan, 75 were a split decision and 119 claims were ineligible.

The data demonstrate that the dispute resolution process is rarely used and more importantly, that New Yorkers are not burdened with overwhelming out-of-network surprise bills. As Congress looks to curb the financial and emotional stress caused by surprise bills at the national level, HANYS urges lawmakers to reject any proposal that would set base payments as a means to resolve payment disputes between insurers and providers. Based on the New York experience, it is clear that this policy is not necessary and that it could only lead to severe unintended consequences.

HANYS also urges Congress to ensure that any national framework does not impede the great strides made in New York.

Sincerely,

A handwritten signature in black ink that reads "Marie B. Grause". The signature is written in a cursive, flowing style.

Marie B. Grause, RN, JD
President

[Additional submissions by Mr. Scott follow:]



April 1, 2019

The Honorable Frederica S. Wilson
Chairwoman
Subcommittee on Health, Education,
Labor, and Pensions
House Committee on Education and
Labor
Washington, D.C. 20515

The Honorable Tim Walberg
Ranking Member
Subcommittee on Health, Education,
Labor, and Pensions
House Committee on Education and
Labor
Washington, D.C. 20515

Dear Chairwoman Wilson and Ranking Member Walberg:

On behalf of the American College of Emergency Physicians (ACEP) and our 38,000 members, thank you for your efforts to protect patients and their families from unexpected high medical bills. ACEP remains committed to the goal of improving price transparency for our patients in a constructive and substantive manner, and we appreciate your leadership in holding this timely hearing.

Patients cannot choose where or when they will need emergency care, and they should not be punished financially for having emergencies. ACEP strongly agrees that patients must truly be taken out of the middle of billing issues that can arise around insurance coverage of emergency care.

As you examine this important issue, we urge you to keep in mind the particular factors that are unique to emergency medicine. In the emergency department, minutes and seconds matter and emergency physicians are often required to exercise their best clinical judgement quickly. Additionally, emergency physicians and their practice of medicine are subject to the Emergency Medical Treatment and Labor Act (EMTALA) that guarantees access to emergency medical care for everyone, regardless of insurance status or ability to pay. This law – an important consumer protection – has had the effect of disincentivizing health plans from entering into fair and reasonable contracts to provide services at appropriate in-network rates.

Because emergency physicians are required to screen and stabilize any patient who comes into the emergency department (under EMTALA), insurance companies are ensured their policyholders are always able to access emergency care. Therefore, they have no real incentive beyond what are often poorly defined and enforced state requirements to maintain an adequate number of emergency physicians in their networks. They are further incentivized to keep their networks narrow since if a policyholder's emergency care happens to be out of network, the patient's deductible is likely significantly higher (as permitted under section 2719A of the Affordable Care Act), which then shifts the majority (if not the entirety) of the cost of the encounter to be paid out of the patient's pocket, rather than the insurer's.

Many of the so-called "surprise bills" that patients face following an emergency encounter actually turn out to simply be due to a surprise lack of coverage – where patients discover that the costly insurance premiums they have dutifully paid each month have in actuality provided them with little to no protection against the cost of care due to high deductibles and other opaque or complicated health plan designs.

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Dean Whitson, JD, MBA, CAE

As Congress begins developing potential legislative solutions to take the patient out of the middle and eliminate balance billing practices, we believe there are successful, comprehensive policy solutions already in effect in certain states that would be informative to any federal approach. In particular, we believe the examples of New York and Connecticut provide a solid foundation for federal legislation. Brief summaries of these laws are provided in the following pages.

We agree strongly that more must be done to protect patients and their families from unexpected high medical bills and provide greater stability and transparency in these encounters. To this end, earlier this year ACEP released a proposed framework of policy solutions to protect emergency patients. Our detailed framework is also included in the following pages, but there are six key provisions:

- 1) **Balance billing is prohibited** — When a patient receives out-of-network emergency care, the emergency services provider cannot make any demand for such payment from the patient.
- 2) **Streamline the process to ensure patients only have a single point of contact for emergency medical billing and payment** — Under ACEP's proposal, insurers will directly pay any coinsurance, copay, and deductible for emergency care to the provider, and can then collect back these amounts from the patient. This will put an end to patients receiving and having to reconcile the multiple, confusing bills and explanations of benefits that result from the many providers who often need to be involved in a single emergency episode.
- 3) **Ensure the patient responsibility portion for out-of-network emergency care is no higher than it would be in-network** — When facing an emergency, patients or their family members do not have time to try and figure out where their care will be in-network, so they should not be punished financially for being unable to do so. Under current law, while copays and coinsurance must be the same for emergency patients whether they are in- or out-of-network, deductibles can be much higher—often double.
- 4) **Require insurers to more clearly convey beneficiary plan details** — This would include printing the deductible on each insurance card. While a simple step, it can help patients better understand the limits of their insurance coverage and reduce the surprise when they later get a bill.
- 5) **Require insurers to more clearly explain their rights related to emergency care** — Policyholders deserve to have this in plain, easy-to-understand clear language.
- 6) **Take the Patient Out of Insurer-Provider Billing Disputes** — ACEP wants to prevent provider/insurer billing disputes. To expedite and simplify this process, ACEP is calling for the creation of an arbitration process to settle network issues, similar to that used in New York (as described in the following pages).

ACEP believes these core principles are necessary first and foremost to protect patients seeking emergency medical care. Additionally, they provide an outline for a policy solution we believe that is not overly burdensome or costly to implement at the federal level, is based on models that have already proven successful at the state level and have not led to inflated costs in those states, and would establish a system that ensures fair and equitable negotiation between providers and insurers.

We also note our strong concerns with proposals that would either provide a single bundled payment from a hospital for emergency services or would set a benchmark payment at a certain level of Medicare rates. A bundled payment would not actually address the underlying cost issues, but instead merely shift the venue for negotiation under the assumption that hospitals would somehow be able to better negotiate with physicians than insurers. With regard to proposals based on a percentage of Medicare rates, this approach is flawed in that 1) Medicare rates were never intended to reflect market rates and have not kept pace with inflation; 2) according to CMS' own actuaries, Medicare rates are not expected to keep pace with the average rate of physician cost increases¹; 3) Medicare rates were never designed for the general population but rather an age-specific group (e.g., does not include pediatrics or obstetrics); and, 4) Medicare is shifting toward a value-based payment approach, and it is unclear how it could even be used as a basis for determining a benchmark rate in future years.

Once again, ACEP thanks you for your leadership on this effort to protect patients from unexpected medical bills. We appreciate the opportunity to provide these comments, and we stand ready to work with you to develop meaningful reforms.

¹ 2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2018.pdf>

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Should you have any questions, please do not hesitate to contact Laura Wooster, ACEP's Associate Executive Director of Public Affairs, at lwooster@acep.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Vidor Friedman".

Vidor Friedman, MD, FACEP
ACEP President

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Framework for Protecting Patients When Emergency Care is Out-of-Network

Background

By oath and by law, emergency physicians will treat any patient, regardless of their ability to pay. Federal law under the Emergency Medicine Treatment and Labor Act (EMTALA) forbids emergency care providers from discussing with the patient any potential costs of care or details of their particular insurance coverage until they are screened and stabilized. Patients can't choose where and when they will need emergency care – so they should not be punished financially for having emergencies.

Expanded Patient Protections that Truly Take the Patient Out of the Middle

- When a patient receives out-of-network emergency care, the emergency services provider cannot make any demand for payment from the patient -- balance billing is prohibited;
- The patient won't pay any more out-of-pocket (i.e. coinsurance, copay, and deductible) than they would have paid if their emergency care were in-network (currently such protection only applies to coinsurance and co-pays);
- Insurers will directly pay any coinsurance, copay, and deductible for emergency care to the provider.
 - Insurers can then collect back these amounts from the patient. This ensures patients only have a **single point of contact** for emergency medical billing and payment, and will no longer receive and have to reconcile multiple, confusing bills and EOBs that result from the many providers that are often involved in a single emergency episode.
- To ensure policyholders better understand the limits of their insurance coverage and *all* potential out-of-pocket costs when seeking care, insurers will be required to display the patient's deductible amount on policyholders' insurance cards.
- Insurers must provide their policyholders with clear, concise and meaningful explanations of their plans' emergency services benefits, an up-to-date list of in- and out-of-network providers, and beneficiary rights under EMTALA.

Take the Patient Out of Insurer-Provider Billing Disputes

- The insurer will pay directly to the emergency care provider within 30 days the amount of the deductible and cost-sharing (plus an additional amount as determined below). When provider-insurer disputes arise over reimbursement for out-of-network emergency services, the following will be used to resolve them:
 - The payment amount will be determined under any state law that takes a comparable approach to this proposal;
 - For claims under \$750 (amount to be adjusted for inflation), the balance will be paid in full. For inflation-adjusted amounts over \$750, the insurer will pay an interim payment directly to the provider.
- Required payments will be made within 30 days of claim submission. Failure to do so will trigger civil monetary penalties (CMPs) of \$500 per day.
- Either party may trigger the alternative dispute resolution (ADR) process described below within 30 days of the provider receiving the interim payment.

Alternative Dispute Resolution (ADR)

- HHS will maintain a database of ADR entities that meet certain qualifications (e.g. freedom from conflicts of interest, reasonable fees) to resolve disputes. Costs related to this will be offset by any collected CMPs, as referenced above. HHS may delegate responsibility of the database to a third party such as the American Arbitration Association or to any state that already undertakes a similar function.
- The emergency care provider and insurer will submit to the arbitrator the amount that was charged or billed for the emergency medical services, and the interim amount paid, respectively. Either party may consolidate multiple disputed claims between them into a single adjudication.
- The arbitrator will select one of these two amounts as the payment amount, and in doing so consider the following:
 - The provider's level of skill, education and training,
 - The nature of the services provided,
 - The circumstances and complexity of the case,
 - 80th percentile of charges for comparable services in the same geographical area, as determined by a transparent and wholly independent Medical Claims Database (such as FAIR Health),
 - 150% of the average in-network rate for comparable services in the same geographical area as determined by a transparent and wholly independent Medical Claims Database (such as FAIR Health)
- Arbitration will be completed within 30 calendar days of either party commencing the ADR process. Any payment owed by one party to the other must be made within 15 calendar days of a determination. The costs of the ADR shall be borne by the non-prevailing party.

Commission on Access to Quality and Affordable Emergency Care.

HHS will establish a Commission on Access to Quality and Affordable Emergency Care with diverse, cross-sector representation to study and provide recommendations to Congress within three years of bill enactment on specified matters including:

- Adequacy of patient protections, including network adequacy standards and clarity of enrollee notification language from insurers
- If the bill's new processes surrounding out-of-network emergency care are providing sufficient provider protections to ensure continued access to high-quality emergency care for patients;
- The merits of establishing supplemental funding for uncompensated care by incurred by emergency physicians pursuant to their practice of medicine under the requirements of EMTALA.

State Models: New York

In 2015, New York implemented a law that banned balanced billing and established an arbitration process for out-of-network emergency services.

Not all claims are included in the independent dispute resolution (IDR) process. Smaller claims for emergency services that are currently less than \$683.22 (annually adjusted for inflation) and do not exceed 120 percent of “usual and customary cost” (UCR) are automatically exempted. UCR is defined as the 80th percentile of all charges for a health service rendered by a provider in the same or similar specialty and provided in the same geographic region as reported by a benchmarking database maintained by a nonprofit organization. New York identifies the FAIR Health charge database as an independent entity that can calculate UCR.

Under the established IDR process, the arbitrator picks either the charge set by the provider or the allowed amount offered by the insurer, without modification. The party whose amount is not chosen must pay for the cost of arbitration (estimated by the State of NY to range from \$225 to \$325 per appeal), as well as any outstanding amounts as a result of the decision.

This “loser pays” baseball-style arbitration process has proven to be an effective way of incentivizing providers to charge reasonable rates, while at the same time encouraging insurers to pay appropriate and reasonable amounts. Since both parties have this powerful incentive to act fairly, most claims do not even need to go into the IDR process. As seen in the chart below, out of the millions of visits to the emergency department in 2018, only 849 emergency claims went to arbitration (out of an estimated 7-8 million emergency visits statewide). As well, the decisions rendered on these were evenly split, further demonstrating that the system is working.

Emergency Services

Total received	849
Not eligible	162
Still in process	139
Decision rendered	548
Health Plan payment more reasonable	143
Provider charges more reasonable	176
Split decision	165
Settlement reached	64

The New York law has preserved access to emergency care and has not led to significant increases in insurance premiums. In fact, the Kaiser Family Foundation has shown that premiums in New York have grown more slowly than rates for the rest of the nation over the last five years.² Similarly, studies have shown that the law has lowered the rate of out-of-network bills by 34 percent and lowered in-network emergency physician payments by 9 percent.

² Kaiser Family Foundation (2015-2019): “Marketplace Average Benchmark Premiums,” <https://www.kff.org/e404bd/>

State Models: Connecticut

The Connecticut law, passed in 2016, bans balanced billing and sets a minimum benefit standard for out-of-network emergency services based on the greatest of three payment amounts: 1) the in-network amount; 2) the usual, customary, and reasonable (UCR) rate; and 3) the Medicare amount. The UCR is defined in law as the 80th percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported in a benchmarking database.³ Like New York, Connecticut has identified FAIR Health as the independent entity that should be used to determine UCR. FAIR Health data illustrate that provider charges in CT have not increased beyond the rate of inflation since the law was implemented. And similarly to the experience in New York, data shows that premiums grew more slowly in Connecticut than the rest of the nation.

Also included in Connecticut's law are greater out-of-pocket protections for consumers. As previously noted in this response, under federal law, cost-sharing for out-of-network emergency services cannot be greater than cost-sharing for in-network emergency services but is defined as only the co-payment and co-insurance. Connecticut includes deductibles in the definition, along with co-payments and co-insurance. **ACEP supports a change in federal law that would level deductibles for out-of-network and in-network emergency services.**

³ Public Act No. 15-146, "An Act Concerning Hospitals, Insurers and Health Care Consumers,"

April 02, 2019

The Honorable Frederica S. Wilson
Chair
Subcommittee on Health, Employment,
Labor and Pensions
Washington, DC 20515

The Honorable Tim Walberg
Ranking Member
Subcommittee on Health, Employment,
Labor and Pensions
Washington, DC 20515

Dear Chair Wilson and Ranking Member Walberg:

We applaud you for holding a hearing examining surprise billing. Reflecting the goal of employers to protect patients from surprise medical bills without undermining network participation or resulting in higher health care costs for all consumers, we urge Congress to pass legislation consistent with the following provisions:

Protect Patients from Surprise Medical Bills

- The goal of any federal surprise balance billing legislative solution is to protect patients in situations in which they lack a choice of providers. It is vitally important, however, that any legislative solutions not discourage network participation or result in higher health care costs for all consumers. Patients often lack any meaningful choice of provider when they obtain care in out-of-network emergency rooms, and when a patient receives services in in-network facilities from out-of-network professionals, particularly with respect to a small number of provider specialties.
- To protect consumers and families, federal legislation must ensure that patient cost-sharing is limited to in-network amounts for emergency services performed at an out-of-network facility or for treatment by out-of-network facility-based physicians performed at in-network facilities, and prohibit providers from imposing additional “surprise” balance bills in these circumstances.
- Congress should implement this change through an amendment to section 2719A of the Public Health Service Act (“PHSA”), which applies to both group and individual commercial insurance, and which would apply to insured and self-funded group health plans through section 715 of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”).

Disclosure and Transparency

- For surprise balance billing that occurs at an in-network facility and follow-up care from emergency treatment at an out-of-network facility, federal legislation must require disclosure of out-of-network professional costs at the time of scheduling. This disclosure will help ensure that patients can make an informed decision and schedule procedures when an in-network professional is available.
- Facilities such as hospitals should also be required to list prominently on their websites, whether they lack available providers who participate in networks which the facility participates in – including what those specialties are, and the likelihood that a patient may thus be seen by an out-of-network provider.

- Much of the surprise over unexpected balance billing can be eliminated by providing this disclosure.
- Congress could implement this disclosure requirement directly on hospitals (through Medicare's minimum requirements for hospitals under 42 USC § 1395x(e)(1)-(8)), or through an amendment to section 2718(e) of the PHSA, which requires hospitals to disclose standard charges for items and services provided by the hospitals.

Required Reimbursement

- Out-of-network providers frequently bill well in excess of negotiated rates and Medicare reimbursement for these services, as opposed to the actual value of the service provided. A study by Ge Bai and Gerard F. Anderson, published in JAMA in 2017 comparing physician charge-to-Medicare payment ratio across specialties found that anesthesiology had the highest median (5.8), followed by interventional radiology (4.5), emergency medicine (4.0), and pathology (4.0).
- To ensure equitable payment for the services provided without discouraging network participation or resulting in higher costs for all consumers, legislation must set a reasonable federal reimbursement structure that (1) establishes a federal cap for emergency services at an out-of-network facility at 125 percent of the Medicare rate, and (2) requires all providers at an in-network facility to accept in-network rates.
- Conversely, without reasonable limitations on the reimbursement rates, out-of-network providers in surprise balance billing situations will have an incentive to bill even higher rates in order to achieve maximum payment through any binding arbitration mechanism. Binding arbitration is an inefficient and ineffective approach to addressing surprise billing and should not be included as a legislative solution. The experience of the mediation process in Texas is instructive. According to a recent report, the Texas Department of Insurance received just 43 requests from consumers for mediation in 2013. In 2014, the number of requests grew to more than 600 and have climbed steeply ever since. There were 4,519 requests in 2018, creating a significant backlog.
- Requiring facilities to bundle medical services for covered procedures into a single payment also could help address this problem if structured properly. In the case of bundled services performed by out-of-network providers, the costs of those services within the bundle cannot exceed either the allowable in-network rate or 125% of Medicare. But, care must be taken to ensure that the contracted bundled payment is final and not merely a progress point toward further negotiation.
- Congress should implement this change through an amendment to section 2719A of the PHSA, which applies to both group and individual commercial insurance, and which would apply to insured and self-funded group health plans through section 715 of ERISA.

Ambulance and Outsourced Emergency Departments

- A significant concern to both patients and plans are the massive costs associated with non-participating ambulance, air ambulance, and emergency department services.

- According to GAO's analysis of the most complete data identified for air ambulance transports of privately-insured patients, 69 percent of about 20,700 transports in the data set were out-of-network in 2017.
- Ambulance, air ambulance, and emergency services are essential to ensure that patients receive the care they need in the most urgent of situations. Subjecting patients in the most dire of circumstances to balance billing exposes patients to material liabilities in order to receive the care they need.
- Any legislative solution for surprise balance billing should also specify that ambulances and air ambulance services are considered emergency services for purposes of the statutory limitations on balance billing and reimbursement rates.
- Further, Congress should include provisions to eliminate problematic incentives in which an in-network facility could profit by allowing or encouraging an outsourced out-of-network emergency department to surprise bill in-network patients.
- Congress should implement this change through an amendment to section 2719A of the PHSA, which applies to both group and individual commercial insurance, and which would apply to insured and self-funded group health plans through section 715 of ERISA.

We look forward to working with you to address the burden of surprise medical billing.

Sincerely,

American Benefits Council
 Associated Builders and Contractors, Inc.
 Associated General Contractors
 Auto Care Association
 Colorado Business Group on Health
 Council for Affordable Health Coverage
 Economic Alliance for Michigan
 Florida Health Care Coalition
 Food Marketing Institute
 Greater Philadelphia Business Coalition on Health
 HealthCare 21 Business Coalition
 Houston Business Coalition on Health
 Louisiana Business Group on Health
 Midwest Business Group on Health
 National Alliance of Healthcare Purchaser Coalitions
 National Association of Health Underwriters
 National Association of Wholesaler-Distributors
 National Business Group on Health
 National Restaurant Association
 National Retail Federation
 Pacific Business Group on Health
 Partnership for Employer-Sponsored Coverage
 Retail Industry Leaders Association
 Retailers Association of Massachusetts
 Rhode Island Business Group on Health

Self-Insurance Institute of America, Inc.
Silicon Valley Employers Forum
Small Business & Entrepreneurship Council
Society of Professional Benefit Administrators
St. Louis Area Business Health Coalition
The Council of Insurance Agents & Brokers
The ERISA Industry Committee
Wyoming Business Coalition on Health

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Statement for the Record

of the

American Medical Association

for the record

**U.S. House of Representatives Committee on Education and Labor
Subcommittee on Health, Employment, Labor and Pensions**

**Re: Examining Surprise Billing; Protecting Patients
from Financial Pain**

April 2, 2019

**Division of Legislative Counsel
(202) 789-7426**

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STATEMENT

of the

American Medical Association

to the

**U.S. House of Representatives Committee on Education and Labor
Subcommittee on Health, Employment, Labor and Pensions****Re: Examining Surprise Billing: Protecting Patients from Financial Pain****April 2, 2019**

The American Medical Association (AMA) appreciates the opportunity to present our views to the U.S. House of Representatives Committee on Education and Labor, Subcommittee on Health, Employment, Labor and Pensions concerning unanticipated medical bills. As health insurance plans increasingly rely on narrow and often inadequate networks of contracted physicians, hospitals and pharmacies to control costs, even patients who are diligent about seeking care from in-network physicians may face unanticipated medical bills from out-of-network providers that participate in their care. Physicians are limited in their ability to help patients avoid these unanticipated costs because like patients, they may not know in advance who will be involved in an episode of care, let alone other providers' contract status with all the insurance plans in their communities. Health insurers must be incentivized to negotiate fair contracts with physicians to ensure that networks are sufficiently robust.

The problem of unanticipated out-of-network bills is complex and requires a balanced approach to resolve. The AMA agrees that any solution must keep patients out of the middle of payment rate negotiations and ensure that when patients seek emergency care or otherwise do not have the opportunity to select their provider, they should not be responsible for cost sharing beyond what they would face if they had seen an in-network provider. Any proposed solutions should also require both providers and insurers to be transparent about anticipated charges and the amount of those charges that insurance will cover. We also agree that if balance billing is banned, there must be a process in place to ensure that providers receive fair reimbursement for their services.

The AMA encourages Congress to look to states that have already acted to address unanticipated medical bills, specifically those state laws that have functioned well such as New York and Connecticut. The AMA is committed to working with Congress to find a workable solution for all stakeholders that protects patients from unanticipated out-of-network bills.

Key Principles in Addressing Unanticipated Medical Bills

There are several key principles that must be a part of any solution proposed to address unanticipated out-of-network medical bills. First, oversight and enforcement of network adequacy is needed. Robust network adequacy standards include, but are not limited to, an adequate

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ratio of emergency physicians, hospital-based physicians, and on-call specialists and subspecialists to patients, as well as geographic and driving distance standards and maximum wait times. Provider directories must also be accurate and updated regularly to be useful to patients seeking care from in-network providers. In addition, insurers should be held to complying with the prudent layperson standard in existing law for determining coverage for emergency care, so that insured patients are not liable for unexpected costs simply because they were unable to accurately self-diagnose ahead of time whether their symptoms were, in fact, due to an emergency medical condition.

Any solution to address unanticipated medical bills must also require transparency so that all patients who choose in advance to obtain scheduled care from out-of-network physicians, hospitals or other providers are informed prior to receiving care about their anticipated out-of-pocket costs. When scheduling services for patients, providers should be transparent about their own anticipated charges, and insurers should be transparent about the amount of those charges they will cover.

In general, the AMA urges Congress to avoid any solutions that arbitrarily cap payment for physicians treating out-of-network patients. If pursued, guidelines on what out-of-network providers are paid should reflect actual charge data for the same service in the same geographic area and should not be based on a percentage of Medicare rates, which have become increasingly inadequate in covering overhead costs or be based on in-network rates, as either standard would eliminate the need for insurers to negotiate contracts in good faith.

The AMA could support a legislative solution that provides for a mediation or sequential alternative dispute resolution (ADR) process for those circumstances where the minimum payment standard is insufficient due to factors such as the complexity of the patient's medical condition, the special expertise required, comorbidities, and other extraordinary factors. Arbiters should not be required to consult in-network or Medicare rates when making final determinations regarding appropriate reimbursements.

Finally, as noted previously, the AMA strongly supports solutions that keep patients out of the middle of payment rate negotiations. Patients should only be responsible for in-network cost-sharing amounts when experiencing unanticipated medical bills.

Successful State Models

Many states have acted to address unanticipated out-of-network billing and there are several existing state models that have worked well to protect patients from surprise medical billing. The AMA points to New York's balance billing law as a well-functioning model for several reasons including:

- The law protects patients from unanticipated out-of-network bills.
- The law emphasizes the role of network adequacy in solving the "surprise" billing problem and puts in place new requirements to regulate networks and affords patients the right to an independent external appeal to be treated by a non-network provider if the network is inadequate.
- The law establishes a strong independent dispute resolution (IDR) process made by a reviewer with training and experience in health care billing, reimbursement, and usual and customary charges in consultation with a licensed physician in active practice in the same or similar specialty as the physician providing the service that is the subject of the dispute.

- The IDR process requires consideration of factors, including the rate that non-participating physicians charge for the service in the area based on independent data, usual and customary charge for the service based on independent data, the complexity of the case, and the physician's experience, training and education.
- There are no data that we know of that suggest that the law has resulted in either premium increases or a dramatic narrowing of networks.

The AMA also views the Connecticut law on unanticipated out-of-network care for emergency services as a potential model for all unanticipated out-of-network care situations because:

- The law protects patients from unanticipated out-of-network bills for care received at an in-network hospital.
- The law creates a solution by establishing a payment standard that incorporates charge data from an independent data source.
- There is no evidence that we know of that suggest law has resulted in premium increases, dramatic narrowing of networks, or higher rates of out-of-network physicians.

Facilitating In-Network Contracting

It is important to recognize that most physicians want to be included in payers' networks, if fair contracts are offered. However many physicians are in a weak bargaining position relative to commercial health insurers. Therefore, Congress must incentivize insurers to come to the negotiating table with physicians and offer fair contracts. The most promising way for policymakers to facilitate contracting between providers and health plans is to ensure regulation of provider networks. Strong network adequacy requirements create a more balanced environment for all stakeholders where: insurers are incented to maintain meaningful access to in-network providers by offering providers competitive contracts; providers are incented to come to the table knowing that it will be a fairer process; and patients will have access to in-network care and get greater value for their premiums paid.

While there has been a great deal of discussion about the growth of narrower provider networks, relatively little has been done to create or enforce network adequacy requirements, especially as they relate to hospital-based providers. Ensuring that, at a minimum, in-network providers are available at in-network hospitals should be the first step for legislators and regulators in addressing unanticipated out-of-network care at in-network hospitals. Moreover, ensuring that patients have appropriate access to primary and specialty care will go a long way in preventing emergency department visits and other hospitalizations that may lead to unanticipated out-of-network bills.

The basis of network adequacy standards should be quantitative, measurable requirements on the front-end, before insurance products are brought to market. The quantitative standards should include minimum time and distance requirements, maximum patients-to-provider ratios, and maximum wait times. In addition, and specific for hospital-based specialties, it is critical that standards also measure access to in-network physicians at in-network hospitals.

Meaningful regulation of provider networks must also be ongoing. Consistent monitoring of the network's ability to provide in-network hospital-based care is particularly important, given that patients may not evaluate access to these providers simply through a directory or other tool, as is normally the case when choosing a provider.

Finally, it is important to recognize the connection between accurate provider directories and meaningful access to in-network providers for patients. The AMA encourages greater oversight of provider directories and stronger requirements that they be transparent and up-to-date. Patients need access to robust, up-to-date provider directories to enable them to determine which providers are in-network as they purchase their plans, and which providers continue to be in-network as their medical needs change. Additionally, providers need accurate information from health plans to allow for in-network referrals when further treatment is needed.

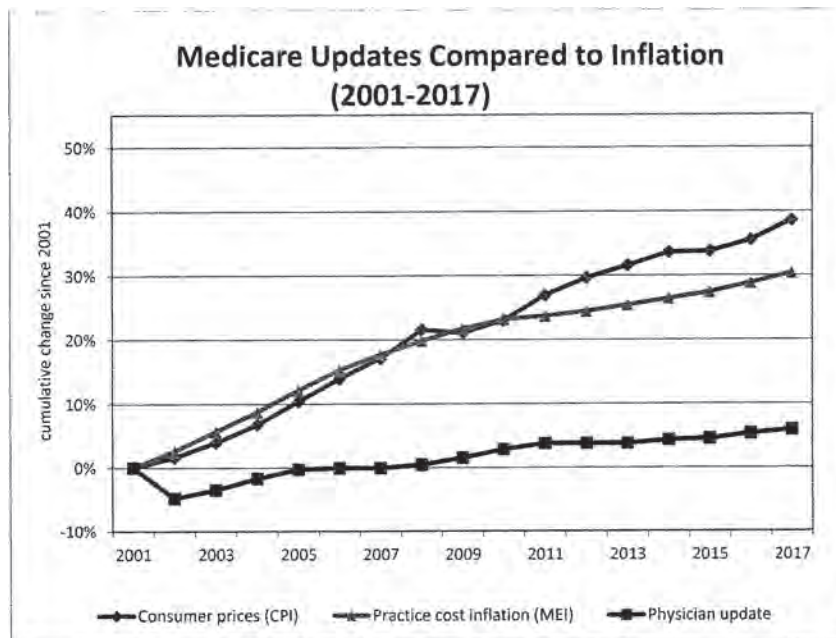
Payment Standards

As AMA has repeatedly pointed out, Medicare payment rates do not reflect the costs of providing care, especially in the commercial market where the population varies greatly. Medicare uses the resource-based relative value scale (RBRVS) system to establish physician payments, determined by the resource costs associated with the total amount of physician resources required to provide a specific service. However, before Medicare rates are finalized, they go through adjustment and conversion processes to meet federal budgetary requirements. Adjustments are done in a budget neutral manner, meaning that if an adjustment increases the payment for one service, it must account for this increase by decreasing payment in another. This establishes artificial decreases in payment for many physician services every year. And before the final Medicare payment is set, geographically adjusted values are multiplied by a conversion factor - a monetary payment determined by Medicare each year that changes based on the Medicare economic index, adjustments pertaining to budget neutrality and other adjustments stipulated by legislation. After everything is complete, the resulting payment rates are not reflective of markets rates for physician services.

As illustrated by the chart below, Medicare physician payments have not kept up with inflation over the past decade. According to data from the Medicare Trustees, Medicare physician payment rates have barely changed over the last decade and a half, increasing just six percent from 2001 to 2017, or just 0.4 percent per year on average. And, under the Medicare Access and CHIP Reauthorization Act (MACRA), physician payment rates will be frozen for calendar years 2020 through 2025.

In comparison:

- The cost of running a medical practice has increased 30 percent between 2001 and 2017, or 1.7 percent per year. Inflation in the cost of running a medical practice, including increases in physician office rent, employee wages, and professional liability insurance premiums, is measured by the Medicare Economic Index, or MEI.
- Economy-wide inflation, as measured by the Consumer Price Index, has increased 39 percent over this time period (or 2.1 percent per year, on average).



Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics

Over time, the adequacy of Medicare physician payment rates has eroded significantly. Adjusted for inflation in practice costs, Medicare physician payment rates have declined 19 percent from 2001 to 2017, or by 1.3 percent per year on average. As such, the AMA opposes efforts to cap or benchmark out-of-network physician payments on a percentage of Medicare. Linking out-of-network rates to Medicare would eliminate any incentive for insurers to build adequate networks or offer physicians fair contracts.

Thank you for the opportunity to offer our input. We look forward to working with you and your colleagues to help determine the best way to protect patients from costly surprise medical bills.

**Statement for the Record
to the
House Committee on Education and Labor**

Surprise Billing

**Garry Brydges, DNP, MBA, ACNP-BC, CRNA ,
FAAN,
President, American Association of Nurse Anesthetists**

1 April 2019

Introduction

Chairman Scott and Ranking Member Foxx, thank you for the opportunity to offer this statement for the record. The American Association of Nurse Anesthetists (AANA) is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists, with membership that includes more than 53,000 CRNAs and student nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 45 million anesthetics to patients each year in the United States. CRNAs provide acute, chronic, and interventional pain management services. In some states, CRNAs are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

Address the Underlying Causes of Surprise Billing by Directing CMS to Issue a Proposed Rule on Provider Non-Discrimination Provision and by Promoting Adequate Provider Networks in Medicare Advantage Plans and Health Plans Inside the Marketplace

The AANA appreciates the Committee's concern regarding patients being surprised by out-of-network bills. The economic burden of receiving care out-of-network can be substantial for patients. Furthermore, knowing which providers and services are in-network and out-of-network is a huge burden for the patient as well as the provider and the facility. The Committee can address this issue best by addressing the underlying causes, such as inadequate networks offered by insurance plans and plans engaging in discrimination against providers based on their licensure or certification. While this is not an issue under Medicare Part B, as Medicare recognizes CRNAs as qualified providers and CRNAs must accept assignment as a condition for payment,¹ this is an issue with private health plans, thus potentially affecting the private payer market and Medicare Advantage plans.

Therefore, it is important to highlight the harms of discrimination CRNAs currently face in the selection criteria that certain health plans develop, which determines the selection of providers that participate in their networks. CRNAs, acting within the scope of their license or certification under applicable state law or regulation, have experienced discrimination with respect to participation in qualified health plans, thus forcing them to become an out-of-network provider. Such discrimination may exacerbate surprise billing, impair consumer choice, reduce competition, and affect healthcare costs.

We recommend that the Committee direct CMS to use its authority to further implement the federal provider nondiscrimination law by issuing a proposed rule. In 2010, Congress passed this provision in the Patient Protection and Affordable Care Act (Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), "Non-Discrimination in Health Care, 42 USC §300gg-5),² which prohibits health plans from discriminating against qualified licensed

¹ See 42 §414.60 (c).

² Patient Protection and Affordable Care Act, Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), Non-Discrimination in Healthcare (42 U.S.C. §.300gg-5). The statutory provision reads as follows: "(a) Providers.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any healthcare

healthcare professionals, such as CRNAs, solely on the basis of their licensure. This law promotes access to healthcare and consumer choice of healthcare professionals and helps reduce healthcare costs through competition. It prohibits discrimination based on provider licensure that keeps patients from getting the care they need.

To promote patient access to high quality healthcare, market competition and cost efficiency, all qualified health plans must all avoid discrimination against qualified, licensed healthcare professionals, such as CRNAs, solely on the basis of licensure or certification. Proper implementation of the provider nondiscrimination provision is crucial because health plans have wide latitude to determine the quantity, type, and geographic location of healthcare professionals they include in their networks, based on the needs of their enrollees. However, when health plans organize their healthcare delivery in such a way that discriminate against whole classes of qualified licensed healthcare professionals by licensure or certification, for example, by prohibiting reimbursement for anesthesia and pain management services provided by CRNAs, patient access to care is impaired, consumer choice suffers, and healthcare costs climb for lack of competition. Additionally, such discrimination provides incentives for the use of higher-cost providers without improving quality or access to care. Promoting nondiscrimination encourages the use of qualified, licensed, and certified healthcare professionals such as CRNAs who perform the same services to the same high level of quality as other qualified providers.

While we recognize that CMS has developed network adequacy standards in Medicare Advantage plans and in the Marketplace, the Committee should direct CMS to do more to ensure that health carriers maintain networks that are sufficient in numbers and types of providers to assure that all services to covered persons will be accessible to them without unreasonable delay. The AANA believes that patients benefit the greatest from a healthcare system where they receive easily accessible care from an appropriate choice of safe, high quality and cost-effective providers, such as CRNAs. Therefore, we request that CRNAs be included in all health carrier network plans, which will help ensure network adequacy, access and affordability to consumers.

AANA Comment: Direct HHS to Work with Stakeholders in Developing Guidance to Educate Consumers on Questions to Ask Their Insurance Companies

We also recommend that the Committee direct the Department of Health and Human Services to work with healthcare stakeholders, such as CRNAs, in developing consumer guidance documents on surprise billing and out-of-network coverage and resources for assistance. For instance, this guidance could provide consumers with the education needed to know what questions to ask their insurance plans prior to procedures and where to go for help. We are happy to assist in the development of these patient tools.

Conclusion

provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any healthcare provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

In conclusion, addressing some of the underlying causes of surprise billing, such as inadequate networks offered by insurance plans and plans engaging in discrimination against providers based on their licensure or certification, along with patient education would help reduce the sticker shock associated with needed medical services and would promote patient access to a range of beneficial, safe and cost-efficient healthcare professionals, consistent with public interests in quality, access and cost-effectiveness. The AANA and its members look forward to collaborating with the Committee on this very important issue.



**Statement for the Record to the
House Committee on Education and Labor
Subcommittee on Health, Employment, Labor, and Pensions
Subcommittee Hearing
"Examining Surprise Billing: Protecting Patients from Financial Pain"
April 2, 2019**

On behalf of the AAFP, representing 131,400 family physicians and medical students, thank you for the opportunity to submit this statement for the record to the U.S. House Committee on Education and Labor concerning the hearing, *Examining Surprise Billing: Protecting Patients from Financial Pain*.

The AAFP appreciates the Committee's interest in protecting patients and their families from unanticipated medical bills. We share your concerns that such bills drive up patient out-of-pocket costs and threaten to damage the patient-physician relationship. As the nation's largest medical association of primary care physicians, we are committed to the strategic goal of ensuring health care coverage for all – a goal based on AAFP policy which recognizes that health is a basic human right for every person. The right to health includes universal access to timely, acceptable and affordable health care of appropriate quality. This goal requires health care system reforms that aim to serve all Americans, be foundational in primary care, and work to and reduce barriers such as price and accessibility that limit people from obtaining health care coverage.

Unfortunately, health insurance plans too often restrict patients' access to physicians by adopting narrow networks of contracted physicians, hospitals, pharmacies, and other providers. Even patients who strive to seek care from in-network physicians and hospitals can find themselves with unanticipated out-of-network bills from providers who are not in their insurance plan's network.

The AAFP joined more than 100 state and national medical organizations on a February 7 letter to House Ways and Means Committee Chairman Richard Neal (D-MA) and Ranking Member Kevin Brady (R-TX) urging them to protect Americans from unexpected medical costs. The letter is available at: <https://www.aafp.org/dam/AAFP/documents/advocacy/legal/administrative/LT-WaysMeans-SurpriseBilling-020719.pdf>

The AAFP and co-signatories urged consideration of several policies, including:

- Insurer accountability: Narrow networks contribute to surprise billing. Strong oversight and enforcement of network adequacy is needed from both federal and state governments.
- Limits on patient responsibility: Patients should only be responsible for in-network cost-sharing rates when experiencing unanticipated medical bills.
- Transparency for scheduled health care: When scheduling services for patients, providers should be transparent about their own anticipated charges, and insurers should be transparent about the amount of those charges they will cover.
- Benchmark payments: In general, caps on payment for physicians treating out-of-network patients should be avoided. If pursued, guidelines or limits on what out-of-network providers

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are paid should reflect actual charge data for the same service in the same geographic area from a statistically significant and wholly independent database. These should not be based on increasingly inadequate Medicare rates or on in-network rates, which would hinder good-faith contract negotiation from insurers.

- Keeping patients from being middlemen: Payment rate negotiations should be between insurers and those who provide medical care. To ensure that patients aren't stuck doing that work, "physicians should be provided with direct payment/assignment of benefits from the insurer."

The AAFP appreciates the opportunity to share these comments and welcomes the opportunity to work with policy makers to achieve positive outcomes on these and other policies. For more information, please contact Teresa Baker, Senior Government Relations Representative, at 202-232-9033 or tbaker@aafp.org.

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Statement
of the
American Hospital Association
for the
Committee on Education and Labor
Subcommittee on Health, Employment, Labor and Pensions
of the
U.S. House of Representatives
"Examining Surprise Billing: Protecting Patients from Financial Pain"
April 2, 2019

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit for the record our comments on surprise medical billing.

We believe the last thing a patient should worry about while receiving health care services is an unanticipated medical bill that impacts their out-of-pocket costs and undermines the trust and confidence that patients have in their caregivers. Hospitals and health systems are deeply concerned about the impact of such bills and are committed to finding a solution that first and foremost protects patients.

The AHA Board of Trustees believes addressing surprise medical bills to protect patients is a top priority for our members. Following are the AHA board-approved principles.

GUIDING PRINCIPLES

America's hospitals and health systems are committed to protecting patients from surprise bills and support a federal legislative solution to do so.



Surprise billing typically occurs when a patient receives an unexpected bill for care they thought was covered by their health plan, or when they receive a bill for out-of-network emergency services. Some forms of coverage, including Medicare and Medicaid, have strong patient protections against surprise billing. However, other types of coverage, most notably self-funded, employer-sponsored plans regulated through the Employee Retirement Income Security Act of 1974 (ERISA), do not contain the same protections. While many state governments have attempted to address this issue, only a few have passed comprehensive protections, and states have limited regulatory oversight of ERISA plans.

The three most typical scenarios for when a patient receives an unexpected bill occur when: (1) a patient accesses emergency services outside of their insurance network, including from providers while they are away from home; (2) a patient has acted in good faith to obtain care within their network but unintentionally receives care from an out-of-network physician providing services in an in-network hospital; or (3) a health plan denies coverage for emergency services saying they were unnecessary. In all of these situations, we believe it is critical to protect patients from surprise bills.

We have developed the following principles to help inform the debate regarding surprise medical billing in the scenarios outlined above. In the event a patient chooses to go out-of-network for non-emergency care, these principles should not apply. In February of this year, the AHA and five other national hospital associations sent a joint letter to Congress outlining our position using these principles as a guide (see attachment 1).

PROTECT THE PATIENT. Any public policy solution should protect patients and remove them from payment negotiations between insurers and providers.

Patients, regardless of the type of health care coverage they have, should be protected from gaps in insurance coverage that result in surprise bills. Patients should have certainty regarding their cost-sharing obligations, which should be based on an in-network amount. Patients should not be "balance billed" in the situations described above, meaning they should not receive a bill from the provider beyond their cost-sharing obligations. Patients should not have to bear the burden of serving as an intermediary between health plans and providers, rather health plans should be responsible for paying providers directly.

ENSURE PATIENTS HAVE ACCESS TO EMERGENCY CARE. Any public policy solution should ensure that patients have access to and coverage of emergency care.

This requires that health plans adhere to the "prudent layperson standard" and not deny payment for emergency care that, in retrospect, the health plan claimed was not an emergency. Recent actions by some health plans to deny coverage of emergency services puts patients' physical, mental and financial health at risk.

PRESERVE THE ROLE OF PRIVATE NEGOTIATION. Any public policy solution should ensure providers are able to continue to negotiate appropriate payment rates with health plans.

The government should not establish a fixed payment amount for out-of-network services. Health plans and providers take into account a number of factors when negotiating rates. Any rate or methodology sufficiently simple for national use would not be able to capture these factors. In addition, a fixed payment rate could undermine patients' ability to access in-network clinicians by giving health plans less of an incentive to enlist physicians and facilities to join their networks because they can rely on a default out-of-network payment rate. Providers and health plans should be able to develop networks that meet consumers' needs, and not be compelled to enter into contracts that could thwart the development of more affordable coverage options that support coordinated care.

EDUCATE PATIENTS. Any public policy solution should include an educational component to help patients understand the scope of their health care coverage and how to access their benefits.

All stakeholders – health plans, employers, providers and others – should undertake efforts to improve patients' health care literacy and support them in navigating their health coverage and the health care system.

ENSURE ADEQUATE PROVIDER NETWORKS AND GREATER HEALTH PLAN TRANSPARENCY. Any public policy solution should include greater oversight of health plan provider networks and the role health plans play in helping patients access in-network care.

Patients should have access to easily understandable provider network information to ensure they can make informed health care decisions, including accurate listings for hospital-based physicians in health plan directories and websites. Patients also should have adequate access to in-network providers, including hospital-based specialists at in-network facilities, rather than simply a minimum number of physicians and hospitals. Federal and state regulators should ensure both the adequacy of health plan provider networks and the accuracy of provider directories. Health plans should be responsible for an efficient and timely credentialing process to minimize the amount of time a physician is "out-of-network."

SUPPORT STATE LAWS THAT WORK. Any public policy solution should take into account the interaction between federal and state laws.

Many states have undertaken efforts to protect patients from surprise billing, but federal action is necessary to protect patients in self-insured employer-sponsored plans regulated under the Employee Retirement Income Security Act, which cover the majority of privately insured individuals. Any federal solution should provide a default to state laws that meet the federal minimum for consumer protections.

ADDRESSING OTHER ISSUES

Notice and Disclosure. Many stakeholders see a role for hospitals in notifying patients of the potential for out-of-network care in non-emergency settings, and most hospitals have some form of notice-and-disclosure protocols in place. Some existing notice requirements at the state level include that hospitals:

- notify patients that they may be provided care from physicians not in the patient's network;
- post the health plans they participate in, as well as their contracted physician groups;
- inform patients before scheduling non-emergency services as to network status of care providers; and
- provide patients with the medical codes and estimated fees for any potential out-of-network care.

While we believe that providing the patient such network status information is important, it is not in and of itself a solution to surprise medical bills. The nature of emergencies, and the legal requirements regarding how and when coverage may be discussed, make providing notice in some of these instances difficult. Notice may not be particularly effective in other scenarios as well. Additional paperwork can often be confusing for patients, especially in instances where they may not have another timely alternative for care.

Network Adequacy and Patient Education. Today, hospitals work with patients and their insurers to help them navigate the health care system, including scheduling follow-up care with in-network providers. These efforts have grown commensurate with the growth in high-deductible health plans and narrow insurance networks. Patients enrolled in these newer health plan products often lack an understanding of their out-of-pocket obligations before their plan coverage starts, or that their plan's narrow network limits their access to hospitals and providers. Ensuring adequate networks and patient education regarding the health insurance products they purchase is critical to addressing surprise medical bills.

Bundling of Emergency Department Services. Some stakeholders are promoting the use of "bundling" of hospital and physician services as a way to reduce the incidence of surprise medical billing. While full details on the approach are not yet available, the model, as currently explained, would have insurers negotiate and contract with hospitals for a single rate for emergency care. Hospitals, presumably, would then be responsible for negotiating and contracting with physicians for their services. This concept may seem simple and straightforward in theory; in reality, however, this approach would be administratively complex, fundamentally change the relationship between hospitals and their physician partners, and, alone, do nothing to protect patients from surprise bills. We strongly oppose such a model.

The unique nature of emergency care – namely the uncertainty and potential for high variation – makes it a poor candidate for bundled payments. Several variations of bundled payments for episodes of care have been implemented over the past decade with mixed success. Developing such an arrangement involves a complex array of clinicians, statisticians, lawyers and others to define the services and duration of the bundle, to appropriately price it, and to ensure that any financial relationships between the various providers adhere to state and federal law, including the Stark law and Anti-kickback Statute. To date, the greatest success in bundling has been for services for which the clinical care is well defined and little variation is expected, such as for certain planned joint replacements. For the vast majority of these bundles, physicians and hospitals continue to negotiate their own rates with insurers. Any individual visit to an emergency department can involve countless possible services – from initial diagnosis and confirmatory tests to trauma and complicated surgical procedures involving multiple physicians and other providers, depending on an array of factors. Simply put: Bundled payments are not appropriate for emergency care.

Bundled payments alone also do nothing to stop patients from receiving surprise bills and may put patient access to care at risk. In fact, the proponents of this model note that it must be coupled with a state or federal law that specifically bans balance billing. This ban is the solution to surprise bills, and one that we support. Bundling, therefore, appears to meet some other objective, including allowing insurers to transfer to hospitals their responsibility for establishing comprehensive physician networks and managing the associated financial risk. Hospitals are not set up to manage this type of risk, and patient access to care in their communities could be threatened if they are unsuccessful.

Reference Pricing. We urge committee members to reject legislative proposals specifying a national reimbursement rate for out-of-network services. Health plans and hospitals have a longstanding history of resolving out-of-network emergency service claims, and this process should not be disrupted. We are particularly concerned that any attempt at setting a reimbursement standard in law will have significant consequences, including the creation of a disincentive for insurers to maintain adequate provider networks. Growth in the use of no-network, reference-based pricing models in the commercial market suggests this is already a growing strategy, and one that would accelerate if the insurer could simply default to a government-established, out-of-network rate or methodology.

The process of rate negotiation is a core function of managing a health plan. The process takes into account a number of factors that could not be accounted for in a government rate or methodology. For example, health plans and providers often consider their entire lines of business, volume, quality, partnerships on special programs or initiatives, and other factors when setting rates. Any rate or methodology sufficiently simple for national use would not be able to capture the many factors that health plans and providers consider in individual markets, and health plans should not be absolved of the core function of establishing provider networks, including negotiating rates with providers.

Air Ambulances. Some of our hospital and health system members have raised concerns about the increase in surprise billing for air ambulance services and the need for federal engagement on this issue. The Federal Aviation Administration (FAA) regulates air ambulances, and federal law pre-empts states from regulating rates, routes and services of air carriers, which has limited state governments' ability to address air ambulance balance billing issues.

The Government Accountability Office recently released a report on air ambulance surprise bills that found that, between 2010 and 2014, the median prices charged by air ambulance providers for helicopter transports approximately doubled, and the number of air ambulance helicopters grew by more than 10 percent.¹ In addition, the agency found that, in 2017, about two-thirds of air ambulance transports for privately insured patients were out of network, insurers typically paid only a portion of the out-of-network services, and almost all of the consumer complaints involved balance bills of over \$10,000. As required by the FAA Reauthorization Act of 2018, the Secretary of Transportation has formed an advisory committee on air ambulance patient billing. The advisory committee is directed to recommend ways to protect consumers from surprise air ambulance bills. While this issue is not in the jurisdiction of the committee, we would ask you to consider air ambulance service issues while developing legislation solutions related to surprise medical billing.

CONCLUSION

We thank you for the opportunity to share the hospital and health system field's principles and concerns as they relate to surprise billing. We appreciate that this issue is a priority for Congress, as it is for our field and our patients. We have outlined a solution to the issue of surprise billing, and urge Congress to enact legislation.

¹ GAO-19-292 Air ambulance www.gao.gov/assets/700/697683.pdf



February 20, 2019

Dear Congressional and Committee Leadership:

On behalf of our member hospitals, health systems and other health care organizations, we are fully committed to protecting patients from "surprise bills" that result from unexpected gaps in coverage or medical emergencies. We appreciate your leadership on this issue and look forward to continuing to work with you on a federal legislative solution.

Surprise bills can cause patients stress and financial burden at a time of particular vulnerability: when they are in need of medical care. Patients are at risk of incurring such bills during emergencies, as well as when they schedule care at an in-network facility without knowing the network status of all of the providers who may be involved in their care. **We must work together to protect patients from surprise bills.**

As you debate a legislative solution, we believe it is critical to:

- **Define "surprise bills."** Surprise bills may occur when a patient receives care from an out-of-network provider or when their health plan fails to pay for covered services. The three most typical scenarios are when: (1) a patient accesses emergency services outside of their insurance network, including from providers while they are away from home; (2) a patient receives care from an out-of-network physician providing services in an in-network hospital; or (3) a health plan denies coverage for emergency services saying they were unnecessary.
- **Protect the patient financially.** Patients should have certainty regarding their cost-sharing obligations, which should be based on an in-network amount. Providers should not balance bill, meaning they should not send a patient a bill beyond their cost-sharing obligations.
- **Ensure patient access to emergency care.** Patients should be assured of access to and coverage of emergency care. This requires that health plans adhere to the "prudent layperson standard" and not deny payment for emergency care that, in retrospect, the health plan determined was not an emergency.

- **Preserve the role of private negotiation.** Health plans and providers should retain the ability to negotiate appropriate payment rates. The government should not establish a fixed payment amount or reimbursement methodology for out-of-network services, which could create unintended consequences for patients by disrupting incentives for health plans to create comprehensive networks.
- **Remove the patient from health plan/provider negotiations.** Patients should not be placed in the middle of negotiations between insurers and providers. Health plans must work directly with providers on reimbursement, and the patient should not be responsible for transmitting any payment between the plan and the provider.
- **Educate patients about their health care coverage.** We urge you to include an educational component to help patients understand the scope of their health care coverage and how to access their benefits. All stakeholders – health plans, employers, providers and others – should undertake efforts to improve patients' health care literacy and support them in navigating the health care system and their coverage.
- **Ensure patients have access to comprehensive provider networks and accurate network information.** Patients should have access to a comprehensive network of providers, including in-network physicians and specialists at in-network facilities. Health plans should provide easily-understandable information about their provider network, including accurate listings for hospital-based physicians, so that patients can make informed health care decisions. Federal and state regulators should ensure both the adequacy of health plan provider networks and the accuracy of provider directories.
- **Support state laws that work.** Any public policy should take into account the interaction between federal and state laws. Many states have undertaken efforts to protect patients from surprise billing. Any federal solution should provide a default to state laws that meet the federal minimum for consumer protections.

We look forward to opportunities to discuss these solutions and work together to achieve them.

Sincerely,

American Hospital Association
 America's Essential Hospitals
 Association of American Medical Colleges
 Catholic Health Association of the United States
 Children's Hospital Association
 Federation of American Hospitals



COLLEGE of AMERICAN
PATHOLOGISTS

**Statement for the Record
United States Senate Committee on Education and Labor
Subcommittee on Health, Education, Labor, and Pensions
Examining Surprise Billing: Protecting Patients from Financial Pain**

April 2, 2019

**Statement by
College of American Pathologists**

The College of American Pathologists (CAP) appreciates the opportunity to share our comments in response to the Committee's hearing on the issue of unexpected out-of-network medical bills for patients. We appreciate the discussion of this important issue so that all stakeholders can work together and formulate financial protections for patients who need care that requires out-of-network physicians at in-network facilities. The CAP has been constructively engaged on this issue for many years. It has always been our position that patients should not be financially penalized for the failure of health insurance plans to provide in-network access to hospital-based physician specialties.

As the world's largest organization of board-certified pathologists and leading provider of laboratory accreditation and proficiency testing programs, the CAP serves patients, pathologists, and the public by fostering and advocating excellence in the practice of pathology and laboratory medicine worldwide. The CAP believes that to protect patients from gaps in their health insurance coverage, insurers and providers should settle all payments without the patient's involvement, even if an independent arbitrator settles disputes. Network adequacy standards for health plans should be set, and at a minimum there should be network standards for ensuring that an appropriate number of specialty physicians are available to provide medically necessary services at "in-network" facilities. Additionally, we think it critically important that out-of-network payment mechanisms not, in any way, deter, displace or discourage equitable health plan contracting for physician services, as we believe such contracting is critical to maintaining the private commercial marketplace that consumers wish to avail. Finally, any reimbursement for out of network services should be based on data compiled by independent, non-affiliated organizations, like FAIR Health Inc., or a state's all-payor claims database (APCD). For these reasons, we urge a fully deliberative and engaged physician specialty stakeholder process as has occurred to date in multiple states to produce an optimal legislative outcome that protects patients and preserves the non-governmental health care marketplace.

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COLLEGE of AMERICAN PATHOLOGISTS

Remove burden of surprise bills from patients

Limiting patient cost sharing is an essential part of any Congressional action. Through no fault of their own, patients are caught off guard when an insurer doesn't cover certain physician services. Patients do not need additional financial stress when they are at their most vulnerable. Congress should create a system whereby insurers and providers can come to agreement independent of the patient, who should only pay for care at an in-network rate. Alternative dispute resolution (ADR) can help address this problem. If there is a dispute on payment between an insurer and provider, an independent arbitrator can step in, consider factors pertaining to the case (complexity, duration, etc.), as well as geographically-based charges by providers and payments from insurers in order to determine the fair market value of the physician service.

We can look to the states to find examples of what is working well. Several states have policies that protect patients from out-of-network bills resulting from gaps in health insurance plan contracting. States with laws that are reasonable and that appropriately protect patients include: Arizona, New Jersey, Maryland, Massachusetts, Illinois, Minnesota, Florida, Colorado, and New Hampshire.

In our view, the optimal state law protecting patients from surprise medical billing is the law enacted by New York State. Not only is there mediation/arbitration between insurers and providers, but the payment methodology upon which the "usual and customary rate" (UCR) is calculated is based upon the 80th percentile of FAIR health database charges, so as to reflect the market value of physician services. In New York, patients are financially saved harmless and there is a way for disputes between providers and plan payers to be resolved, and it relies on a payment rate that is acceptable to the provider community.

Enact network adequacy standards

Inadequate networks are the root cause of surprise bills. Without adequate networks of contracted physicians, a patient cannot be properly guarded from out of network health care at an in-network facility. If there are fewer out of network providers to begin with, there will be fewer patients receiving their bills. Furthermore, transparency cannot solve the problem for patients as many physician services are unexpected and cannot be anticipated by the patient. For example, written estimates of pathology services in advance of providing the service cannot provide reliable or useful information for patients. The need for, or type of pathology services needed in a procedure cannot be reliably predicted. Moreover, patients under anesthesia during a procedure cannot exercise choice or control over pathology or laboratory referrals. Thus, creating regulatory standards that require health insurance plans contract with the requisite

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number of providers capable of the full array of physician care, including pathology and laboratory services, in an in-network facility is paramount to reducing surprise bills.

It is important to recognize that the vast majority of providers, including pathologists, wish to contract with health plans. Health plans have deliberately and systematically denied network participation to, or ejected pathologists and clinical laboratories from network participation, and states are starting to take notice. In December of 2017, the Washington State insurance commissioner fined a health insurer \$1.5 million and detailed steps it must take to fix its provider networks. Most recently, in Texas, the Center for Public Policy Priorities reported in 2014 that one health plan in the state had no pathologist providers at 20% of their in-network hospitals. Then, in October 2018, this particular health plan was fined \$700,000 by the Texas Department of Insurance for failure to contract with a hospital-based physician specialty in multiple counties.

The CAP supports federal enactment of network adequacy requirements similar to the law of Louisiana (Network Adequacy Act 22§1019.1 et seq.) that expressly requires health insurance plans to "maintain a network of providers that includes but is not limited to providers that specialize in mental health and substance abuse services, facility-based physicians, and providers that are essential community providers." Facility-based physicians are defined in the Louisiana Act to include: "anesthesiologist, hospitalist, intensivist, neonatologist, pathologist, radiologist, emergency room physician, or other on-call physician, who is required by the base health care facility to provide covered health care." Such requirements should be subject to regulatory oversight and enforcement to ensure that enrollees (patients) have reasonable and timely access to in-network physician specialists at in-network hospitals and facilities. California (Code of Regulations (CCR) Title 10, Section 2240.5 (d) (14)) and New Hampshire (RSA 420.J:7 II(e)) are two other states with specific hospital-based physician network adequacy requirements. However, at present, the vast majority of states have no such hospital-based physician network adequacy requirement and thus should be compelled under federal law to adopt such requirements.

Fair reimbursement for out-of-network services

In order to encourage health plans to contract for physician services, and to ensure that the health care delivery system is financially viable, a fair market rate should be paid for physician services. In general, caps on payment for physicians treating out-of-network patients should be avoided. If pursued, guidelines or limits on what out-of-network providers are paid should reflect actual charge data for the same service in the same geographic area from a statistically significant and wholly independent database.

They should not be based on a percentage of Medicare rates, which have become increasingly inadequate in covering overhead costs, nor should they be based on in-network rates, which would eliminate the need for insurers to negotiate contracts in good faith. Any prohibition, whether state or federal, on billing from out-of-network providers

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not chosen by the patient should be paired with a corresponding payment process that is keyed to the market value of physician services.

Summary

As the committee moves to address this issue, it's of paramount importance to strike a compromise that holds patients harmless if they are treated by a physician who is out-of-network, but also allows providers and insurers to come to agreement on outstanding bills. The CAP would be supportive of any legislative proposal that includes:

- 1.) Language that holds patients harmless and enacts a process, like ADR, that would allow insurers and providers to settle any billing disputes without involving the patient.
- 2.) Inclusion of network adequacy standards that ensure a proper number of physicians can provide services at in-network facilities.
- 3.) If a payment benchmark is proposed, that Medicare is not used. Instead there is a balance of geographic rates from an independent database to inform either an arbitrator in an ADR process, or a general rate for services provided from an out-of-network provider.

Thank you for your consideration of this important issue and we look forward to working with your committee to come up with the best solution for ensuring patients have in-network access to physician services or are otherwise protected from out-of-network charges that result from health plan inadequacies. If you would like to meet, or have any questions, please contact Michael Hurlbut, Assistant Director, Legislation and Political Action, at mhurlbu@cap.org or 202-354-7112.

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April 9, 2019

U.S. House of Representatives
Committee on Education & Labor
Subcommittee on Health, Employment, Labor, and Pensions

Re: Hearing on "Examining Surprise Billing: Protecting Patients from Financial Pain"

Chairwoman Wilson, Ranking Member Walberg, members of the subcommittee:

Community Catalyst is a national, non-profit health care advocacy organization dedicated to quality affordable health care for all. We respectfully submit the following statement on the issue of surprise medical bills discussed at the hearing on April 4, 2019.

We appreciate the opportunity to weigh in on this important issue that is a top health concern for many individuals and families in this country.¹ Evidence shows over fifty percent of privately insured patients have been surprised by a medical bill they thought would be covered, and twenty percent of those bills were the result of a doctor not being a part of a patient's insurance network.² These surprise medical bills are often excessively high, which can result in hundreds and thousands of dollars in medical debt or even bankruptcy.³

Although at least 25 states have taken initial steps to protect their residents from surprise medical bills, only Congress can fully close the gaps and loopholes that leave patients vulnerable to severe financial distress. Congress is in a better position to protect more consumers due to ERISA preemption that excludes consumers in self-funded plans from benefiting from state protections.

¹ Ashley Kirzinger, Bryan Wu, Cailey Muñana, and Mollyann Brodie. Kaiser Health Tracking Poll – Late Summer 2018: The Election, Pre-Existing Conditions, and Surprises on Medical Bills. *The Kaiser Family Foundation*, September 05, 2018. <https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-late-summer-2018-the-election-pre-existing-conditions-and-surprises-on-medical-bills/>. Accessed April 5, 2019

² NORC at the University of Chicago. Press Release: New Survey Reveals 57% of Americans Have Been Surprised by a Medical bills. August 30, 2018. <http://www.norc.uchicago.edu/NewsEvents/Publications/PressReleases/Pages/new-survey-reveals-57-percent-of-americans-have-been-surprised-by-a-medical-bill.aspx>. Accessed April 5, 2019

³ Liz Hamel, Mira Norton, Karen Pollitz, Larry Levitt, Gary Claxton, and Mollyann Brodie. The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey. *The Kaiser Family Foundation*, January 05, 2016. <https://www.kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey/>. Accessed April 5, 2019

Community Catalyst works to ensure consumer interests are represented wherever important decisions about health and the health system are made: in communities, courtrooms, statehouses and on Capitol Hill.

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We commend the Committee for holding their hearing on the 4th and the witnesses for the excellence they presented. We would like to reinforce and expand on several points that were made at the hearing.

In general, we strongly urge the Committee to adopt strong consumer protections that hold consumer harmless from surprise medical bills in all situations where they cannot reasonably be expected to ensure they are receiving in-network care. At the same time, it is critical to put in place policies that curb provider monopoly power on pricing and ensure quality networks. Since it is difficult for Congress to assess competitive conditions in every market, you might want to consider an approach that would set both a floor to prevent insurers from forcing providers to accept unreasonably low rates, but also a ceiling to keep providers from pushing the rates too high.

Finally, federal policies on surprise medical bills should apply to all states as minimum requirements. However, states should be allowed to go beyond the federal floor to create additional consumer protections and further lower health care costs. We also urge the Committee to put in place a mechanism for oversight, enforcement and evaluation.

Detailed Policy Recommendations

We strongly believe that if done correctly, ending surprise balance billing is one way to not only protect people from excessive bills and the risk of medical debt, but also to work to lower health care costs overall. We encourage the Committee to adopt a comprehensive approach, which should include the following policy elements:

Prohibit surprise medical bills.⁴ As noted by Madam Chairwoman Wilson in her opening statement, *"the victims of surprise medical billing often have no control over whether their medical provider is in- or out-of-network."* Therefore, to hold consumers harmless from surprise medical bills, Congress should explicitly prohibit providers from balance billing patients in all situations where they cannot reasonably be expected to ensure they are receiving in-network care. Those situations include, but are not limited to:

- *Emergency care, including ground and air ambulance transportation.* In many cases, emergency physicians and the hospitals where they work do not contract with the same insurers. As a result, despite going to an in-network hospital for emergency care, a patient might be treated by an out-of-network physician. Nationwide, one in five in-patient emergency admissions leads to a surprise medical bill, and more than half of these cases involved ambulance transportation.⁵

⁴ For additional consumer protections, please see our recent policy report: Ending Surprise Balance Billing: Steps to Protect Patients and Reduce Excessive Health Care Costs. February 2019. <https://www.communitycatalyst.org/resources/publications/document/2019/balance-billing/CC-BalanceBilling-Report-FINAL.pdf>

⁵ Christopher Garmon and Benjamin Chertock. One In Five Inpatient Emergency Department Cases May Lead To Surprise Bills. Health Affairs, Vol. 36, No. 1. <https://doi.org/10.1377/hlthaff.2016.0970>. Accessed April 5, 2019

In regards to air ambulance services, the recent report conducted by the U.S. Government Accountability found that in 2017 two-thirds of air ambulance transports for patients with private insurance were out-of-network. Almost all of the consumer complaints about balance bills, reviewed for the report, were over \$10,000.⁶ Some states have attempted to collect information from patients in the effort to raise awareness of balance bills related to air ambulance.⁷ However, due to the Airline Deregulation Act of 1978 (ADA) that explicitly precludes states from regulating air transportation, including air ambulances, states are unable to put in place policies that can protect their residents from exorbitant out-of-network charges from for-profit air ambulance companies. This particularly affects patients living in many rural parts of the country, who sometimes rely on air ambulance services to access emergency care. Federal policymakers alone have the power to regulate air ambulances by amending the ADA.

- *Unexpectedly receiving care from out-of-network providers (including ancillary providers and specialty providers) at an in-network facility.* Similar to emergency physicians, providers such as anesthesiologists, pathologists, radiologists, neonatologists, or assistant surgeons might be out-of-network even though they work at an in-network facility. For example, a patient could arrange for a hip replacement with an in-network surgeon at an in-network facility, but the assistant surgeon helping with the surgery and the radiologist performing the MRI could be out-of-network. In these situations, patients have no means to check if any out-of-network providers are part of their care team.
- *Inadvertently receiving care from out-of-network providers due to inaccurate provider directories.* A patient could do everything right to make sure they receive care from providers that have contracted with their health plan, but if they unknowingly rely on an inaccurate provider directory, they could end up inadvertently receiving care from an out-of-network provider.

Require transparency and disclosure of provider network status and estimated out-of-network charges. Consumers should be informed when care is out-of-network and their potential financial obligations. However, Congress should be cautious of the use of consumer notifications. As explained above, there are many situations in which a normally prudent person cannot be expected to manage the process of ensuring that every provider is in-network. Therefore, *it is critical that consumer protections should not be tied to notices or triggered by notice failure.* Disclosure and transparency requirements *should not* be a substitute for consumer protections from surprise medical bills; they should be a complement.

⁶ United States Government Accountability Office, Air Ambulance: Available Data Show Privately-Insured Patients Are At Financial Risk. Report to Congressional Committees, March 2019. <https://www.gao.gov/assets/700/697684.pdf>. Accessed October 18, 2018.

⁷ In the effort to raise awareness of this problem, state officials from Montana and Michigan reviewed 58 cases of balance billing resulting from air ambulances since 2013 and found that patients were balance billed an average of \$31,000. (Sources: Consumers Union (March 2017). Health Policy Report: Up in the Air: Inadequate Regulation for Emergency Air Ambulance Transportation. <https://consumersunion.org/wp-content/uploads/2017/04/Up-In-The-Air-Inadequate-Regulation-for-Emergency-Air-Ambulance-Transportation.pdf>; and United States Government Accountability Office (July 2017). Air Ambulance: Data Collection and Transparency Needed to Enhance DOT Oversight. Report to the Committee on Transportation and Infrastructure, House of Representatives. <https://www.gao.gov/assets/690/686167.pdf>)

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Establish a process to resolve payment disputes between insurers and out-of-network providers that includes provider payment standards in surprise scenarios. Consumers should not bear the burden of resolving surprise medical bills. At the same time, it is necessary to have a system that puts downward pressure on monopoly prices while ensuring that provider payments are adequate. To accomplish these goals, it is important to establish a payment resolution process that (a) encourages insurers and providers to settle their disagreements between themselves; (b) does not put upward pressure on premiums; and (c) does not provide financial incentives for providers to remain out-of-network. A number of approaches, if designed carefully, are consistent with these goals:

- One option would be for Congress to establish a “baseball” arbitration process as a fallback option if these two parties are unable to reach a resolution on their own—where each party submits their “best and final” offer. An arbitrator would then choose one or the other. However, where there is an arbitration involved, it is crucial that provider charges should not be used as a benchmark for resolving disputes as charges, especially for specialty services, most often resulting in surprise bills are often excessively high. For example, a 2017 study published in the Journal of the American Medical Association (JAMA) found that the average anesthesiologist, radiologist and pathologist charge is four times more for their services than what Medicare pays for similar services while for general practice the charge is only 1.6 times higher than the Medicare rate.⁸
- Another approach is to enhance the negotiating leverage of payers by following the example of Medicare Advantage (MA) and setting a ceiling on out-of-network prices. The ceiling on out-of-network charges has allowed MA plans to negotiate payment rates that are equivalent to, or sometimes even lower than Medicare. Under Medicare rules, out-of-network providers cannot charge MA beneficiaries more than Medicare FFS rates—a cap that also has had the effect of constraining rates for in-network providers.⁹ A study conducted by Berenson et. al. found that MA plans “nominally pay only 100-105 percent of traditional Medicare rates” citing the statutory and regulatory requirements that maintain parity in pricing for hospital services.¹⁰ As with the arbitration approach, it is important that any rate ceiling not cause premiums to increase or give providers a financial incentive to remain out-of-network.

Oversight, evaluation and enforcement. To ensure that consumers are effectively protected from surprise medical bills, Congress should consider requiring mechanisms to oversee, evaluate and enforce these protections. HHS and other relevant agencies should track the prevalence of and resolutions to out-of-network billing disputes and ensure that patients are not erroneously billed. Oversight evaluation and enforcement will help ensure that both the consumer protections and

⁸ Ge Bai and Gerard F. Anderson. “Variation in the Ratio of Physician Charges to Medicare Payments by Specialty and Region.” JAMA. 2017; 317(3):315-318. doi:10.1001/jama.2016.16230. Accessed April 5, 2019.

⁹ Murray R. Hospital Charges And The Need For A Maximum Price Obligation Rule For Emergency Department & Out-Of-Network Care. Health Affairs. <https://www.healthaffairs.org/doi/10.1377/hblog20130516.031255/full/>. Published May 16, 2013. Accessed April 5, 2019.

¹⁰ Berenson RA, Sunshine JH, Helms D, Lawton E. Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices. Health Affairs. 2015;34(8):1289-1295. doi:10.1377/hlthaff.2014.1427. Accessed April 5, 2019

payment resolution process are working as intended and can identify the need for further improvements or corrections.

Thank you again for the opportunity to provide comments on this important issue. As individuals and families struggle to pay for health care services, it is clear that what people want is for policymakers to find a way to make their health insurance premiums and out-of-pocket cost sharing more affordable. We urge the Committee to take bold actions to protect consumers and control overall health care costs.

Respectfully submitted,



Michael Miller
Director, Strategic Policy

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[Additional submission by Mr. Walberg follows:]

April 02, 2019

The Honorable Frederica S. Wilson
Chair
Subcommittee on Health, Employment,
Labor and Pensions
Washington, DC 20515

The Honorable Tim Walberg
Ranking Member
Subcommittee on Health, Employment,
Labor and Pensions
Washington, DC 20515

Dear Chair Wilson and Ranking Member Walberg:

We applaud you for holding a hearing examining surprise billing. Reflecting the goal of employers to protect patients from surprise medical bills without undermining network participation or resulting in higher health care costs for all consumers, we urge Congress to pass legislation consistent with the following provisions:

Protect Patients from Surprise Medical Bills

- The goal of any federal surprise balance billing legislative solution is to protect patients in situations in which they lack a choice of providers. It is vitally important, however, that any legislative solutions not discourage network participation or result in higher health care costs for all consumers. Patients often lack any meaningful choice of provider when they obtain care in out-of-network emergency rooms, and when a patient receives services in in-network facilities from out-of-network professionals, particularly with respect to a small number of provider specialties.
- To protect consumers and families, federal legislation must ensure that patient cost-sharing is limited to in-network amounts for emergency services performed at an out-of-network facility or for treatment by out-of-network facility-based physicians performed at in-network facilities, and prohibit providers from imposing additional "surprise" balance bills in these circumstances.
- Congress should implement this change through an amendment to section 2719A of the Public Health Service Act ("PHSA"), which applies to both group and individual commercial insurance, and which would apply to insured and self-funded group health plans through section 715 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Disclosure and Transparency

- For surprise balance billing that occurs at an in-network facility and follow-up care from emergency treatment at an out-of-network facility, federal legislation must require disclosure of out-of-network professional costs at the time of scheduling. This disclosure will help ensure that patients can make an informed decision and schedule procedures when an in-network professional is available.
- Facilities such as hospitals should also be required to list prominently on their websites, whether they lack available providers who participate in networks which the facility participates in – including what those specialties are, and the likelihood that a patient may thus be seen by an out-of-network provider.

- Much of the surprise over unexpected balance billing can be eliminated by providing this disclosure.
- Congress could implement this disclosure requirement directly on hospitals (through Medicare's minimum requirements for hospitals under 42 USC § 1395x(e)(1)-(8)), or through an amendment to section 2718(e) of the PHSA, which requires hospitals to disclose standard charges for items and services provided by the hospitals.

Required Reimbursement

- Out-of-network providers frequently bill well in excess of negotiated rates and Medicare reimbursement for these services, as opposed to the actual value of the service provided. A study by Ge Bai and Gerard F. Anderson, published in JAMA in 2017 comparing physician charge-to-Medicare payment ratio across specialties found that anesthesiology had the highest median (5.8), followed by interventional radiology (4.5), emergency medicine (4.0), and pathology (4.0).
- To ensure equitable payment for the services provided without discouraging network participation or resulting in higher costs for all consumers, legislation must set a reasonable federal reimbursement structure that (1) establishes a federal cap for emergency services at an out-of-network facility at 125 percent of the Medicare rate, and (2) requires all providers at an in-network facility to accept in-network rates.
- Conversely, without reasonable limitations on the reimbursement rates, out-of-network providers in surprise balance billing situations will have an incentive to bill even higher rates in order to achieve maximum payment through any binding arbitration mechanism. Binding arbitration is an inefficient and ineffective approach to addressing surprise billing and should not be included as a legislative solution. The experience of the mediation process in Texas is instructive. According to a recent report, the Texas Department of Insurance received just 43 requests from consumers for mediation in 2013. In 2014, the number of requests grew to more than 600 and have climbed steeply ever since. There were 4,519 requests in 2018, creating a significant backlog.
- Requiring facilities to bundle medical services for covered procedures into a single payment also could help address this problem if structured properly. In the case of bundled services performed by out-of-network providers, the costs of those services within the bundle cannot exceed either the allowable in-network rate or 125% of Medicare. But, care must be taken to ensure that the contracted bundled payment is final and not merely a progress point toward further negotiation.
- Congress should implement this change through an amendment to section 2719A of the PHSA, which applies to both group and individual commercial insurance, and which would apply to insured and self-funded group health plans through section 715 of ERISA.

Ambulance and Outsourced Emergency Departments

- A significant concern to both patients and plans are the massive costs associated with non-participating ambulance, air ambulance, and emergency department services.

- According to GAO's analysis of the most complete data identified for air ambulance transports of privately-insured patients, 69 percent of about 20,700 transports in the data set were out-of-network in 2017.
- Ambulance, air ambulance, and emergency services are essential to ensure that patients receive the care they need in the most urgent of situations. Subjecting patients in the most dire of circumstances to balance billing exposes patients to material liabilities in order to receive the care they need.
- Any legislative solution for surprise balance billing should also specify that ambulances and air ambulance services are considered emergency services for purposes of the statutory limitations on balance billing and reimbursement rates.
- Further, Congress should include provisions to eliminate problematic incentives in which an in-network facility could profit by allowing or encouraging an outsourced out-of-network emergency department to surprise bill in-network patients.
- Congress should implement this change through an amendment to section 2719A of the PHSA, which applies to both group and individual commercial insurance, and which would apply to insured and self-funded group health plans through section 715 of ERISA.

We look forward to working with you to address the burden of surprise medical billing.

Sincerely,

American Benefits Council
 Associated Builders and Contractors, Inc.
 Associated General Contractors
 Auto Care Association
 Colorado Business Group on Health
 Corporate Health Care Coalition
 Council for Affordable Health Coverage
 Economic Alliance for Michigan
 Florida Health Care Coalition
 Food Marketing Institute
 Greater Philadelphia Business Coalition on Health
 HealthCare 21 Business Coalition
 Houston Business Coalition on Health
 Louisiana Business Group on Health
 Midwest Business Group on Health
 National Alliance of Healthcare Purchaser Coalitions
 National Association of Health Underwriters
 National Association of Wholesaler-Distributors
 National Business Group on Health
 National Restaurant Association
 National Retail Federation
 Pacific Business Group on Health
 Partnership for Employer-Sponsored Coverage
 Retail Industry Leaders Association
 Retailers Association of Massachusetts

Rhode Island Business Group on Health
Self-Insurance Institute of America, Inc.
Silicon Valley Employers Forum
Small Business & Entrepreneurship Council
Society of Professional Benefit Administrators
St. Louis Area Business Health Coalition
The Council of Insurance Agents & Brokers
The ERISA Industry Committee
Wyoming Business Coalition on Health

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[Questions submitted for the record and their responses follow:]

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April 12, 2019

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Mr. Frederick Isasi, J.D., MPH
Executive Director
Families USA
1225 New York Avenue, NW, Suite 800
Washington, D.C. 20005

Dear Mr. Isasi:

I would like to thank you for testifying at the April 2, 2019, Subcommittee on Health, Education, Labor, and Pensions hearing on "Examining Surprise Billing: Protecting Patients from Financial Pain."

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later Wednesday, April 24, 2019, for inclusion in the official hearing record. Your responses should be sent to Daniel Foster of the Committee staff. He can be contacted at the main number 202-225-3725 should you have any questions.

We appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

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Health, Employment, Labor, and Pensions Subcommittee Hearing
"Examining Surprise Billing: Protecting Patients from Financial Pain"
Tuesday, April 2nd, 2019
10:15am

REPRESENTATIVE HALEY M. STEVENS (MI)

Surprise medical bills lead to devastating consequences for consumers throughout the country.

1. Is there a way to determine just how large these expenses are for consumers?
2. How prepared are Americans for these unexpected expenses?

REPRESENTATIVE DAVID P. ROE (TN)

1. Insurers typically do not disclose the type of plan that covers a claim. So, patients and providers cannot determine which federal protections apply to the visit. For instance, patients don't know if certain annual and lifetime limits apply to their required contribution. And providers don't know whether the federal minimum payment standard for emergency care applies. Patients and providers may need to expend a great deal of time, energy and money to gather this simple, yet essential, plan information. Given that, do you think federal legislation should require health care insurance policy numbers to designate the type of plan? For instance, if policy numbers included a "-E" at the end when it is an ERISA plan, this would clear up a lot of confusion. What are your thoughts on this approach?
2. While emergency physicians account for only four percent of physicians, they provide 67 percent of all care to uninsured patients and 50 percent of all care given to Medicaid and CHIP patients. Further, in emergency medicine, only commercially-insured claims are profitable. Uninsured, Medicare, and Medicaid claims all have negative profit margins. Even when a claim is covered by commercial insurance, emergency physicians collect only an estimated 30 to 40 percent of patient cost-sharing. In light of this, federal and state laws treat emergency care differently in order to protect access to the nation's health care safety net. The emergency physician is mandated by federal law to provide both in-network and out-of-network care. Do you think federal legislation should mandate that commercial insurers provide appropriate coverage for this federally mandated care?
3. It's clear that patients in the same location have different risk for receiving a surprise bill depending on which insurance plan they have. What differentiates these plans? Does federal law ensure that networks provide adequate and transparent choices for their patients? What are the incentives that have led insurance plans to create narrow, inadequate networks?

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4. Patients in these networks receive surprise bills because there isn't the provider base to support the care these patients require. How do we reverse the incentives to allow more providers to be in network and taking care of more patients, which is obviously in their interest to do? Have any states tried to create standards for network adequacy and keep track of the plans' performance? What has the result been for patients in those states?

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April 12, 2019

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Mr. Jack Hoadley, Ph.D.
Research Professor Emeritus
Georgetown University: Health Policy Institute
McCourt School of Public Policy
4064 Ridgeview Circle
McLean, VA 22101

Dear Professor Hoadley:

I would like to thank you for testifying at the April 2, 2019, Subcommittee on Health, Education, Labor, and Pensions hearing on "Examining Surprise Billing: Protecting Patients from Financial Pain."

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later Wednesday, April 24, 2019, for inclusion in the official hearing record. Your responses should be sent to Daniel Foster of the Committee staff. He can be contacted at the main number 202-225-3725 should you have any questions.

We appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

000605

JA366

Health, Employment, Labor, and Pensions Subcommittee Hearing
 "Examining Surprise Billing: Protecting Patients from Financial Pain"
 Tuesday, April 2, 2019
 10:15am

REPRESENTATIVE DONALD NORCROSS (NJ)

1. Some states have limited arbitration to either large claims (e.g., Arizona has a \$1000 threshold) or to disputes over a certain threshold (i.e., "amount in dispute"). For instance, the New Jersey law states that dispute resolution is available if the "difference between the carrier's and the provider's final offer is not less than \$1000." Therefore, for a \$1500 bill from an out-of-network provider, if the carrier has agreed to pay \$300, but the provider still believes he or she should receive an additional \$1200, then the "amount in dispute" is over \$1000 and, as such, eligible for arbitration. Given that nuance, which do you believe is a better threshold – total claim amount or amount in dispute – and why?

REPRESENTATIVE DAVID P. ROE (TN)

1. Insurers typically do not disclose the type of plan that covers a claim. So, patients and providers cannot determine which federal protections apply to the visit. For instance, patients don't know if certain annual and lifetime limits apply to their required contribution. And providers don't know whether the federal minimum payment standard for emergency care applies. Patients and providers may need to expend a great deal of time, energy and money to gather this simple, yet essential, plan information. Given that, do you think federal legislation should require health care insurance policy numbers to designate the type of plan? For instance, if policy numbers included a "-E" at the end when it is an ERISA plan, this would clear up a lot of confusion. What are your thoughts on this approach?
2. While emergency physicians account for only four percent of physicians, they provide 67 percent of all care to uninsured patients and 50 percent of all care given to Medicaid and CHIP patients. Further, in emergency medicine, only commercially-insured claims are profitable. Uninsured, Medicare, and Medicaid claims all have negative profit margins. Even when a claim is covered by commercial insurance, emergency physicians collect only an estimated 30 to 40 percent of patient cost-sharing. In light of this, federal and state laws treat emergency care differently in order to protect access to the nation's health care safety net. The emergency physician is mandated by federal law to provide both in-network and out-of-network care. Do you think federal legislation should mandate that commercial insurers provide appropriate coverage for this federally mandated care?
3. It's clear that patients in the same location have different risk for receiving a surprise bill depending on which insurance plan they have. What differentiates these plans? Does federal law ensure that networks provide adequate and transparent choices for their

patients? What are the incentives that have led insurance plans to create narrow, inadequate networks?

4. Patients in these networks receive surprise bills because there isn't the provider base to support the care these patients require. How do we reverse the incentives to allow more providers to be in network and taking care of more patients, which is obviously in their interest to do? Have any states tried to create standards for network adequacy and keep track of the plans' performance? What has the result been for patients in those states?

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Ms. Ilse Schuman
Senior Vice President, Health Policy
American Benefits Council
1501 M Street, NW, Suite 600
Washington, D.C. 20005

Dear Ms. Schuman:

I would like to thank you for testifying at the April 2, 2019, Subcommittee on Health, Education, Labor, and Pensions hearing on "Examining Surprise Billing: Protecting Patients from Financial Pain."

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later Wednesday, April 24, 2019, for inclusion in the official hearing record. Your responses should be sent to Daniel Foster of the Committee staff. He can be contacted at the main number 202-225-3725 should you have any questions.

We appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

000608

JA369

177

Health, Employment, Labor, and Pensions Subcommittee Hearing
 “Examining Surprise Billing: Protecting Patients from Financial Pain”
 Tuesday, April 2, 2019
 10:15am

REPRESENTATIVE DAVID P. ROE (TN)

1. Insurers typically do not disclose the type of plan that covers a claim. So, patients and providers cannot determine which federal protections apply to the visit. For instance, patients don't know if certain annual and lifetime limits apply to their required contribution. And providers don't know whether the federal minimum payment standard for emergency care applies. Patients and providers may need to expend a great deal of time, energy and money to gather this simple, yet essential, plan information. Given that, do you think federal legislation should require health care insurance policy numbers to designate the type of plan? For instance, if policy numbers included a "-E" at the end when it is an ERISA plan, this would clear up a lot of confusion. What are your thoughts on this approach?
2. While emergency physicians account for only four percent of physicians, they provide 67 percent of all care to uninsured patients and 50 percent of all care given to Medicaid and CHIP patients. Further, in emergency medicine, only commercially-insured claims are profitable. Uninsured, Medicare, and Medicaid claims all have negative profit margins. Even when a claim is covered by commercial insurance, emergency physicians collect only an estimated 30 to 40 percent of patient cost-sharing. In light of this, federal and state laws treat emergency care differently in order to protect access to the nation's health care safety net. The emergency physician is mandated by federal law to provide both in-network and out-of-network care. Do you think federal legislation should mandate that commercial insurers provide appropriate coverage for this federally mandated care?
3. It's clear that patients in the same location have different risk for receiving a surprise bill depending on which insurance plan they have. What differentiates these plans? Does federal law ensure that networks provide adequate and transparent choices for their patients? What are the incentives that have led insurance plans to create narrow, inadequate networks?
4. Patients in these networks receive surprise bills because there isn't the provider base to support the care these patients require. How do we reverse the incentives to allow more providers to be in network and taking care of more patients, which is obviously in their interest to do? Have any states tried to create standards for network adequacy and keep track of the plans' performance? What has the result been for patients in those states?

000609

JA370

REPRESENTATIVE RUSS FULCHER (ID)

1. In your testimony, you mentioned that while employers seek to ensure employees are aware of the higher costs of out-of-network services, more “assistance” is needed, such as “contracting with other entities” to negotiate the bill. Can you elaborate on that? How can we generate more affordable choices and options for the consumer?
2. What do you see as the main challenges to requiring third-party providers from contracting with the insurance company that services a particular hospital or clinic, so that the consumer can at least know the potential price of the service and help control prices that are charged by the third-party provider?
3. Typically, employees turn to the benefits manager at their job for help with a surprise bill (a charge they didn’t know they had to pay because it wasn’t covered on their insurance). What can we do to help these employers have more health care insurance and non-insurance options that might lower costs?

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April 12, 2019

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Ms. Christen Linke Young, J.D.
Fellow, USC-Brookings Schaeffer Initiative on Health Policy
The Brookings Institution
1775 Massachusetts Avenue, NW
Washington, D.C. 20036

Dear Ms. Young:

I would like to thank you for testifying at the April 2, 2019, Subcommittee on Health, Education, Labor, and Pensions hearing on "Examining Surprise Billing: Protecting Patients from Financial Pain."

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later Wednesday, April 24, 2019, for inclusion in the official hearing record. Your responses should be sent to Daniel Foster of the Committee staff. He can be contacted at the main number 202-225-3725 should you have any questions.

We appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

000611

JA372

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Health, Employment, Labor, and Pensions Subcommittee Hearing
 “Examining Surprise Billing: Protecting Patients from Financial Pain”
 Tuesday, April 2nd, 2019
 10:15am

REPRESENTATIVE HALEY M. STEVENS (MI)

Many experts, including some of your colleagues at the Brookings Institution, have discussed a multi-pronged approach to addressing surprise billing.

1. Can you share your thoughts on developing policies that treat the balance of the bill as an in-network charge, and therefore covered by the patient's insurance?
2. What about prohibiting balance billing altogether?

REPRESENTATIVE DAVID P. ROE (TN)

1. Insurers typically do not disclose the type of plan that covers a claim. So, patients and providers cannot determine which federal protections apply to the visit. For instance, patients don't know if certain annual and lifetime limits apply to their required contribution. And providers don't know whether the federal minimum payment standard for emergency care applies. Patients and providers may need to expend a great deal of time, energy and money to gather this simple, yet essential, plan information. Given that, do you think federal legislation should require health care insurance policy numbers to designate the type of plan? For instance, if policy numbers included a "-E" at the end when it is an ERISA plan, this would clear up a lot of confusion. What are your thoughts on this approach?
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000612

JA373

4. Patients in these networks receive surprise bills because there isn't the provider base to support the care these patients require. How do we reverse the incentives to allow more providers to be in network and taking care of more patients, which is obviously in their interest to do? Have any states tried to create standards for network adequacy and keep track of the plans' performance? What has the result been for patients in those states?

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April 24, 2019

The Honorable Bobby Scott, Chairman
House Committee on Education and Labor
U.S. House of Representatives
Washington, DC 20005

Dear Chairman Scott:

On April 2, 2019, the House Education and Labor Subcommittee on Health, Labor, and Pensions convened a hearing on "Examining Surprise Billing: Protecting Patients from Financial Pain," at which I testified on behalf of my organization, Families USA (FUSA). After the hearing, Members of the Committee submitted questions for the record to all witnesses. Below, please find responses to these questions prepared by the FUSA Staff.

Thank you again for the opportunity to testify. If any Committee Members or staff would like to discuss these answers further or need any other support, we would be very happy to provide assistance. Please feel free to reach out to me or Shawn Gremminger, FUSA Senior Director of Federal Relations at SGremminger@familiesusa.org or 202-628-3030.

Sincerely,

A handwritten signature in dark ink, appearing to read "Frederick Isasi", is written over a horizontal line.

Frederick Isasi
Executive Director

FamiliesUSA.org
1225 New York Avenue, NW, Suite 800
Washington, DC 20005
main 202-628-3030 / fax 202-347-7117

000614

JA375

Frederick Isasi, Executive Director, Families USA
Answers to Questions for the Record

Health, Employment, Labor, and Pensions Subcommittee Hearing
"Examining Surprise Billing: Protecting Patients from Financial Pain"
Tuesday, April 2nd, 2019
10:15am

REPRESENTATIVE HALEY M. STEVENS (MI)

Surprise medical bills lead to devastating consequences for consumers throughout the country.

1. Is there a way to determine just how large these expenses are for consumers?

Answer: Surprise medical bills can result in hundreds, thousands, and even tens-of-thousands of completely unanticipated out-of-pocket costs for consumers.¹ For example, to learn about the magnitude of surprise bills, the New York Department of Financial Services surveyed insurance plans in the state on whether they received bills from out-of-network emergency providers that were greater than \$2,500 and more than 200% of the Medicare rate. All insurers surveyed reported receiving bills that met these criteria. On average, these bills totaled \$7,006, of which insurers paid \$3,228 and consumers paid \$3,778.² These data from New York are representative of consumer experience throughout the nation.³

2. How prepared are Americans for these unexpected expenses?

Answer: Surprise medical bills can be thousands or even tens-of-thousands of dollars⁴ and most American families have little to no ability to absorb the cost of surprise medical bills. For example, the Federal Reserve reports that 40 percent of Americans do not have the savings to cover an unexpected \$400 expense (i.e., requiring them to either sell a possession or increase their borrowing).⁵ We would posit that consumers who do everything they can to prevent unaffordable medical costs by buying insurance and working to properly navigate the complex health care system rightfully expect that they will be protected from egregious out-of-pocket costs.

These unexpected medical costs take a toll on wellbeing and health: A larger percentage of the population actually fear medical bills from a serious illness than the serious illness itself (40 percent vs.

¹ Cooper, Zack and Fiona Scott Morton. "Out-of-Network Emergency-Physician Bills — An Unwelcome Surprise" *New England Journal of Medicine*. 2016. <https://www.nejm.org/doi/full/10.1056/NEJMp1608571>.

² New York State Department of Financial Services, "How New Yorkers Are Getting Stuck with Unexpected Medical Bills from Out-of-Network Providers." New York State. 2012. http://www.statecoverage.org/files/NY-Unexpected_Medical_Bills-march_7_2012.pdf.

³ Cooper, Zack and Fiona Scott Morton, op. cit.

⁴ Cooper, Zack and Fiona Scott Morton, op. cit.

⁵ Board of Governors of the Federal Reserve System. "Report on the Economic Wellbeing of U.S. Households in 2017." Federal Reserve. 2018. <https://www.federalreserve.gov/publications/files/2017-report-economic-well-being-us-households-201805.pdf>.

33 percent).⁶ What's more, according to the American Psychological Association, the stress associated with medical bill anxiety can actually make people sicker.⁷

With no way to protect themselves against surprise medical bills and insufficient recourse when bills do occur, families need Congress to step up and protect them from this harm.

REPRESENTATIVE DAVID P. ROE (TN)

1. Insurers typically do not disclose the type of plan that covers a claim. So, patients and providers cannot determine which federal protections apply to the visit. For instance, patients don't know if certain annual and lifetime limits apply to their required contribution. And providers don't know whether the federal minimum payment standard for emergency care applies. Patients and providers may need to expend a great deal of time, energy and money to gather this simple, yet essential, plan information. Given that, do you think federal legislation should require health care insurance policy numbers to designate the type of plan? For instance, if policy numbers included a "-E" at the end when it is an ERISA plan, this would clear up a lot of confusion. What are your thoughts on this approach?

Answer: Families USA strongly supports more transparency in health insurance. Clearer descriptions of health plans, including network type and breadth, cost-sharing amounts, excluded services, and other information consumers understand and need would help people navigate the complex health care system. When it comes to surprise medical bills, however, we believe that transparency is helpful, but it is not sufficient to address the problem.

Even if transparency measures are successful in providing consumers a deeper understanding of their health plan, they cannot prevent surprise bills from occurring. Current law, including under ERISA, allows out-of-network providers to balance bill consumers for hundreds, thousands, or even tens-of-thousands of dollars for care that they could not avoid.⁸ For example, the surprise, out-of-network claim may have been generated because of an emergency in which the patient had no choice of provider. Or, the claim might have occurred for an out-of-network service attendant to an in-network service (sometimes referred to an "auto-referral"), such as out-of-network anesthesiology services occurring attendant to in-network surgical services.⁹

⁶ NORC at the University of Chicago and West Health Institute. "Americans' Views of Healthcare Costs, Coverage, and Policy." NORC at the University of Chicago. 2018. <https://www.westhealth.org/wpcontent/uploads/2018/03/WHI-Healthcare-Costs-Coverage-and-Policy-Issue-Brief.pdf>.

⁷ American Psychological Association. "Stress in America: Uncertainty about Health Care." APA. 2018. <https://www.apa.org/news/press/releases/stress/2017/uncertainty-health-care.pdf>.

⁸ Cooper, Zack and Fiona Scott Morton, op. cit.

⁹ Adler, Loren, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, and Erin L. Duffy. "State Approaches to Mitigating Surprise Out-of-Network Billing." USC-Brookings Schaeffer Initiative for Health Policy. 2019. <https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing/>.

While some limited protections are in place to ease the burden out-of-pocket costs for health care consumers, even when they are fully and properly applied, consumers can still receive very large surprise bills.¹⁰ For example, annual out-of-pocket maximums only apply to in-network care, so they cannot decrease the burden of surprise medical bills, which by definition are out-of-network.¹¹ Even the savviest consumers receive surprise bills, despite buying insurance and doing all they can to properly navigate the health care system, because current law does not provide sufficient protections.¹²

Finally, it's worth noting that health insurance literacy levels vary significantly among America's families.¹³ Average consumers, and their health care providers, may not be familiar with federal health care laws such as ERISA. When patients are in need of urgent care, they should not be penalized for failing to know whether federal law is properly applied to their health plan. Instead they should be able to prioritize their recovery and count on the health care system, and U.S. laws, to automatically protect them from egregious charges they incur due to no fault of their own.

2. While emergency physicians account for only four percent of physicians, they provide 67 percent of all care to uninsured patients and 50 percent of all care given to Medicaid and CHIP patients. Further, in emergency medicine, only commercially-insured claims are profitable. Uninsured, Medicare, and Medicaid claims all have negative profit margins. Even when a claim is covered by commercial insurance, emergency physicians collect only an estimated 30 to 40 percent of patient cost-sharing. In light of this, federal and state laws treat emergency care differently in order to protect access to the nation's health care safety net. The emergency physician is mandated by federal law to provide both in-network and out-of-network care. Do you think federal legislation should mandate that commercial insurers provide appropriate coverage for this federally mandated care?

Answer: It is important to note that federal law vis-à-vis EMTALA does not require emergency department (ED) physicians to treat all patients presenting in the ED. Instead it requires that physicians screen and, in the limited instances in which a patient has an emergency medical condition, stabilize (not treat) these patients.¹⁴

Furthermore, despite the widespread assertion by the provider community, it is not a given that the Medicare and Medicaid programs are not covering costs for hospitals.¹⁵ Experts believe in some

¹⁰ Adler, Loren, Mark Hall, Caitlin Brandt, Paul B. Ginsburg, and Steven M. Lieberman. "Stopping surprise medical bills: Federal action is needed." The Brookings Institution. 2017. <https://www.brookings.edu/opinions/stopping-surprise-medical-bills-federal-action-is-needed/>.

¹¹ Glover, Lacie. "Health Insurance Deductible vs. Out-of-Pocket Maximum." NerdWallet. 2016. <https://www.nerdwallet.com/blog/health/whats-difference-deductible-pocket-maximum/>.

¹² Adler, Loren, Mark Hall, Caitlin Brandt, Paul B. Ginsburg, and Steven M. Lieberman, op. cit.

¹³ Norton, Mira, Liz Hamel and Mollyann Brodie. "Assessing Americans' Familiarity With Health Insurance Terms and Concepts" Kaiser Family Foundation. 2014. <https://www.kff.org/health-reform/poll-finding/assessing-americans-familiarity-with-health-insurance-terms-and-concepts/>.

¹⁴ Centers for Medicare & Medicaid Services. "Emergency Medical Treatment & Labor Act (EMTALA)." CMS. Retrieved April 24, 2019. <https://www.cms.gov/regulations-and-guidance/legislation/emtala/>.

¹⁵ Stensland, Jeffery, Zachary R. Gaumer, and Mark E. Miller. "Contrary To Popular Belief, Medicaid Hospital Admissions Are Often Profitable Because Of Additional Medicare Payments." Health Affairs. 2015. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0599>.

instances Medicare and Medicaid payments are more than sufficient to cover costs.¹⁶ Private coverage simply tends to reimburse at higher rates than Medicare and Medicaid. Emergency physician charges are high relative to other physicians, including radiologists, pathologists, cardiologists, and surgeons. Typically, emergency physicians' billed charges are four to five times what Medicare pays for the same service.¹⁷ However, the range of charges among emergency physicians is wide: a study of one large insurer's claims found that out-of-network emergency physicians set charges at an average of almost eight times what Medicare pays.¹⁸ Comparatively, general surgeons typically charge two to three times Medicare rates.¹⁹

Economic experts argue that high out-of-network rates charged by emergency physicians are attributable less to the actual cost of delivering care and more to the economic incentives created when patients enter emergency departments in need of urgent care and unable to wait for an in-network provider.²⁰ When consumers are not in a position to refuse out-of-network care, a physician's incentive to enter a contract with an insurer for an in-network rate is reduced. Economic incentives create a situation where emergency physicians can remain out-of-network with some or even all area insurers, charge high rates, and still count on a steady patient volume.²¹

Federal law does require that health plans cover emergency services²² and these requirements apply to ERISA plans as well as fully insured plans.²³ Specifically, health plans must cover emergency services without prior authorization, even from out-of-network providers and facilities.²⁴ In addition, if emergency services are provided out-of-network, health plans must not charge consumers more for those services than they would if the services were delivered in-network. However, consumers may be balance billed by out-of-network providers for amounts that the insurer does not reimburse. Additionally, health plans do not have to count the balanced-billed payments or cost-sharing amounts towards consumers' in-network deductible and out-of-pocket maximum (see additional discussion below).²⁵

Importantly, federal law and corresponding regulations set a minimum amount that health plans, including ERISA plans, must pay out-of-network providers in emergency situations. Specifically, health plans, including ERISA plans, must pay out-of-network emergency providers *the greatest of*: 1) median in-network rates, 2) usual and customary rates, or 3) the Medicare rate for the service provided.²⁶

¹⁶ Op. Cit.

¹⁷ Adler, Loren, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, and Erin L. Duffy, op. cit.

¹⁸ Cooper, Zack and Fiona Scott Morton, op. cit.

¹⁹ Adler, Loren, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, and Erin L. Duffy, op. cit.

²⁰ Ibid.

²¹ Ibid.

²² SEC. 2719A [42 U.S.C. 300gg-19a]- Patient Protections. <https://www.hhs.gov/sites/default/files/ppacacon.pdf>;

29 CFR § 2590.715-2719A(b) - Patient protections. <https://www.law.cornell.edu/cfr/text/29/2590.715-2719A>.

²³ 29 CFR § 2590.715-2719A(b) - Patient protections. <https://www.law.cornell.edu/cfr/text/29/2590.715-2719A>.

²⁴ 29 CFR § 2590.715-2719A(b)(2)(i). <https://www.law.cornell.edu/cfr/text/29/2590.715-2719A>.

²⁵ 29 CFR § 2590.715-2719A(b), op. cit.

²⁶ 29 CFR § 2590.715-2719A(b)(3)(i). <https://www.law.cornell.edu/cfr/text/29/2590.715-2719A>.

However, there are no protections in federal law that prevent emergency providers from billing consumers the difference between what an insurer pays for the service and the provider's charge for the service.²⁷ This amount— the surprise balance bill— can equal hundreds, thousands, or even tens-of-thousands of dollars based on the charge set by an emergency physician.²⁸ America's families bear the consequences of high out-of-network emergency charges, which are passed down in the form of surprise medical bills. Congress can protect consumers from this financial harm by enacting legislation that applies to all health plans, including ERISA plans. This legislation should ban surprise out-of-network balance billing while also holding down premium costs.

3. It's clear that patients in the same location have different risk for receiving a surprise bill depending on which insurance plan they have. What differentiates these plans? Does federal law ensure that networks provide adequate and transparent choices for their patients? What are the incentives that have led insurance plans to create narrow, inadequate networks?

Answer: Recent studies have examined whether a correlation exists between insurance plan type and likelihood of receiving a surprise bill. These studies have shown that regardless of where consumers get their coverage— whether individual market, small group market or large group market where networks tend to be broader— the risk of surprise medical bills is nearly the same.²⁹ For example, in both fully insured and self-insured ERISA plans, roughly one in five emergency department visits involved care from an out-of-network provider that could result in a surprise bill.³⁰

Researchers also have examined whether a plan's specific network model is correlated to the rate of out-of-network billing.³¹ Health plan provider network models, such as health maintenance organizations (HMOs), point of service (POS) plans, and preferred provider networks (PPOs), are typically distinguished by four factors: 1) whether enrollees are required to designate a primary care provider, 2) whether specialist care requires consumers to obtain primary care referrals, 3) the degree to which the plan provides coverage for out-of-network services,³² and the breadth of the network.³³ However, in all

²⁷ *Ibid.*

²⁸ Cooper, Zack and Fiona Scott Morton, *op. cit.*

²⁹ *Ibid.*

³⁰ Garmon, Christopher and Benjamin Chartock. "One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills." *Health Affairs*. Vol 36, No. 1, 2017. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970>; Claxton, Gary, Matthew Rae, Cynthia Cox, and Larry Levitt. "An analysis of out-of-network claims in large employer health plans." *Peterson-Kaiser Health System Tracker*. 2018. <https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-healthplans/#item-start>; Cooper, Zack and Fiona Scott Morton, *op. cit.*

³¹ Garmon, Christopher and Benjamin Chartock, *op. cit.*

³² Aetna. "HMO, POS, PPO, EPO and HDHP with HSA: What's the difference?" accessed April 22, 2019 at: <https://www.aetna.com/health-guide/hmo-pos-ppo-hdhp-whats-the-difference.html>; Cigna. "What's the Difference Between an HMO, EPO, and PPO?" accessed April 22, 2019 at: <https://www.cigna.com/individuals-families/understanding-insurance/hmo-ppo-epo>.

³³ Polsky, Dan and Janet Weiner. "The Skinny on Narrow Networks in Health Insurance Marketplace Plans." University of Pennsylvania Leonard Davis Institute of Health Economics. 2015. <https://ldi.upenn.edu/sites/default/files/pdf/the-skinny-on-narrow-networks.pdf>. The authors of this study found that although narrow networks are more associated with some network models, such as HMOs, than other

network types, emergency care is generally covered even if provided out-of-network.³⁴ Despite these distinguishing factors, research has found minimal variation in surprise bill rates. For example, one study that examined surprise bill rates for consumers in HMO, POS, and PPO plans, respectively, found little variation in the rate of out-of-network claims for inpatient care that could lead to surprise bills at in-network facilities.³⁵

Research showing similar rates of surprise billing across plan types is not surprising given what is known about the causes of surprise billing and the care settings in which surprise bills most frequently occur. Studies have found that surprise bills occur most frequently in situations where a consumer is not in a position to choose a provider: that is, in emergency situations or facility-based care situations such as during surgeries.³⁶ In these instances, providers can remain out-of-network and set high charges but are still guaranteed a high volume of patients because consumers have no way out when their need for care is urgent.³⁷ Due to these perverse incentives, regardless of whether consumers have narrow or broad network plans, they are at risk for surprise medical bills.³⁸ Network breadth is not a predictor of surprise billing and addressing network adequacy will not protect consumers from surprise medical bills. Consumers need Congress to enact protections that will prevent consumers from experiencing surprise medical bills, regardless of the type of health plan they have.

Although improving network adequacy will not solve the issue of surprise medical billing, Families USA supports these efforts so that consumers can get the care they need, in a timely manner, without having to travel too far.³⁹ As insurers modify networks to hold down premium costs, including the creation of narrow networks,⁴⁰ it is important to ensure that networks can still provide access to all covered services. Federal law and corresponding regulations include protections to ensure that consumers with Affordable Care Act marketplace health plans can access adequate provider networks.⁴¹ However, in recent years the federal government has scaled back network adequacy regulations, deferring more authority to the states. Previously applied quantitative metrics for guaranteeing network adequacy and federal review of networks in commercial plans have been eliminated.⁴² Additionally, a federal plan to label networks by their breadth to improve transparency for consumers was never implemented beyond

models, such as PPOs, narrow networks are prevalent among all network models including HMO, PPO, and POS plans.

³⁴ Cigna, *op. cit.*

³⁵ Garmon, Christopher and Benjamin Chartock, *op. cit.*

³⁶ Adler, Loren, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, and Erin L. Duffy, *op. cit.*

³⁷ *Ibid.*

³⁸ *Ibid.*

³⁹ Claire McAndrew, "Standards for Health Insurance Provider Networks: Examples from the States." Families USA, 2014. <https://familiesusa.org/product/standards-health-insurance-provider-networks-examples-states>.

⁴⁰ Dafny, Leemore, Igal Hendel, Victoria Marone, and Christopher Ody. "Narrow Networks On The Health Insurance Marketplaces: Prevalence, Pricing, And The Cost Of Network Breadth." Health Affairs. 2017. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1669>.

⁴¹ SEC. 1311 [42 U.S.C. 13031] AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS; 45 CFR § 156.230 - Network adequacy standards.

⁴² Hall, Mark and Caitlin Brandt, "Network Adequacy Under The Trump Administration." Health Affairs. 2017. <https://www.healthaffairs.org/doi/10.1377/hblog20170914.061958/full/>.

a four-state pilot.⁴³ Families USA supports Congress taking action to improve policy in these areas in addition to addressing the urgent priority of surprise medical bills.

4. Patients in these networks receive surprise bills because there isn't the provider base to support the care these patients require. How do we reverse the incentives to allow more providers to be in network and taking care of more patients, which is obviously in their interest to do? Have any states tried to create standards for network adequacy and keep track of the plans' performance? What has the result been for patients in those states?

Answer: When it comes to the provider types most associated with surprise billing, such as anesthesiologists, emergency physicians, radiologists, pathologists, and surgeons, commonsense policies to rein in surprise billing also can have the positive impact of bringing more of these physicians in-network. Our current system incentivizes these providers to remain out-of-network. Even if these providers do not contract with any insurers, they can count on a steady stream of patients in the emergency department or in a facility-based care setting, and they can balance bill those patients for any amount an insurance company won't pay. With commonsense prohibitions on balance billing, such providers will be newly incentivized to negotiate with insurers, as practicing only out-of-network will no longer remain a lucrative option.⁴⁴

Importantly, remaining out-of-network is not always a decision made by individual physicians. Hospitals often offload physician staffing for their emergency departments to third-party management companies that have no responsibility to ensure physician staff participate in the same provider networks as the hospital.⁴⁵ In fact, two-thirds of hospitals in the U.S. outsource the staffing of their emergency departments to third-party physician management firms.⁴⁶ Research shows that out-of-network claims are higher in hospitals that contract with common staffing companies.⁴⁷ All too often, these firms use a business model that leverages the higher prices that can be charged with an out-of-network status.⁴⁸ Surprise billing legislation can eliminate the perverse incentive to profit from out-of-network care that consumers incur due to no fault of their own.

Although designed to address a somewhat different problem, many states do have laws regarding network adequacy.⁴⁹ Over half of states have some type of quantitative standard to measure the

⁴³ Dickson, Virgil. "CMS won't expand pilot that checks network adequacy on HealthCare.gov." Modern Healthcare. 2017. <https://www.modernhealthcare.com/article/20170614/NEWS/170619951/cms-won-t-expand-pilot-that-checks-network-adequacy-on-healthcare-gov>.

⁴⁴ Adler, Loren, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, and Erin L. Duffy, op. cit.

⁴⁵ Cooper, Zack and Fiona Scott Morton, op. cit.

⁴⁶ Dalavagas, Jason. "Coverage Initiation: Envision Healthcare Holdings." 2014. Value Line. http://www.valueline.com/Stocks/Highlights/Coverage_Initiation_Envision_Healthcare_Holdings.aspx#XJWAFVKjIU.

⁴⁷ Cooper, Zack, Fiona Scott Morton, and Nathan Shekita. "Surprise! Out-of-Network Billing for Emergency Care in the United States." Yale University. 2017. <https://www.nber.org/papers/w23623.pdf>.

⁴⁸ Cooper, Zack, Fiona Scott Morton, and Nathan Shekita, op. cit.

⁴⁹ Claire McAndrew. "Standards for Health Insurance Provider Networks: Examples from the States." Families USA. 2014. <https://familiesusa.org/product/standards-health-insurance-provider-networks-examples-states>.

adequacy of commercial health plan networks. However, these standards are not comprehensive. For example, less than 20 states have standards to ensure consumers can obtain an appointment with a provider in a timely manner.⁵⁰ States that do have network adequacy standards have been able to take action when health plans do not make care available to enrollees without unreasonable delay, including fining insurers and requiring corrective action.⁵¹ If the federal government were to implement similar standards, it would guarantee protection for families in every state, regardless of where they live or what health plan they have.

⁵⁰ Giovannelli, Justin, Kevin Lucia, and Sabrina Corlette. "Regulation of Health Plan Provider Networks." Health Affairs. 2016. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0728.898461/full/>.

⁵¹ Gold, Jenny. "Kaiser Permanente Cited — Again — For Mental Health Access Problems." California Healthline. 2017. <https://californiahealthline.org/news/kaiser-permanente-cited-again-for-mental-health-access-problems/>.

REPLIES TO MEMBER QUESTIONS

JACK HOADLEY, GEORGETOWN UNIVERSITY

REPRESENTATIVE DONALD NORCROSS (NJ)

QUESTION 1. Some states have limited arbitration to either large claims (e.g., Arizona has a \$1000 threshold) or to disputes over a certain threshold (i.e., "amount in dispute"). For instance, the New Jersey law states that dispute resolution is available if the "difference between the carrier's and the provider's final offer is not less than \$1000." Therefore, for a \$1500 bill from an out-of-network provider, if the carrier has agreed to pay \$300, but the provider still believes he or she should receive an additional \$1200, then the "amount in dispute" is over \$1000 and, as such, eligible for arbitration. Given that nuance, which do you believe is a better threshold – total claim amount or amount in dispute – and why?

RESPONSE: The principle in the most states that use arbitration systems is that they are used to settle differences between the insurer and the out-of-network provider, in conjunction with rules that guarantee that the consumer pays no more than normal cost sharing. Thus, the consumer should be protected regardless of these thresholds. Nevertheless, any dollar threshold can put the consumer at risk if it means providers believe they have not been paid adequately.

This approach contrasts with a few states in which laws place the consumer would be a risk for a balance bill that falls short of the threshold. The reason for a threshold is avoid the cost of arbitration when the amount in question is small. But even a small bill may be too much for a consumer to take on.

I do not see a compelling logic for one threshold definition over the other. The amount in dispute definition would be more restrictive (given the same dollar amount), so it would lead to fewer arbitration cases. In cases where the bill is large, but the parties are close (say \$2,000 versus \$2,200), it should be easy to reach a private agreement. But the most important consideration is that arbitration is used in conjunction with rules that protect the consumer regardless of the outcome of the arbitration.

REPRESENTATIVE DAVID P. ROE (TN)

QUESTION 1. Insurers typically do not disclose the type of plan that covers a claim. So, patients and providers cannot determine which federal protections apply to the visit. For instance, patients don't know if certain annual and lifetime limits apply to their required contribution. And providers don't know whether the federal minimum payment standard for emergency care applies. Patients and providers may need to expend a great deal of time, energy and money to gather this simple, yet essential, plan information. Given that, do you think federal legislation should require health care insurance policy numbers to designate the type of plan? For instance, if policy numbers included a "-E" at the end when it is an ERISA plan, this would clear up a lot of confusion. What are your thoughts on this approach?

RESPONSE: Yes, the challenge of knowing what type of insurance is in place is a problem for consumers, who are generally unaware of the category to which their insurance applies. There is a basic disclosure requirement in the ACA, applicable to non-grandfathered ACA-covered plans and ERISA plans, that calls

on plans to provide a uniform explanation of coverage which includes limitations such as the absence of annual and lifetime limits. Within ERISA there is a general requirement (section 102) that the content of the summary plan description sent to enrollees includes "the type of administration of the plan," which should mean that it indicates clearly whether it is self-insured or fully insured. Nevertheless, the average consumer is unlikely to be aware of this information or to understand its implications. Furthermore, providers would not have any of this information and probably rely on their patients to provide insurance information. So a requirement to add an indicator on the plan ID and have that indicator appear on the member's insurance could help reduce confusion for consumers and providers. That said, in considering a protection against balance billing, the lack of clarity among consumers about the type of plan they are enrolled makes it more compelling to have a uniform protection at the federal level that prohibits balance billing in all plan types – individual plans, small-group plans, large-group plans, and self-funded plans.

QUESTION 2. While emergency physicians account for only four percent of physicians, they provide 67 percent of all care to uninsured patients and 50 percent of all care given to Medicaid and CHIP patients. Further, in emergency medicine, only commercially-insured claims are profitable. Uninsured, Medicare, and Medicaid claims all have negative profit margins. Even when a claim is covered by commercial insurance, emergency physicians collect only an estimated 30 to 40 percent of patient cost-sharing. In light of this, federal and state laws treat emergency care differently in order to protect access to the nation's health care safety net. The emergency physician is mandated by federal law to provide both in-network and out-of-network care. Do you think federal legislation should mandate that commercial insurers provide appropriate coverage for this federally mandated care?

RESPONSE. Under EMTALA, there is an obligation on a hospital and its on-call physicians to provide care to patients who come to the hospital with an emergency condition. The Affordable Care Act (section 2719A) and its related Department of Labor regulations require that non-grandfathered health plans must make a payment to these providers, regardless of their network status, based on the greatest of three amounts that are specified in the law and regulations. Several of the states with laws addressing surprise medical bills go beyond the ACA requirements in one of two ways. They either (1) set a payment standard on the amount that the insurer must pay the provider of emergency services or (2) create a dispute resolution or arbitration process to establish a payment amount. These requirements are typically combined with protections that guarantee that consumers are only liable for normal cost sharing amounts. The Congress, if enacts legislation that follows one of these approaches, has the opportunity to ensure both that the consumer is protected and that payment to the provider is appropriate.

QUESTION 3. It's clear that patients in the same location have different risk for receiving a surprise bill depending on which insurance plan they have. What differentiates these plans? Does federal law ensure that networks provide adequate and transparent choices for their patients? What are the incentives that have led insurance plans to create narrow, inadequate networks?

RESPONSE: We do not have good research evidence to say which plans are most likely to see surprise medical bills. In general, it seems likely that plans with narrow provider networks create a greater risk

for receiving a surprise bill because more providers are outside the network. But an important consideration is where the network physicians are based. A plan could offer a narrow network as one way to lower premiums, but such a plan could work carefully to ensure its network includes the doctors and other clinicians who practice in the hospitals that are in the plan's network. In this latter example, the risk of surprise billing is reduced even in a narrow-network plan.

The Affordable Care Act requires that plans sold on the exchanges must maintain a provider network that is "sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay." But the federal government has deferred to the states in establishing specific standard to implement this provision.

QUESTION 4. Patients in these networks receive surprise bills because there isn't the provider base to support the care these patients require. How do we reverse the incentives to allow more providers to be in network and taking care of more patients, which is obviously in their interest to do? Have any states tried to create standards for network adequacy and keep track of the plans' performance? What has the result been for patients in those states?

RESPONSE: Consumers benefit from plans with narrow networks if they allow coverage to be offered for a lower premium. But for those plans to work for their members, it requires that networks are adequate so that consumers can find network physicians when they need them. And it requires that members have convenient access to accurate provider directories. Consumers benefit from plans with broad networks if they lower the risk of surprise medical bills and make it easier to see the providers they wish to see. It may make sense for both the federal government and state governments to focus more attention on network adequacy. Yet even with a network that could be classified as broad, there will be situations where surprise bills arise. Thus, addressing network adequacy is not a substitute for protecting consumers from balance bills.



April 24, 2019

Written Responses of Ilyse Schuman, American Benefits Council

to Questions from

**Health, Employment, Labor
and Pensions Subcommittee Hearing
“Examining Surprise Billing:
Protecting Patients from Financial Pain”
Tuesday, April 2, 2019, 10:15 a.m.**

Below are the written responses of Ilyse Schuman, Senior Vice President, Health Policy, American Benefits Council, to additional questions submitted by Committee members following the hearing.

REPRESENTATIVE DAVID P. ROE, QUESTION NO. 1:

Insurers typically do not disclose the type of plan that covers a claim. So, patients and providers cannot determine which federal protections apply to the visit. For instance, patients don't know if certain annual and lifetime limits apply to their required contribution. And providers don't know whether the federal minimum payment standard for emergency care applies. Patients and providers may need to expend a great deal of time, energy and money to gather this simple, yet essential, plan information. Given that, do you think federal legislation should require health care insurance policy numbers to designate the type of plan? For instance, if policy numbers included a "-E" at the end when it is an ERISA plan, this would clear up a lot of confusion. What are your thoughts on this approach?

ILYSE SCHUMAN, AMERICAN BENEFITS COUNCIL:

The Council supports increased transparency by requiring providers to inform patients, at the time of scheduling, whether a provider is in-network or out-of-network

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with respect to a given facility or service. We believe that ERISA's existing disclosure requirements between the plan and plan participants and beneficiaries adequately provide necessary details regarding the benefits and protections available under the plan and under applicable state and federal law. The primary information gap in the surprise balance billing context is whether the provider, over whom the patient has no choice in selecting, is in- or out-of-network. While additional information on insurance and benefits cards might facilitate the provider in understanding what payment obligations the patient might have under federal or state law, it would do little to limit the negative impact of surprise balance billing on patients who are left without a meaningful role in choosing providers.

We note that to the extent the provider is out-of-network, the Affordable Care Act's (ACA's) prohibitions on the use of annual and lifetime limits and limitations on annual cost-sharing do not apply to the services performed by the provider.

REPRESENTATIVE DAVID P. ROE, QUESTION NO. 2:

While emergency physicians account for only four percent of physicians, they provide 67 percent of all care to uninsured patients and 50 percent of all care given to Medicaid and CHIP patients. Further, in emergency medicine, only commercially-insured claims are profitable. Uninsured, Medicare, and Medicaid claims all have negative profit margins. Even when a claim is covered by commercial insurance, emergency physicians collect only an estimated 30 to 40 percent of patient cost-sharing. In light of this, federal and state laws treat emergency care differently in order to protect access to the nation's health care safety net. The emergency physician is mandated by federal law to provide both in-network and out-of-network care. Do you think federal legislation should mandate that commercial insurers provide appropriate coverage for this federally mandated care?

ILYSE SCHUMAN, AMERICAN BENEFITS COUNCIL:

It is certainly essential that all Americans have access to emergency care. That having been said, the problem of surprise balance bills will not be solved by shifting the cost of a balance bill for out-of-network emergency care from patients to commercial payers. Doing so merely masks the underlying driver of these balance bills – a market failure by virtue of the fact the emergency physicians experience what a study cited in my testimony describes as “inelastic demand from patients.” Accordingly, these physicians “will not see a reduction in their patient volume if they fail to negotiate contracts with insurers.”¹ The same study found that out-of-network emergency physicians charge, on average, 637% of what the Medicare program would pay for identical services, which is 2.4 times higher than in-network payment rates. The spread between Medicare rates,

¹ <https://www.nber.org/papers/w23623.pdf>

in-network rates and out-of-network billing suggests that more than recouping any negative profit margins is at play. An examination of the distribution of out-of-network billing for emergency care in hospitals across the U.S., which found that out-of-network billing is concentrated in a small number of hospitals, further supports such a conclusion. While 50% of hospitals have out-of-network billing rates below two percent, 15% of hospitals have out-of-network billing rates above 80%.

We also note that current federal regulations already impose reimbursement requirements for out-of-network emergency services (the so-called “Greater of Three Rule”) that seeks to harmonize plan reimbursement of out-of-network emergency services with in-network reimbursement rates.

When patients face the crisis of a medical emergency, they need the most expeditious stabilizing care, leaving them without a meaningful choice between in-network or out-of-network emergency care. This lack of choice by the patient can serve as a powerful incentive for emergency physicians to remain out-of-network. Federal legislation should protect patients at perhaps their greatest moments of medical need without further fueling the market distortions that have given rise to balance bills for emergency care in the first place.

REPRESENTATIVE DAVID P. ROE, QUESTION NO. 3:

It's clear that patients in the same location have different risk for receiving a surprise bill depending on which insurance plan they have. What differentiates these plans? Does federal law ensure that networks provide adequate and transparent choices for their patients? What are the incentives that have led insurance plans to create narrow, inadequate networks?

ILYSE SCHUMAN, AMERICAN BENEFITS COUNCIL:

Federal policy should facilitate and incent building provider networks that deliver high-quality and high-value health care to consumers. To protect access to high quality and high-value care, providers should be encouraged to participate in such networks. Network adequacy should not be used to deflect attention from the underlining drivers of surprise billing – a choice by certain specialty providers not to participate in networks. Neither should network adequacy be used to prohibit exclusion of poor-performing providers from a network. To be clear, the use of more defined, high-value networks is not the reason we have a surprise balance billing problem.

Provider networks are an important, if not essential, tool in our health care delivery system. They allow participants to access quality care at affordable rates for the plan, as well as reduced premium and cost-sharing for the participants. By way of example, one Council member company with almost 130,000 covered lives estimates that without

networks, premiums would increase by \$8,000 – a 45% increase. Plans are continually striving to bring high-value providers into their networks both to foster increased choice and options for enrollees, but also to help manage plan costs (and related premiums) and improve quality.

We believe that hospitals must play a key role in combatting surprise medical billing. The market power that certain hospital-based physician specialties exert certainly drives surprise medical bills. However, the fact remains that hospitals can and must take responsibility for the physicians staffing their hospitals. When a plan contracts with a hospital, it stands to reason that essential services performed at the facility – emergency, anesthesiology, radiology and pathology – would be included in the network.

REPRESENTATIVE DAVID P. ROE, QUESTION NO. 4:

Patients in these networks receive surprise bills because there isn't the provider base to support the care these patients require. How do we reverse the incentives to allow more providers to be in network and taking care of more patients, which is obviously in their interest to do? Have any states tried to create standards for network adequacy and keep track of the plans' performance? What has the result been for patients in those states?

ILYSE SCHUMAN, AMERICAN BENEFITS COUNCIL:

The Council's member companies seek to provide high-quality, affordable coverage to employees and their dependents. Health plan networks are critical to these employer efforts. The Council believes any legislative solution by Congress should address the current incentives that encourage certain hospital-based physician specialties to remain out of network and generate surprise balance bills.

Because they are part of a wider bundle of hospital care and cannot be avoided once the hospital choice is made, emergency physicians (and other specialist physicians like anesthesiologists, pathologists and radiologists) face inelastic demand from patients and will not see a reduction in their patient volume by remaining out-of-network.

Congress should protect patient from surprise balance billing without undermining access to high-value networks or increasing costs for all consumers. Federal legislation should include a reasonable reimbursement structure that (1) establishes a benchmark cap for emergency services at an out-of-network facility at 125 percent of the Medicare Rate and (2) requires all providers at an in-network facility to accept in-network reimbursement rates for all care performed at the facility by all providers associated with the facility. As noted above, network adequacy should not be used to deflect attention from the underlining drivers of surprise billing – a choice by certain specialty providers not to participate in networks. Neither should network adequacy be used to prohibit exclusion of poor-performing providers from a network.

REPRESENTATIVE RUSS FULCHER, QUESTION NO. 1

In your testimony, you mentioned that while employers seek to ensure employees are aware of the higher costs of out-of-network services, more "assistance" is needed, such as "contracting with other entities" to negotiate the bill. Can you elaborate on that? How can we generate more affordable choices and options for the consumer?

ILYSE SCHUMAN, AMERICAN BENEFITS COUNCIL:

Indeed, employers try to limit the incidence of surprise billing to employees in the first place through enhanced communication and awareness. When an employee nonetheless faces a balance bill from an out-of-network provider, employer assistance can take of the form of helping the employee negotiate down the balance bill. A third party retained by the plan, such as a third party administrator, can negotiate with the provider on behalf of the employee to reduce, if not eliminate, the balance bill.

Such assistance, however, does not ban the practice of surprise medical bills nor solve the problem at its root. The best way to generate more affordable choices and options for consumers is to correct a market failure that allows certain specialist for whom patients have no meaningful role in choosing to remain out-of-network and set higher billing rates because patient volume is essentially guaranteed. Federal policy should incentivize building provider networks that deliver high-quality and high-value health care to consumers. Federal legislation to address surprise balance billing should not discourage network participation by guaranteeing reimbursement rates higher than in-network rates or higher than existing applicable ACA requirements. Simply shifting the burden of balance billing from the patient to the plan or employer will no doubt result in higher premiums and increased costs for all consumers. More affordable options for consumers will be generated by eliminating market failures that incentivize providers to remain out of network.

REPRESENTATIVE RUSS FULCHER, QUESTION NO. 2

What do you see as the main challenges to requiring third-party providers from contracting with the insurance company that services a particular hospital or clinic, so that the consumer can at least know the potential price of the service and help control prices that are charged by the third-party provider?

ILYSE SCHUMAN, AMERICAN BENEFITS COUNCIL:

Third-party providers should be required to accept the negotiated in-network rate when providing services at the in-network facility. These facilities could amend their contracts with the providers to condition the provision of services at the facility upon the provider first agreeing to accept the in-network rate negotiated by the facility with the insurance company or third party administrator.

We are not aware of any specific laws that would specifically preclude such an approach. Hospitals must play a key role in combatting surprise medical bills. The market power that certain hospital-based physician specialties exert certainly drives surprise medical bills. However, the fact remains that hospitals can and must take responsibility for the physicians staffing their hospitals. When a plan contracts with a hospital, it stands to reason that essential services performed at the facility – emergency, anesthesiology, radiology and pathology – would be included in the network. Yet, these are the very specialties that, by virtue of their necessity, are unhampered by competitive market forces in setting their rates and electing not to participate in a network.

REPRESENTATIVE RUSS FULCHER, QUESTION NO. 1

Typically, employees turn to the benefits manager at their job for help with a surprise bill (a charge they didn't know they had to pay because it wasn't covered on their insurance). What can we do to help these employers have more health care insurance and noninsurance options that might lower costs?

ILYSE SCHUMAN, AMERICAN BENEFITS COUNCIL:

The benefits manager may well be the first person an employee turns to when they receive a surprise bill from an out-of-network provider. Recognizing the toll that surprise billing can take on working families, many large employers step in to help pick up the balance bill charges even though they are not obligated to do so. As a result, the problem of surprise billing poses an additional financial burden on employers beyond the substantial cost the employers already bear as sponsors of the health plan. Federal legislation should not mandate shifting the cost of balance bills to employers. Federal legislation should, instead, both protect patients from surprise bills and address the competitive market failure that gives rise to unexpected balance bills in the first place.

Hospital-based specialist like anesthesiologist, radiologists, pathologists, and emergency physicians face inelastic demand from patients who have no meaningful role in choosing these providers. Accordingly, these specialists will not have a reduction of patient volume by remaining outside of a health plan's network. A study cited in my testimony on out-of-network billing for emergency care found that physicians charge, on average, 637% of what the Medicare program would pay for identical services, which is

2.4 times higher than in-network payment rates.² Another study comparing physician charge-to-Medicare payment ratios across 54 specialties found that “Physician excess charge was higher for specialties in which patients have fewer opportunities to choose a physician or be informed of the physician’s network status (e.g. anesthesiology).”³ Anesthesiologists were found to be charging more than five times as high as the Medicare rate.

High-value networks of providers are the key to employer efforts to lower costs and improve quality. Federal legislation that enshrines the incentives for these providers to remain out-of-network would undermine the considerable effort that employers, with their health plan partners, undertake to negotiate for effective networks of high value providers. To help employers lower costs, Congress should address this market failure. To ensure equitable payment for providers without discouraging network participation, federal legislation should (1) establish a benchmark cap for emergency services at an out-of-network facility at 125% of the Medicare Rate and (2) require all providers at an in-network facility to accept in-network reimbursement rates for all care performed at the facility by all providers associated with the facility. Clearly, billed charges are out-of-sync with costs and “well-above” typical network rates.⁴ Federal efforts to assist employers in limiting the impact of surprise balance billing should focus on the root cause.

² <https://www.nber.org/papers/w23623.pdf>

³ <https://jamanetwork.com/journals/jama/fullarticle/2598253>

⁴ <http://us.milliman.com/uploadedFiles/insight/2018/changing-landscape-oon-reimbursement.pdf>

REPRESENTATIVE HALEY M. STEVENS (MI)

Many experts, including some of your colleagues at the Brookings Institution, have discussed a multi-pronged approach to addressing surprise billing.

1. Can you share your thoughts on developing policies that treat the balance of the bill as an in-network charge, and therefore covered by the patient's insurance?

Answer: There are two important principles in designing a policy solution to prevent surprise out-of-network billing: (1) protect patients from unexpected high costs and (2) avoid increasing health care spending.

In the types of situations that lead to surprise out-of-network bills (i.e. where the patient is seen by an out-of-network provider that she did not choose), requiring the insurer to treat the allowed costs as in-network for purposes of consumer cost-sharing can be an important part of the solution. It protects the patient from facing a higher or separate deductible and higher coinsurance and copays, and it ensures that amounts accumulate towards the annual out-of-pocket maximum on total cost-sharing.

However, insurers should not be required to pay the full "balance billed" amount to the provider. The balance bill will generally be based on the provider's billed charges, which are not market determined and not subject to any negotiation.¹ If insurers were required to pay the balance billed amount in full, providers could charge any amount they wished and know that the insurer would have to pay that amount. This would likely drive up costs significantly. Therefore, a policy like this must also include some mechanism for determining a reasonable price for the service, either directly or through arbitration, rather than requiring insurers to pay the billed amount.

2. What about prohibiting balance billing altogether?

Answer: Any solution to the problem must prevent providers in these situations from sending balance bills. But if providers are prohibited from balance billing, they are required to accept whatever payment the insurer makes as payment in full. Therefore, a policy like this should also include some mechanism to ensure that the amount paid to the provider is reasonable.

REPRESENTATIVE DAVID P. ROE (TN)

1. Insurers typically do not disclose the type of plan that covers a claim. So, patients and providers cannot determine which federal protections apply to the visit. For instance, patients don't know if certain annual and lifetime limits apply to their required contribution. And providers don't know whether the federal minimum payment standard for emergency care applies. Patients and providers may need to expend a great deal of time, energy and money to gather this simple, yet essential, plan information. Given that, do you think federal legislation should require health care

¹ Indeed, our analysis at the USC-Brookings Schaeffer Initiative for Health Policy found that providers in the specialties most likely to see patients that did not choose them (anesthesiologists and emergency medicine physicians) have especially high charges, even as compared to other kinds of physician specialties. See Loren Adler, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young & Erin L. Duffy, "State Approaches to Mitigating Surprise Out-of-Network Billing," USC-Brookings Schaeffer Initiative for Health Policy (February 2019), available at <https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing/>.

insurance policy numbers to designate the type of plan? For instance, if policy numbers included a "-E" at the end when it is an ERISA plan, this would clear up a lot of confusion. What are your thoughts on this approach?

Answer: The Administrative Simplification provisions of HIPAA include some attempts to standardize how providers and payers communicate about a patient's cost-sharing,² but they leave gaps. Building upon the existing structure can improve patients' and providers' access to information.

Enhanced transparency about cost-sharing can be useful, but I do not believe it will provide a meaningful tool to address surprise out-of-network billing. Surprise out-of-network bills arise when patients are seen by out-of-network providers that they have no role in choosing. Even if providers knew more about the patient's insurance, that would not address the market failure or change the underlying incentives that lead to surprise bills.

2. While emergency physicians account for only four percent of physicians, they provide 67 percent of all care to uninsured patients and 50 percent of all care given to Medicaid and CHIP patients. Further, in emergency medicine, only commercially-insured claims are profitable. Uninsured, Medicare, and Medicaid claims all have negative profit margins. Even when a claim is covered by commercial insurance, emergency physicians collect only an estimated 30 to 40 percent of patient cost-sharing. In light of this, federal and state laws treat emergency care differently in order to protect access to the nation's health care safety net. The emergency physician is mandated by federal law to provide both in-network and out-of-network care. Do you think federal legislation should mandate that commercial insurers provide appropriate coverage for this federally mandated care?

Answer: In situations where patients receive care from a provider they did not choose (including emergency care) the normal market negotiations between providers and payers cannot be relied on to generate a reasonable rate. Therefore, policy solutions often require some mechanism for establishing a rate, whether establishing the rate directly or through arbitration.

3. It's clear that patients in the same location have different risk for receiving a surprise bill depending on which insurance plan they have. What differentiates these plans? Does federal law ensure that networks provide adequate and transparent choices for their patients? What are the incentives that have led insurance plans to create narrow, inadequate networks?

Answer: While more study is needed, the available evidence suggests that surprise out-of-network billing is not caused by narrow networks. Situations that can lead to surprise out-of-network bills have roughly the same prevalence in POS, PPO, and HMO plans³—even though these kinds of insurance products have different approaches to network size and network restrictions. And surprise out-of-network bills appear only slightly more

² See Health Insurance Reform: Standards for Electronic Transactions, 65 Fed. Reg. 50312 (Department of Health and Human Services, August 17, 2000), <https://www.federalregister.gov/documents/2000/08/17/00-20820/health-insurance-reform-standards-for-electronic-transactions>.

³ See Christopher Garmon & Benjamin Chartock, "One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills," 36 Health Affairs No. 1, Appendix Chart A5 (January 2017), available at <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970>.

common in the Marketplace compared to the employer market.⁴ This empirical evidence is consistent with the nature of the market failure that leads to surprise out-of-network bills. When patients do not have a choice about which specialist they see, the provider does not face a price-volume trade-off for going in-network: she will receive the same number of patients regardless of whether or not she joins an insurer's network.

4. Patients in these networks receive surprise bills because there isn't the provider base to support the care these patients require. How do we reverse the incentives to allow more providers to be in network and taking care of more patients, which is obviously in their interest to do? Have any states tried to create standards for network adequacy and keep track of the plans' performance? What has the result been for patients in those states?

Answer: Network adequacy is an important component of state and federal regulation of insurance products, but it is likely not an adequate tool to prevent surprise out-of-network billing. For providers that patients choose, they are able to select from the available in-network providers, and network adequacy ensures sufficient choices are available. But when patients do not choose their provider, that dynamic is not relevant: it doesn't matter whether your issuer has some anesthesiologists in-network, it only matters whether the specific anesthesiologist on call at the hospital on the morning of your surgery is in-network. This calls for a different set of policy solutions.

⁴ Munira Z. Gunja, Sara R. Collins, Michelle M. Doty & Sophie Buetel, "Americans' Experiences with ACA Marketplace Coverage: Affordability and Provider Network Satisfaction," The Commonwealth Fund (July 2016), available at https://www.commonwealthfund.org/sites/default/files/documents/media_files/publications/issue_brief_2016_jul_1883_gunja_americans_experience_aca_marketplace_affordability_v2.pdf.

[Whereupon, at 12:28 p.m., the subcommittee was adjourned.]

○

January 14, 2021

Congressional Budget Office
Estimate for Divisions O Through FF
H.R. 133, Consolidated Appropriations Act, 2021
Public Law 116-260
Enacted on December 27, 2020

The Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have completed an estimate of the direct spending and revenue effects of divisions O through FF of H.R. 133, the Consolidated Appropriations Act, 2021 (enacted on December 27, 2020, as Public Law 116-260).¹ Those divisions affect programs throughout the federal government. CBO and JCT estimate that those provisions will increase deficits by \$175 billion over the 2021-2030 period.

The major provisions of divisions O through FF are described below.

Division O makes technical corrections to the United States-Mexico-Canada Agreement Implementation Act. The budgetary effects stem mostly from an increase in revenues caused by changing the rules for foreign trade zones to standards set previously under the North American Free Trade Agreement and from an increase in direct spending attributable to refunds of certain merchandise-processing fees. CBO estimates that insignificant budgetary effects will arise from a provision that extends the authority of U.S. Customs and Border Protection to collect and spend donations and from one that repeals collections of criminal penalties for several rarely prosecuted offenses.

Division Q modifies existing laws and policies governing financial services and intellectual property. Small direct spending and revenue effects stem from new reporting requirements and from prohibitions on unauthorized streaming of copyright-protected content over the Internet. CBO estimates that other provisions in Division Q will have minimal budgetary effects.

Division X provides emergency temporary support and flexibility for older children in foster care and for kinship families, for foster care prevention services, and for other child welfare services. The division also extends funding through the end of fiscal year 2021 for home visit programs promoting maternal and child health. It also provides additional

1. CBO estimates that divisions P, R, S, T, U, V, and W either will not affect deficits or will have insignificant deficit effects over the 2021-2030 period.

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funding for the MaryLee Allen Promoting Safe and Stable Families Program and support for the court improvement program related to foster care and adoption proceedings.

Division Y increases the number of retired coal miners (and their dependents) who are eligible for health benefits under the United Mine Workers of America 1993 Benefit Plan. It permanently authorizes federal contributions to that plan on behalf of people whose retiree health benefits, provided by an employer in the bituminous coal industry under a coal wage agreement, will otherwise be denied or reduced because of a qualifying bankruptcy proceeding that commenced after 2019. Division Y also authorizes federal subsidy payments for people who became eligible for nonfederal benefits under the 1993 Benefit Plan after December 20, 2019, and who were enrolled in the plan as of the date of enactment of P.L. 116-260.

Division Z modifies existing laws and policies governing the energy sector. Most of the direct spending effects stem from provisions in titles I, II, and IX. Title I increases federal agencies' use of third-party financing for energy efficiency measures. Title II authorizes the Department of Energy to acquire certain materials on behalf of other entities and to develop a schedule for recovering those costs. Title IX expands eligibility for loan guarantees made by the department for projects that use advanced energy technologies. Other titles in Division Z have smaller estimated budgetary effects.

Division AA authorizes the Army Corps of Engineers to construct projects and conduct feasibility studies to improve navigation and flood management, mitigate storm and hurricane damage, and restore ecosystems. Provisions of title I authorize the Corps either to renegotiate the terms of deferred-payment agreements for eligible projects or, in exchange for a waiver of all interest payments, to accept full repayment of outstanding principal amounts by nonfederal sponsors by 2023. Other provisions also reduce payments to the federal government by authorizing the Corps to modify existing water contracts, limit charges for certain new water contracts, and waive amounts owed by a nonfederal sponsor on a harbor project. Title V allows the Secretary of the Army to accept and spend funds from the Tennessee Valley Authority, without further appropriation, for activities related to managing the population of Asian carp in certain rivers.

Division BB establishes requirements related to private health insurance, extends funding for some public health programs, and authorizes new public health activities. Title I establishes patient protections from surprise medical billing, institutes a process to resolve disputes between health care providers and insurers unable to reach agreement on payments for out-of-network health care, and provides \$500 million to federal agencies for implementation. CBO and JCT estimate that in most affected markets in most years,

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smaller payments to some providers would reduce premiums by between 0.5 percent and 1 percent. Lower costs for health insurance would reduce federal deficits because the federal government subsidizes most private insurance through tax preferences for employment-based coverage and through the health insurance marketplaces established under the Affordable Care Act. Titles I and II create rules to govern contracts between insurers and health care providers and establish other requirements for private health insurers related to transparency and providing price information to patients; CBO anticipates that those rules will not affect premiums for private health insurance or the federal budget. Title III extends funding for community health centers and for public health activities related to diabetes.

Division CC makes numerous changes to federal health care programs and other programs in the Department of Health and Human Services. Title I extends several programs and policies that otherwise would have expired by the end of calendar year 2020, including two demonstration programs under Medicare. That title also modifies Medicare payment and coverage rules; in particular, it changes payments to physicians and to providers in rural areas. Title II extends programs under Medicaid that otherwise also would have expired in December 2020, including the Money Follows the Person and Certified Community Behavioral Health Clinic demonstration programs. Title III extends several of the department's human services programs that also would have expired in December 2020, and it reauthorizes and amends certain grant programs. Title IV includes policies that generally reduce federal spending over the 2021-2030 period—largely for Medicare—primarily by reducing payments, including those for prescription drugs furnished in physicians' offices and outpatient hospital departments and to providers of hospice care.

Division DD secures water supplies for the Confederated Salish and Kootenai Tribes in Montana by ratifying the Confederated Salish and Kootenai-Montana Compact made by the federal government, the State of Montana, and those tribes. Division DD also provides funding to capitalize the Séliš-Qlispé Ksanka Settlement Trust Fund.

Division EE extends or modifies dozens of tax provisions, many of which were scheduled to expire at the end of calendar year 2020. The changes include the permanent extension of an expanded deduction for itemized medical expenses and the extension of certain reductions in excise taxes on beer, wine, and distilled spirits. Temporary extensions also are provided for various tax provisions, including tax credits for hiring people from certain targeted groups and for employee retention, paid family and medical leave, and investments in renewable energy. The division also temporarily allows

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businesses to fully deduct expenses for business meals and provides disaster-related tax relief.

Division FF makes changes to a variety of laws. Title VII amends both the eligibility criteria and the formula for calculating eligibility for federal student aid, allows certain incarcerated students to receive Pell grants, repeals a provision setting the maximum period in which borrowers may receive subsidized student loans, and forgives outstanding balances on capital financing loans to historically Black colleges and universities. Title XI provides funding for the Bureau of Reclamation to construct water distribution facilities to implement the Aamodt litigation settlement. Title XII, which establishes the Horseracing Integrity and Safety Authority, affects both revenues and direct spending by levying fees to fund operational expenses. Title XVI allows the Department of Veterans Affairs to record obligations for community health care at the time payment for treatment is approved—the budgetary effects arise from the authority to delay the recording of obligations. Insignificant budgetary effects stem from several other titles. Among those are title III, which authorizes sanctions to deny certain people entry into the United States and blocks transactions in assets and property that are in the United States; and title IX, which affects telecommunications programs administered by the Federal Communications Commission.

Although P.L. 116-260 is appropriation legislation, section 1401 of division O specifies requirements for the budgetary treatment of divisions N through FF. Those requirements do not apply to title VIII of division O or to title XIII of division FF. (The budgetary effects of those provisions are included in CBO's estimate of discretionary spending under division M of the legislation.)²

In keeping with section 1401 of division O, and at the direction of the House and Senate Committees on the Budget, divisions N through FF are considered authorizing legislation rather than appropriation legislation. As a result, the estimated budgetary effects of those divisions are subject to pay-as-you-go procedures. However, section 1401 of division O also requires the estimated budgetary effects stemming from those divisions to be excluded from the pay-as-you-go scorecards maintained by the Senate and the Office of Management and Budget. Furthermore, subsection 1401(d) of division O reset the balances of those scorecards to zero upon the adjournment of the second session of the 116th Congress.

2. See Congressional Budget Office, cost estimate for Division M of H.R. 133, the Consolidated Appropriations Act, 2021 (December 22, 2020), www.cbo.gov/publication/56916.

Estimated Direct Spending and Revenue Effects for Divisions O Through FF

January 14, 2021

By Fiscal Year, Millions of Dollars

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2021- 2025	2021- 2030
INCREASES OR DECREASES (-) IN DIRECT SPENDING ^a												
Division O - EXTENSIONS AND TECHNICAL CORRECTIONS												
Title I - Immigration Extensions												
Estimated Budget Authority	6	6	3	1	2	1	1	1	1	1	18	23
Estimated Outlays	6	6	3	1	2	1	1	1	1	1	18	23
Title VI - USMCA Implementation Act Technical Corrections												
Estimated Budget Authority	181	125	50	25	10	5	5	5	5	5	391	416
Estimated Outlays	159	130	57	32	13	5	5	5	5	5	391	416
Title IX - Adjustment of Status for Liberian Nationals Extension												
Estimated Budget Authority	*	1	1	1	1	1	1	1	1	1	4	9
Estimated Outlays	*	1	1	1	1	1	1	1	1	1	4	9
Division O Total												
Estimated Budget Authority	187	132	54	27	13	7	7	7	7	7	413	448
Estimated Outlays	165	137	61	34	16	7	7	7	7	7	413	448
Division X - SUPPORTING FOSTER YOUTH AND FAMILIES THROUGH THE PANDEMIC^b												
Estimated Budget Authority	741	7	0	0	0	0	0	0	0	0	748	748
Estimated Outlays	707	107	9	1	1	0	0	0	0	0	825	825
Division Y - AMERICAN MINER BENEFITS IMPROVEMENT												
Estimated Budget Authority	11	26	43	56	69	83	91	94	97	100	205	670
Estimated Outlays	11	26	43	56	69	83	91	94	97	100	205	670
Division Z - ENERGY ACT OF 2020												
Title I - Efficiency ^c												
Estimated Budget Authority	8	62	62	62	62	62	62	62	62	62	256	566
Estimated Outlays	2	22	46	62	62	62	62	62	62	62	194	504
Title II - Nuclear ^d												
Estimated Budget Authority	0	200	0	0	0	0	0	-3	-14	-14	200	169
Estimated Outlays	0	5	20	60	60	50	5	-3	-14	-14	145	169
Title IV - Carbon Management ^e												
Estimated Budget Authority	0	0	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	*	1	1	1	1	1	1	1	1	1	4	9
Title IX - Department of Energy Innovation ^f												
Estimated Budget Authority	0	0	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	0	0	1	3	3	6	6	7	7	7	7	40
Division Z Total												
Estimated Budget Authority	8	262	62	62	62	62	62	59	48	48	456	735
Estimated Outlays	2	28	68	126	126	119	74	67	56	56	350	722
Division AA - WATER RESOURCES DEVELOPMENT ACT OF 2020												
Title III - Deauthorizations and Modifications												
Estimated Budget Authority	-220	-125	-109	75	75	75	75	75	75	75	-304	71
Estimated Outlays	-220	-125	-109	75	75	75	75	75	75	75	-304	71
Title V - Other Matters												
Estimated Budget Authority	0	0	2	2	*	*	*	*	*	*	4	2
Estimated Outlays	0	0	1	2	1	*	*	*	*	*	4	2
Division AA Total												
Estimated Budget Authority	-220	-125	-107	77	75	75	75	75	75	75	-300	73
Estimated Outlays	-220	-125	-108	77	76	75	75	75	75	75	-300	73
Division BB - PRIVATE HEALTH INSURANCE AND PUBLIC HEALTH PROVISIONS												
Title I - No Surprises Act												
Estimated Budget Authority	500	-29	-63	-77	-81	-83	-85	-89	-93	-96	250	-196
Estimated Outlays	50	271	37	-27	-81	-83	-85	-89	-93	-96	250	-196
Title III - Public Health Provisions												
Estimated Budget Authority	3,613	4,737	4,737	0	0	0	0	0	0	0	13,087	13,087
Estimated Outlays	1,406	3,442	4,510	2,843	854	15	0	0	0	0	13,055	13,070
Division BB Total												
Estimated Budget Authority	4,113	4,708	4,674	-77	-81	-83	-85	-89	-93	-96	13,337	12,891
Estimated Outlays	1,456	3,713	4,547	2,816	773	-68	-85	-89	-93	-96	13,305	12,874

continued


Estimated Direct Spending and Revenue Effects for Divisions O Through FF
 continued

January 14, 2021

By Fiscal Year, Millions of Dollars

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2021- 2025	2021- 2030
INCREASES OR DECREASES (-) IN DIRECT SPENDING												
Division CC - HEALTH EXTENDERS												
Title I - Medicare Provisions												
Estimated Budget Authority	506	994	1,560	1,300	869	785	1,048	1,267	1,263	1,769	5,229	11,361
Estimated Outlays	484	999	1,560	1,312	873	786	1,048	1,267	1,263	1,769	5,228	11,361
Title II - Medicaid Extenders and Other Policies												
Estimated Budget Authority	1,892	3,916	4,132	418	193	-250	-789	-975	-1,170	-935	10,551	6,432
Estimated Outlays	1,575	3,475	3,806	731	600	20	-722	-975	-1,170	-935	10,187	6,405
Title III - Human Services												
Estimated Budget Authority	122	170	170	20	20	20	20	20	20	20	502	602
Estimated Outlays	1	57	129	156	94	34	19	18	18	18	437	544
Title IV - Health Offsets												
Estimated Budget Authority	-89	-552	-613	-663	-4,287	-1,276	-1,445	-1,716	-1,753	-2,158	-6,204	-14,552
Estimated Outlays	-89	-552	-614	-663	-1,847	-2,352	-2,573	-1,755	-1,753	-2,158	-3,765	-14,356
Title V - Miscellaneous												
Estimated Budget Authority	37	0	0	0	0	0	0	0	0	0	37	37
Estimated Outlays	31	4	2	0	0	0	0	0	0	0	37	37
Division CC Total												
Estimated Budget Authority	2,468	4,528	5,249	1,075	-3,205	-721	-1,166	-1,404	-1,640	-1,304	10,115	3,880
Estimated Outlays	2,002	3,983	4,883	1,536	-280	-1,512	-2,228	-1,445	-1,642	-1,306	12,124	3,991
Division DD - MONTANA WATER RIGHTS PROTECTION ACT												
Estimated Budget Authority	90	92	94	97	100	103	106	110	113	116	473	1,021
Estimated Outlays	17	51	51	52	53	54	55	56	57	57	224	503
Division EE - TAXPAYER CERTAINTY AND DISASTER TAX RELIEF ACT OF 2020												
Title I - Extension of Certain Expiring Provisions												
Estimated Budget Authority	13	4	0	0	0	0	0	0	0	0	17	17
Estimated Outlays	13	4	0	0	0	0	0	0	0	0	17	17
Title II - Other Provisions												
Estimated Budget Authority	9,467	628	0	0	0	0	0	0	0	0	10,095	10,095
Estimated Outlays	9,467	628	0	0	0	0	0	0	0	0	10,095	10,095
Division EE Total												
Estimated Budget Authority	9,480	632	0	0	0	0	0	0	0	0	10,112	10,112
Estimated Outlays	9,480	632	0	0	0	0	0	0	0	0	10,112	10,112
Division FF - OTHER MATTER												
Title VII - FAFSA Simplification												
Estimated Budget Authority	1,572	157	661	687	710	739	769	793	813	810	3,787	7,711
Estimated Outlays	1,531	151	223	651	682	706	730	760	782	798	3,238	7,014
Title XI - Western Water and Indian Affairs ^e												
Estimated Budget Authority	0	0	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	0	15	17	17	25	28	40	13	2	0	74	157
Title XII - Horseracing Integrity and Safety ^h												
Estimated Budget Authority	0	0	13	13	13	13	13	13	13	13	39	104
Estimated Outlays	0	0	9	13	13	13	13	13	13	13	35	100
Title XVI - Recording of Obligations												
Estimated Budget Authority	6,000	0	0	0	0	0	0	0	0	0	6,000	6,000
Estimated Outlays	0	5,400	600	0	0	0	0	0	0	0	6,000	6,000
Division FF Total												
Estimated Budget Authority	7,572	157	674	700	723	752	782	806	826	823	9,826	13,815
Estimated Outlays	1,531	5,566	849	681	720	747	783	786	797	811	9,347	13,271

continued

CBO's Estimate for Divisions O Through FF of the Consolidated Appropriations Act, 2021, Public Law 116-260

Estimated Direct Spending and Revenue Effects for Divisions O Through FF
continued

January 14, 2021

By Fiscal Year, Millions of Dollars

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2021- 2025	2021- 2030
Total Change in Direct Spending												
Estimated Budget Authority	24,450	10,419	10,743	2,017	-2,244	278	-128	-342	-567	-231	45,385	44,393
Estimated Outlays ⁱ	15,151	14,118	10,403	5,379	1,554	-495	-1,228	-449	-646	-296	46,605	43,489
INCREASES OR DECREASES (-) IN REVENUES												
Division O - EXTENSIONS AND TECHNICAL CORRECTIONS												
Title I - Immigration Extensions	*	*	*	*	*	*	*	*	*	-1	*	-1
Title VI - USMCA Implementation Act Technical Corrections	31	86	119	155	193	232	274	320	369	384	584	2,163
Division O Total	31	86	119	155	193	232	274	320	369	383	584	2,162
Division Q - FINANCIAL SERVICES PROVISIONS AND INTELLECTUAL PROPERTY												
Title I - Financial Services Provisions	*	*	*	*	*	*	*	*	0	0	*	-1
Division Y - AMERICAN MINER BENEFITS IMPROVEMENT												
Revenues	*	*	*	*	*	*	*	*	*	*	1	2
Division BB - PRIVATE HEALTH INSURANCE AND PUBLIC HEALTH PROVISIONS												
Title I - No Surprises Act	0	636	1,322	1,581	1,702	1,969	2,164	2,315	2,479	2,655	5,241	16,823
Division CC - HEALTH EXTENDERS												
Title IV - Health Offsets	0	0	5	5	6	6	6	6	6	6	16	46
Division EE - TAXPAYER CERTAINTY AND DISASTER TAX RELIEF ACT OF 2020												
Title I - Extension of Certain Expiring Provisions	-4,880	-11,286	-12,626	-14,088	-14,095	-9,844	-8,564	-8,871	-9,524	-10,006	-56,971	-103,782
Title II - Other Provisions	-16,831	-10,406	-706	-274	-665	-932	-1,374	-1,665	-1,985	-2,400	-28,881	-37,236
Title III - Disaster Tax Relief	-5,752	-1,776	-916	-514	-107	-110	-110	-110	-110	-110	-9,064	-9,617
Division EE Total	-27,463	-23,468	-14,248	-14,876	-14,867	-10,886	-10,048	-10,646	-11,619	-12,516	-94,916	-150,635
Division FF - OTHER MATTER												
Title XII - Horseracing Integrity and Safety ^h	0	0	10	10	10	10	10	10	10	10	30	80
Total Change in Revenues	-27,432	-22,746	-12,792	-13,125	-12,956	-8,669	-7,594	-7,995	-8,755	-9,462	-89,044	-131,523
NET INCREASES OR DECREASES (-) IN THE DEFICIT FROM DIRECT SPENDING AND REVENUES												
Estimated Effect on the Deficit	42,583	36,864	23,195	18,504	14,510	8,174	6,366	7,546	8,109	9,166	135,649	175,012
On-Budget	42,302	36,525	23,017	18,615	14,638	8,590	6,903	8,121	8,724	9,825	135,092	177,258
Off-Budget	281	339	178	-111	-128	-416	-537	-575	-615	-659	557	-2,246

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation

CBO's estimates are relative to CBO's March 2020 baseline, except where noted

The staff of the Joint Committee on Taxation provided estimates for the tax provisions. See Joint Committee on Taxation, *Estimated Revenue Effects of the Revenue Provisions Contained in Rules Committee Print 116-68*, the "Consolidated Appropriations Act, 2021" (December 2020), JCX-24-20, www.jct.gov/publications/2020/jcx-24-20

Components may not sum to totals because of rounding

Titles I and II of division Q; title I of division R; titles IV, VIII, and IX of division U; title III of division W; and titles III and XI of division Z have an insignificant cost over the 2021-2030 period. Title I of division R, title I of division V, and title II of division Z have an insignificant effect on revenues over the 2021-2030 period.

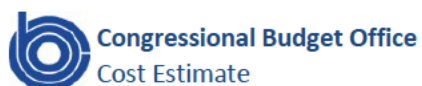
DOE = Department of Energy; FAFSA = Free Application for Federal Student Aid; USMCA = United States-Mexico-Canada Agreement; * = between -\$500,000 and \$500,000

Footnotes appear on the following page

**Estimated Direct Spending and Revenue Effects for Divisions O Through FF**
continued

January 14, 2021

-
- a Public Law 116-260 is appropriation legislation, but section 1401 of division O specifies requirements for the budgetary treatment of divisions N through FF (Those requirements do not apply to title VIII of division O or to title XIII of division FF. The budgetary effects of those provisions are included in CBO's estimate of discretionary spending under division M of the legislation. For more information on the components of division M, see Congressional Budget Office, cost estimate for Division M of H.R. 133, the Consolidated Appropriations Act, 2021, December 22, 2020, www.cbo.gov/publication/56916.) In keeping with section 1401 of division O, and at the direction of the House and Senate Committees on the Budget, divisions N through FF are considered authorizing legislation rather than appropriation legislation. As a result, the estimated budgetary effects of those divisions are subject to pay-as-you-go procedures. However, section 1401 of division O also requires the estimated budgetary effects stemming from those divisions to be excluded from the pay-as-you-go scorecards maintained by the Senate and the Office of Management and Budget. Furthermore, subsection 1401(d) of division O reset the balances of those scorecards to zero upon the adjournment of the second session of the 116th Congress.
 - b Division X allows the Secretary of Health and Human Services to extend various deadlines for maternal and child home visiting programs, including the deadlines by which prior-year appropriations must be spent.
 - c CBO's estimate of the budgetary effects of title I of division Z are measured on a cash basis. Section 3207 of the Concurrent Resolution on the Budget for Fiscal Year 2016 calls for using alternative estimating methods for purposes of budget-related points of order in the Senate for legislation related to activities financed by energy savings performance contracts. Using the required methodology for performance contracts, CBO estimates that, for purposes of budget-related points of order in the Senate, enacting title I of division Z would not affect direct spending, resulting in an estimated cost for that division of \$218 million over the 2021-2030 period. Thus, for purposes of budget-related points of order in the Senate, the estimated increase in direct spending for the act as a whole would be \$504 million smaller than shown in this table.
 - d Section 2001 authorizes DOE to acquire certain materials on behalf of other entities and to develop a schedule for recovering those costs.
 - e Section 4006 modifies DOE's authority to spend certain balances on the National Energy Technology Laboratory. This provision affects outlays only.
 - f Section 9010 expands eligibility for loan guarantees made by DOE for projects that use advanced energy technologies. This provision affects outlays only.
 - g Title XI increases the amount that the Bureau of Reclamation is authorized to spend from funds already provided to the Reclamation Water Settlements Fund to implement the Aamodt litigation settlement. This provision affects outlays only.
 - h Title XII, which establishes the Horseracing Integrity and Safety Authority, affects both revenues and direct spending by levying fees to fund operational expenses.
 - i Of the total outlays estimated for the 2021-2031 period, a reduction of \$1 million is off-budget.
-



February 11, 2020

H.R. 5826, the Consumer Protections Against Surprise Medical Bills Act of 2020, as Introduced on February 10, 2020
Estimated Budgetary Effects

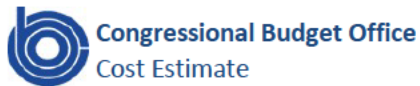
	By Fiscal Year, Millions of Dollars											2020-	2020-
	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2025	2030
Decreases (-) in Direct Spending													
Protections Against Surprise Medical Bills													
Estimated Budget Authority	0	0	*	-32	-65	-76	-82	-88	-91	-94	-99	-173	-625
Estimated Outlays	0	0	*	-32	-65	-76	-82	-88	-91	-94	-99	-173	-625
Increases or Decreases (-) in Revenues													
Protections Against Surprise Medical Bills	0	0	655	1,360	1,629	1,749	2,012	2,203	2,360	2,537	2,728	5,393	17,233
On-budget revenues	0	0	465	965	1,160	1,247	1,474	1,629	1,748	1,881	2,025	3,837	12,595
Off-budget revenues	0	0	190	394	469	502	538	574	612	656	704	1,555	4,638
Transitional Rule Allowing Deduction for Surprise Billing Expenses	-3	-33	-42	-13	0	0	0	0	0	0	0	-90	-90
On-budget revenues	-3	-33	-42	-13	0	0	0	0	0	0	0	-90	-90
Off-budget revenues	0	0	0	0	0	0	0	0	0	0	0	0	0
Increases or Decreases (-) in the Deficit from Direct Spending and Revenues													
Estimated Effect on the Deficit	3	33	-613	-1,379	-1,695	-1,825	-2,094	-2,290	-2,451	-2,631	-2,827	-5,475	-17,769
Estimated Changes in On-Budget Deficits	3	33	-424	-984	-1,225	-1,323	-1,556	-1,717	-1,839	-1,975	-2,124	-3,920	-13,130
Estimated Changes in Off-Budget Deficits	0	0	-190	-394	-469	-502	-538	-574	-612	-656	-704	-1,555	-4,638

Sources: Congressional Budget Office, staff of the Joint Committee on Taxation.

Components may not sum to totals because of rounding; * = between -\$500,000 and \$0.

H.R. 5826 would establish patient protections from surprise medical billing and establish a process to resolve disputes between health care providers and insurers that are unable to reach agreement on payments for out-of-network health care. In determining the most reasonable rates, dispute resolution entities would be instructed to look to the health plan's median payment rate for in-network rate care.

CBO and JCT expect that under the bill, in facilities where surprise bills are likely, average payment rates for both in- and out-of-network care would move toward the median in-network rate, which tends to be lower than average rates. CBO and JCT estimate that in most affected markets in most years, lower payments to some providers would reduce premiums by between 0.5 percent and 1 percent. Lower costs for health insurance would reduce federal deficits because the federal government subsidizes most private insurance through tax preferences for employment-based coverage and through the health insurance marketplaces established under the Affordable Care Act.



February 13, 2020

H.R. 5800, the Ban Surprise Billing Act, as ordered reported by the House Committee on Education and Labor on February 11, 2020
Estimated Budgetary Effects

	By Fiscal Year, Millions of Dollars											2020-	2020-
	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2025	2030
Increases or Decreases (-) in Direct Spending													
Protections Against Surprise Medical Bills													
Estimated Budget Authority	0	0	*	-44	-89	-103	-111	-119	-123	-128	-134	-236	-851
Estimated Outlays	0	0	*	-44	-89	-103	-111	-119	-123	-128	-134	-236	-851
Increases in Revenues													
Protections Against Surprise Medical Bills	0	0	872	1,809	2,170	2,335	2,689	2,944	3,153	3,387	3,642	7,186	23,002
On-budget revenues	0	0	619	1,284	1,544	1,664	1,970	2,176	2,335	2,511	2,701	5,112	16,804
Off-budget revenues	0	0	253	525	625	671	720	768	819	877	940	2,074	6,198
Increases or Decreases (-) in the Deficit from Direct Spending and Revenues													
Estimated Effect on the Deficit	0	0	-872	-1,853	-2,259	-2,438	-2,801	-3,063	-3,276	-3,515	-3,776	-7,423	-23,853
Estimated Changes in On-Budget Deficits	0	0	-619	-1,328	-1,633	-1,767	-2,081	-2,295	-2,458	-2,638	-2,835	-5,348	-17,656
Estimated Changes in Off-Budget Deficits	0	0	-253	-525	-625	-671	-720	-768	-819	-877	-940	-2,074	-6,198

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Components may not sum to totals because of rounding; * = between zero and \$500,000.

H.R. 5800 would establish patient protections from surprise medical billing, and in certain circumstances would require insurers to reimburse out-of-network providers on the basis of the median payment rate for in-network care. The bill also would establish a process for health care providers and insurers to settle disputes over out-of-network bills greater than \$750.

CBO and JCT expect that under the bill, in facilities where surprise bills are likely, average payment rates for both in- and out-of-network care would move toward the median in-network rate, which tends to be lower than average rates. CBO and JCT estimate that in most affected markets in most years, lower payments to some providers would reduce premiums by roughly 1 percent. Lower costs for health insurance would reduce federal deficits because the federal government subsidizes most private insurance through tax preferences for employment-based coverage and through the health insurance marketplaces established under the Affordable Care Act.

Letters

RESEARCH LETTER

Private Equity Acquisitions of Physician Medical Groups Across Specialties, 2013-2016

Acquisition of physician practices by private equity firms has accelerated,^{1,2} with unknown implications for care delivery and patient outcomes. However, available data are limited to single specialties or come from industry reports or opinion articles. A dearth of evidence and the use of nondisclosure agreements at early stages of negotiation have constrained the ability to evaluate this phenomenon empirically.³ In this study, we describe physician group practices acquired in 2013-2016 across specialties.

Methods | We identified US physician group practice acquisitions by private equity firms using the Irving Levin Associates Health Care M&A data set,⁴ which includes manually collected and verified transactional information on a broad set of health care mergers and acquisitions. We excluded practices bought by entities not classified as private equity firms at the time of acquisition. We verified practice names, locations, specialties, and group practice status via Google searches.

We linked acquisitions to the SK&A data set, a commercial data set of verified physician- and practice-level characteristics (eg, specialty, credentials, practice ownership, size, and locations) for US office-based practices. Transactions

that spanned multiple sites and distinct practice names were considered separate acquisitions. Otherwise, we aggregated all practice sites observed in the SK&A data set and matched these to 1 observation from the M&A data set.

Linkages involved (1) fuzzy matching for nonexact records of a practice name in the SK&A data set with reported acquisitions in the M&A data set and (2) manual searches for nonmatches to identify name changes using publicly available records and practice websites. Within practices, we excluded physicians with primary administrative roles.

Match rates between practices in the SK&A data set and the M&A data set were 87% in 2013, 82% in 2014, 90% in 2015, and 87% in 2016. We benchmarked estimates against industry reports to ascertain data quality and integrity, and described numbers of practices, sites, and physicians in acquired practices across specialties.

Results | Of approximately 18 000 unique group medical practices, there were 355 physician practice acquisitions (1426 sites and 5714 physicians) by private equity firms from 2013 to 2016, increasing from 59 practices in 2013 to 136 practices in 2016 (Table 1). Acquired practices had a mean of 4.0 sites, 16.3 physicians in each practice, and 6.2 physicians affiliated with each site. Overall, 81.4% of these medical practices reported accepting new patients, 83.4% accepted Medicare, and 60.3% accepted Medicaid. The majority of acquired practices were in the South (43.9%).

Table 1. Characteristics of Physician Medical Groups Acquired by Private Equity Groups, 2013-2016 (N = 355)

		Year of Acquisition			
Characteristic	Total	2013	2014	2015	2016
Acquired by private equity group					
No. of practices	355	59	72	88	136
No. of sites	1426	216	308	386	516
No. of physicians ^a	5714	843	1413	1576	1882
Physicians per practice, mean (SD) [median]	16.3 (26.3) [7]				
Sites per practice, mean (SD) [median]	4.0 (7.8) [1]				
Physicians per site, mean (SD) [median]	6.2 (12.7) [2]				
Practice accepts new patients, No. (%)	289 (81.4)				
Practice accepts Medicare, No. (%)	296 (83.4)				
Practice accepts Medicaid, No. (%)	214 (60.3)				
Location of practice by US region, No. (%) ^b					
South	184 (43.9)				
Midwest	90 (21.5)				
Northeast	69 (16.5)				
West	76 (18.1)				

^a Each physician was associated with only 1 practice but may have been affiliated with multiple sites within a practice.

^b Some acquisitions spanned multiple US regions and are counted more than once; therefore, the total is 419 for this characteristic instead of 355.

Letters

Table 2. Specialties of Medical Groups and Physicians Among Those Acquired by Private Equity Firms, 2013-2016

Specialty (Specialist Description)	Specialty Practices					Specialty Physicians				
	Total, No. (%) ^a	Year of Acquisition ^b				Total, No. (%) ^a	Year of Acquisition ^b			
		2013	2014	2015	2016		2013	2014	2015	2016
Total	355 (100)	59	72	88	136	5714 (100)	843	1413	1576	1882
Anesthesiology (anesthesiologist)	69 (19.4)	10	20	15	24	1894 (33.1)	246	593	458	597
EM (emergency physician)	43 (12.1)	10	6	10	17	901 (15.8)	150	184	148	419
Family practice (family practitioner)	39 (11.0)	7	9	6	17	515 (9.0)	90	123	164	138
Dermatology (dermatologist)	35 (9.9)	1	5	11	18	334 (5.8)	11	26	86	211
Pediatrics (pediatrician)	20 (5.6)	4	8	5	3	166 (2.9)	9	61	57	39
Internal medicine (internist)	12 (3.4)	2	5	2	3	365 (6.4)	64	183	79	39
Ophthalmology (ophthalmologist)	11 (3.1)	0	2	2	7	134 (2.3)	6	35	68	25
Radiology (radiologist)	8 (2.3)	0	0	2	6	252 (4.4)	4	13	159	76
Urology (urologist)	8 (2.3)	5	1	1	1	92 (1.6)	13	37	37	5
Gastroenterology (gastroenterologist)	8 (2.3)	0	0	6	2	82 (1.4)	4	4	48	26
Cardiology (cardiologist)	8 (2.3)	1	0	1	6	106 (1.9)	32	14	28	33
Obstetrics/gynecology (obstetrician/gynecologist)	7 (2.0)	0	0	2	5	83 (1.5)	8	14	28	33
Hematology/oncology (hematologist/oncologist)	5 (1.4)	2	1	2	0	86 (1.5)	29	9	44	4
Orthopedic surgery (orthopedic surgeon)	5 (1.4)	0	0	2	3	130 (2.3)	0	13	43	74
Otolaryngology (otolaryngologist)	3 (0.8)	0	0	1	2	13 (0.2)	0	0	4	9
Nephrology (nephrologist)	2 (0.5)	0	0	0	2	19 (0.3)	0	7	2	10
Neurology (neurologist)	1 (0.3)	0	0	0	1	55 (1.0)	11	19	5	20
Psychiatry (psychiatrist)	1 (0.3)	0	0	1	0	22 (0.4)	5	2	2	13
Pulmonology (pulmonologist)	1 (0.3)	1	0	0	0	31 (0.5)	13	6	5	7
Pathology (pathologist)	1 (0.3)	1	0	0	0	23 (0.4)	15	2	3	3
Multispecialty	68 (19.4)	15	15	19	19					
Other types of specialty physicians										
Urgent care specialist						124 (2.2)	41	16	32	35
Neonatologist						79 (1.4)	44	25	10	0
Physical medicine/rehabilitation specialist						30 (0.5)	10	6	7	7
General surgeon						36 (0.6)	9	4	6	17
Radiation oncologist						26 (0.5)	2	2	10	12
Endocrinologist						17 (0.3)	1	2	10	4
Allergist/immunologist						10 (0.2)	1	5	3	1
Rheumatologist						15 (0.3)	2	3	3	7
Other specialist						74 (1.3)	23	7	34	10

Abbreviation: EM, emergency medicine.

^a The percentages represent the proportion of total acquisitions across all years.^b Data are expressed as total numbers for each year.

The most commonly represented medical groups included anesthesiology (19.4%), multispecialty (19.4%), emergency medicine (12.1%), family practice (11.0%), and dermatology (9.9%) (Table 2). From 2015 to 2016, there was also an increase in the number of acquired cardiology, ophthalmology, radiology, and obstetrics/gynecology practices.

Within acquired practices, anesthesiologists represented 33.1% of all physicians; emergency medicine specialists, 15.8%; family practitioners, 9.0%; and dermatologists, 5.8%.

Discussion | Private equity acquisitions of physician practices increased across specialties from 2013 to 2016 but still consti-

tuted a small proportion of group physician practices in the United States. Industry reports suggest further growth in 2017-2018 private equity acquisitions, particularly in ophthalmology, dermatology, urology, orthopedics, and gastroenterology.⁵ These data, which show acquired practices to have several sites and many physicians, match private equity firms' typical investment strategy of acquiring "platform" practices with large community footprints and then growing value by recruiting additional physicians, acquiring smaller groups, and expanding market reach.

Research is needed to understand the effect of these acquisitions and to mitigate unintended consequences. Private

equity firms expect greater than 20% annual returns,³ and these financial incentives may conflict with the need for longer-term investments in practice stability, physician recruitment, quality, and safety. There may be additional pressures to increase revenue streams (eg, elective procedures and ancillary services), direct more referrals internally, and rely on lower-cost clinicians.⁶

Key limitations include that the data are based on publicly announced transactions and therefore underestimate total acquisitions, particularly of smaller practices, and that available data lag behind the rapid pace of private equity acquisitions.

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Author Contributions: Drs Zhu and Polsky had full access to the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: Zhu, Polsky.

Acquisition, analysis, or interpretation of data: All authors.

Drafting of the manuscript: Zhu, Hua.

Critical revision of the manuscript for important intellectual content: All authors.

Statistical analysis: Zhu, Hua.

Administrative, technical, or material support: Zhu, Hua.

Supervision: Zhu, Polsky.

Conflict of Interest Disclosures: None reported.

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COMMENT & RESPONSE

Unmeasured Confounding in Observational Studies of Management of Cerebellar Intracranial Hemorrhage

To the Editor In a propensity score-matched cohort of 578 patients from 4 observational cohort studies, Dr Kuramatsu and colleagues showed that evacuation of medium-sized intracerebellar hematomas (approximate volume, 20 cm³)

was not associated with better functional outcome.¹ Assessing treatment effectiveness in observational data is challenging because treatment decisions are based on patient characteristics that also are typically predictive of outcome, causing confounding by indication. Although the authors addressed this potential bias with propensity scores, we would like to emphasize the possibility of residual confounding.

In their study, surgically treated patients were younger, had worse Glasgow Coma Scale scores at presentation, had larger hematomas, and more often had intraventricular hemorrhage. In matching patients with the same risk of undergoing a surgical evacuation (the propensity), the authors suggested that treatment groups with similar prognosis were created. However, while measured confounding seems to have been properly addressed, unmeasured confounding may still be a problem. Many factors may influence decision-making in these patients, including frailty and preexisting conditions that could be contraindications for surgery. Contexts with strong measured confounding are also likely to show substantial unmeasured confounding. Propensity score matching is a statistically efficient alternative for regression-based covariate adjustment but still relies on the assumption that no unmeasured treatment preferences strongly relate to prognosis.^{2,3}

A methodological study on comparable treatment considerations found that unmeasured confounding is not merely a theoretical problem.³ In post hoc analyses of traumatic brain injury cohorts, analytical methods for surgery in traumatic intracranial hematomas and intracranial pressure-guided treatment were compared; propensity score matching was unable to account for unmeasured imbalances between treatment groups. A simulation study confirmed that propensity score matching resulted in an invalid estimate of the treatment effect in the case of unmeasured confounding,³ which also was shown in other fields.⁴

Our view is that unmeasured confounding is an insurmountable problem in observational studies of acute neurosurgical decisions. A promising alternative for effect estimation is instrumental variable analysis. Although this method has its own difficulties, such as defining appropriate instruments and the necessity of large samples, it is not biased by unmeasured confounding.^{3,5} Since the cohort in the study by Kuramatsu and colleagues came from 64 centers with likely differing practice culture among institutions, have the authors considered a regional comparison of treatment strategies?

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Changes in Hospital Income, Use, and Quality Associated With Private Equity Acquisition

Joseph D. Bruch, BA; Suhas Gondi, BA; Zirui Song, MD, PhD

IMPORTANCE Rigorous evidence describing the relationship between private equity acquisition and changes in hospital spending and quality is currently lacking.

OBJECTIVE To examine changes in hospital income, use, and quality measures that may be associated with private equity acquisition.

DESIGN, SETTING, AND PARTICIPANTS This cohort study identified 204 hospitals acquired by private equity firms from 2005 to 2017 and 532 matched hospitals not acquired by private equity. Using a difference-in-differences design, this study evaluated changes in net income, charges, charge to cost ratios, case mix index (a measure of reported illness burden), share of discharges for patients with Medicare or Medicaid coverage, discharges per year, and aggregate hospital quality measures associated with private equity acquisition through 3 years after acquisition, adjusted for case mix, hospital beds, calendar year, and adjustment for multiple hypothesis testing. In subgroup analyses, changes in outcomes for private equity-owned Hospital Corporation of America (HCA) hospitals and non-HCA hospitals relative to matched controls were assessed.

PRIMARY OUTCOMES AND MEASURES Eight hospital income and use measures and 3 aggregate hospital quality measures were examined.

RESULTS Relative to 532 control hospitals, the 204 private equity-acquired hospitals showed a mean increase of \$2 302 391 (95% CI, \$956 660-\$3 648 123; $P = .009$) in annual net income, an increase of \$407 (95% CI, \$296-\$518; $P < .001$) in total charge per inpatient day, an increase of 0.61 (95% CI, 0.48-0.73; $P < .001$) in emergency department charge to cost ratio, an increase of 0.31 (95% CI, 0.26-0.37; $P < .001$) in total charge to cost ratio, an increase of 0.02 (95% CI, 0.01-0.02; $P = .007$) in case mix index, and a decrease of 0.96% (95% CI, 0.46%-1.45%; $P = .002$) in share of Medicare discharges. Medicaid's share of discharges (-0.16%; 95% CI, -0.86% to 0.53%; $P > .99$) and total hospital discharges (98; 95% CI, -54 to 250; $P > .99$) did not change differentially in a statistically significant manner. The aggregate quality score for acute myocardial infarction increased by 3.3% (95% CI, 1.6%-5.0%; $P = .002$), and the aggregate score for pneumonia increased by 2.9% (95% CI, 1.8%-3.9%; $P < .001$) in private equity-acquired hospitals relative to controls. The aggregate score for heart failure (1.3%; 95% CI, -0.2% to 2.7%; $P = .92$) did not differentially change in a statistically significant manner. In subgroup analyses, HCA hospitals showed similar findings to the entire sample. Among non-HCA hospitals, the only statistically significant relative changes were the increase in the emergency department charge to cost ratio (0.30; 95% CI, 0.12-0.48; $P = .02$) and the decrease in Medicare's share (-1.15%; 95% CI, -1.88% to -0.43%; $P = .02$). Non-HCA hospitals showed a decrease in the aggregate heart failure score (-3.3%; 95% CI, -5.3% to -1.3%; $P = .01$) and no statistically significant changes in the aggregate score for acute myocardial infarction (2.4%; 95% CI, -0.7% to 5.4%; $P > .99$) or pneumonia (0.2%; 95% CI, -1.4% to 1.7%; $P > .99$).

CONCLUSIONS AND RELEVANCE Hospitals acquired by private equity were associated with larger increases in net income, charges, charge to cost ratios, and case mix index as well as with improvement in some quality measures after acquisition relative to nonacquired controls. Heterogeneity in some findings was observed between HCA and non-HCA hospitals.

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Private equity investment in health care has markedly increased in recent years. The total disclosed value of private equity deals in health care reached \$78.9 billion in 2019, up from \$23.1 billion in 2015.^{1,2} Private equity firms use capital from institutional investors and individuals to acquire assets, such as hospitals and physician practices. After acquisition, private equity fund managers use the control offered by their newly purchased ownership stake to increase the value of the asset before selling it generally for a profit, typically in 3 to 7 years. Common strategies to enhance the value of acquired businesses include cutting costs and increasing efficiency.

In North America, the health care provider sector, which includes for purposes of this study hospitals, physician practices, and laboratory services, comprised more than half of all private equity health care deals in 2019.¹ Several factors may explain why health care is attractive to private equity firms.³ First, demand for health care has historically been relatively stable through economic fluctuations. Second, many health care delivery markets are fragmented, presenting opportunities for private equity firms to acquire numerous hospitals or physician practices to consolidate market power and to extract higher payments from payers. Third, private equity fund managers may seek to profit from increasing the efficiency of care delivery in a health care system in which up to a quarter of spending may be waste.⁴ To date, private equity acquisitions of physician practices have been noted in specialties such as dermatology, ophthalmology, radiology, and primary care.⁵⁻¹⁰ As practices and hospitals struggle with lost revenue during the coronavirus disease 2019 pandemic, they may become more susceptible to private equity acquisition.¹¹

Although prior research has evaluated changes in quality following hospital mergers,¹² little empirical evidence exists on changes in hospital income, use, or quality after a hospital is acquired by a private equity firm, despite the well-documented increase in such acquisitions.¹³⁻¹⁷

We identified US hospitals acquired by private equity firms between 2005 and 2017 and evaluated changes in hospital income, use, and quality associated with private equity acquisition for 3 years after the acquisition. Because a single acquisition (Hospital Corporation of America [HCA] acquired by Kohlberg Kravis Roberts, Bain Capital, and Merrill Lynch Global) constitutes a significant portion of all hospitals acquired in this time period, we separately analyzed hospitals in the HCA acquisition and those involved in other private equity (non-HCA) acquisitions in subgroup analyses.

Methods

Data Acquisition

We created a novel data set of acute care hospitals in the US that were acquired by private equity firms. Private equity firms often do not directly purchase a hospital. Instead, the purchaser is frequently a subsidiary company that the private equity firm owns. In addition, the hospital is often part of a large health system or delivery organization being acquired by private equity. Given the intricacies of the acquisition structure,

Key Points

Question Is the acquisition of a hospital by a private equity firm associated with changes in hospital income, use, and quality?

Findings In this analysis of 204 private equity-acquired hospitals and 532 similar hospitals that were not acquired by private equity, net income, charges, charge to cost ratios, and the case mix index differentially increased for private equity-acquired hospitals after acquisition relative to controls. Some quality measures improved among a subset of private equity-acquired hospitals relative to controls; Medicare's share of discharges decreased for private equity-acquired hospitals after acquisition relative to controls.

Meaning Private equity acquisitions were associated with changes in a range of hospital-level economic measures and with improvements in a subset of quality measures.

data on hospitals acquired by private equity firms are difficult to assemble. To overcome these challenges, we used S&P Global Market Intelligence software to obtain a list of all transactions whereby a private equity firm gained control of a hospital by directly purchasing it, having a portfolio company purchase the hospital, or by owning a majority of the stock in a health system. We supplemented these data with information from quarterly Merger and Acquisition reports by Irving Levin Associates. We then used documents from the US Securities and Exchange Commission, official press releases, and hospital websites to verify that the hospital was acquired. To verify that the firm (or parent company) acquiring the hospital was considered private equity, we consulted the PitchBook database, which provides information on company profiles.¹⁸ Drawing from the above resources, we assembled an original data set of 217 US acute care hospitals between 2005 and 2017 that transitioned from not being owned by private equity to being owned by private equity (eTable 1 in the [Supplement](#)), of which 135 hospitals (62.2%) were part of the 2006 acquisition of HCA. The Institutional Review Board of Harvard Medical School approved this work. In this analysis, all data were in the public domain, and no data were at the human subject level.

We obtained Medicare Cost Report data from 2002 to 2018. These data come from the Healthcare Provider Cost Reporting Information System and reflect yearly annual cost reports that Medicare-certified institutions submit to Medicare. Medicare Cost Reports contain information on facility characteristics, hospital use, costs, reimbursements, patient discharges, and other financial statement data. Using Medicare Cost Reports, we verified that all hospitals included in the sample were acute care hospitals and that their names and Centers for Medicare and Medicaid Services (CMS) provider numbers matched the records of private equity transactions. We extracted data on hospital income, use, and facility characteristics.

Finally, we obtained hospital case mix index data on discharges using publicly available Acute Inpatient CMS files. The case mix index value is the sum of diagnosis-related group weights for all Medicare discharges divided by the number of discharges.

Hospital Income and Use

We collected yearly data on the following hospital income and use measures: net income (total revenue minus total expenses), total charge per inpatient day, emergency department charge to cost ratio, total charge to cost ratio (a reflection of hospital markups that has been used elsewhere¹⁹), case mix index (a measure of disease burden), the share of discharges accounted for by patients with Medicare, the share of discharges accounted for by patients with Medicaid, and total hospital discharges (defined in eTable 2 in the Supplement).

To address rare outlier values, we followed established methods and winsorized all hospital income and use measures to the 95th and 5th percentiles; in other words, we set all values above and below those thresholds to their respective threshold value. This technique reduces the influence of severe outliers (which may reflect errors in data entry) and is commonly done in research using Medicare Cost Reports.^{20,21}

We also gathered several facility-level attributes. Ownership was defined as nonprofit, government, or for-profit. Hospital referral region (HRR) data were obtained from the Dartmouth Atlas. The HRRs represent regional health care markets between which variation in medical care has been investigated.

Process Quality Measures

We extracted quality of care process measures from Hospital Compare, a CMS website that provides information on hospital performance using quality measures. Because Hospital Compare has changed its process of care measures over time, we found only 8 individual measures that remained relatively consistent in definition during the period of the study. These 8 process measures pertained to 3 conditions: heart failure, acute myocardial infarction, and pneumonia. For the analyses, we used these 3 aggregate measures, which are the weighted averages of individual measures in each condition.

Statistical Analysis

We used a difference-in-differences design within an event study framework to assess changes in outcomes associated with private equity acquisition of hospitals. We used an analytic design similar to that in Joynt et al,²² who evaluated hospital conversions from nonprofit to for-profit status. Private equity-acquired hospitals were matched to control hospitals at event time 0 (the year of acquisition). We used nearest neighbor matching on total beds and exact matching on year, ownership, US geographic region (Northeast, Midwest, South, and West), and teaching hospital status. We allowed for up to 8 controls per private equity-acquired hospital. In total, we found data and matches for 204 of the 217 hospitals. There were 532 matched controls.

In the event study, we lined up all hospitals and their outcome data at event time 0, the year of acquisition, and looked back 3 years prior to private equity acquisition and 3 years after private equity acquisition. Because full cost report data are available only to 2018, hospitals acquired in 2016 and 2017 contributed 2 years and 1 year of data following acquisition, respectively. The year of acquisition was excluded as a washout period from all analyses. We followed the same design for pro-

cess quality measures but could only include 2 years prior to acquisition and 3 years after acquisition and only among hospitals acquired from 2005 to 2013. This truncated period was necessary because most quality measures were only consistent from 2004 to 2016. We reported missing observations in eTable 3 in the Supplement.

We used a linear mixed-effects model to compare changes in outcomes among private equity-acquired hospitals relative to control hospitals from before to after the acquisition. We included year fixed effects to adjust for secular trends in the outcomes. We controlled for case mix index. To capture the multilevel study design, we included a random intercept term for the matched group and the provider group, which is the unique Medicare identification number for the hospital. We defined the “Treatment” indicator as a hospital that transitioned from not owned by private equity to being acquired by private equity. We defined a “Post” indicator that represents event years after private equity acquisition:

$$\text{Outcome}_{ijk} = \alpha + \tau(\text{Treatment})_{jk} + \delta(\text{Post})_{ijk} + \beta(\text{Treatment} \times \text{Post})_{ijk} + \sum_{t=2003}^{2018} \gamma_t(\text{Year})_{ijk} + \omega(\text{Case Mix Index})_{ijk} + \varphi(\text{Total Beds})_{ijk} + \nu_{jk} + \gamma_k + \varepsilon_{ijk}.$$

In this model, “Outcome” denotes an outcome of interest, such as total hospital discharges or quality for event year i in hospital j in matched group k . The adjusted difference-in-differences estimate is denoted by the coefficient β on the interaction term “Treatment $\times$ Post.” “Case Mix Index” and “Total Beds” were mean values centered prior to entry into the model; ν is the random intercept for each provider group, and γ is the random intercept for each matched group. Evaluating 11 outcomes in total, we used the Bonferroni correction to adjust for multiple comparisons testing and reported Bonferroni-corrected P values.²³ A 2-sided value of $P < .05$ was considered statistically significant.

We conducted several sensitivity analyses. First, because some of the hospitals had fiscal years that did not correspond to the calendar year, we extended our washout period, excluding time 0 as well as time 1 and time -1 to prevent the precise time of acquisition from being possibly captured in the before or after period. Second, we included HRR fixed effects interacted with year to better capture mean within-region changes over time. In a third sensitivity analysis, we removed case mix index and total beds from our model.

Although there is debate over whether to match on pre-intervention outcomes, matching on preintervention outcome levels may reduce bias when treatment is based on pre-intervention outcomes.^{24,25} Thus, in a fourth sensitivity analysis, we performed exact matching on year, ownership, region, and teaching status and performed nearest neighbor matching on net income, total inpatient charges per day, charge to cost ratio, case mix index, total proportion of discharges with public health insurance (Medicare and Medicaid discharges), and hospital discharges.

We tested for differences in preacquisition trends between the private equity-acquired hospitals and control hospitals by performing joint F tests of the hypothesis that preintervention interactions between the treatment and

event time indicators are zero for time -2 and -1 (with time -3 as the reference) for hospital income and use outcomes. For quality measures, we tested the interaction between private equity acquisition and time -1 (with time -2 as the reference). In subgroup analyses, we assessed changes in outcomes associated with the acquisition of HCA hospitals and non-HCA hospitals separately. All statistical analyses were conducted using R software, version 3.6.1 (The R Foundation).

Results

The characteristics of 204 private equity-acquired hospitals during the year of the acquisition (time 0) and 532 control hospitals are shown in Table 1. Most hospitals in the sample were nonteaching (149 private equity-acquired hospitals [73.0%]; 393 control hospitals [73.9%]), for-profit (172 private equity-acquired hospitals [84.3%]; 448 control hospitals [84.2%]), and located in the Southern US Census region (125 private equity-acquired hospitals [61.3%]; 325 control hospitals [61.1%]).

Hospital Income and Use

Changes in hospital income and use are shown in Table 2, with mean values before and after private equity acquisition. Means were calculated using an unadjusted model, which included a random intercept for the matched group and for the provider group, with no covariates. The charge to cost ratio, a representative outcome, is plotted in the Figure, which shows an increase for private equity-owned hospitals after acquisition relative to controls.

In adjusted analyses, private equity-acquired hospitals demonstrated a mean increase of \$2 302 391 (95% CI, \$956 660-\$3 648 123; $P = .009$) in annual net income, an increase of \$407 (95% CI, \$296-\$518; $P < .001$) in total charge per inpatient day, an increase of 0.61 (95% CI, 0.48-0.73; $P < .001$) in emergency department charge to cost ratio, an increase of 0.31 (95% CI, 0.26-0.37; $P < .001$) in total charge to cost ratio, and an increase of 0.02 (95% CI, 0.01-0.02; $P = .007$) in case mix index relative to control. Medicare's share of discharges decreased by 0.96% (95% CI, 0.46%-1.45%, $P = .002$) in private equity-acquired hospitals relative to controls. Medicaid's share of discharges (-0.16%; 95% CI, -0.86% to 0.53%, $P > .99$) and total hospital discharges (98; 95% CI, -54 to 250; $P > .99$) did not change differentially in a statistically significant manner.

Process Quality Measures

Unadjusted levels and changes in quality measures are shown in Table 3. In adjusted analysis, the aggregate score for acute myocardial infarction increased by 3.3 percentage points (95% CI, 1.6%-5.0%; $P = .002$) and for pneumonia by 2.9 percentage points (95% CI, 1.8%-3.9%; $P < .001$) in private equity-acquired hospitals relative to controls. The aggregate score for heart failure (1.3 percentage points; 95% CI, -0.2% to 2.7%; $P = .92$) did not differentially change in a statistically significant manner.

Table 1. Characteristics of 204 Private Equity-Acquired Hospitals and 532 Control Hospitals^a

Characteristic	Hospitals, No. (%)	
	Private equity acquisition	Control
Hospital ownership		
Nonprofit	29 (14.2)	76 (14.3)
Government	3 (1.5)	8 (1.5)
For profit	172 (84.3)	448 (84.2)
Geographic region		
South	125 (61.3)	325 (61.1)
West	37 (18.1)	97 (18.2)
Northeast	21 (10.3)	55 (10.3)
Midwest	21 (10.3)	55 (10.3)
Teaching hospital	55 (27.0)	139 (26.1)
Hospital size by total No. of beds, mean No.	212	200
Small (<150 beds), %	30.9	40.8
Medium (150-350 beds), %	56.4	45.1
Large (>350 beds), %	12.8	14.2

^a Private equity-acquired hospitals were matched to controls at event time 0 (time of acquisition). R Package MatchIt was used to generate at most 8 controls per private equity-acquired hospital. We used nearest neighbor matching on total beds and exact matching on year, ownership, geographic region, and teaching hospital status. Values are calculated using weights derived from matching. Within matched groups, we weighted each target as 1 and assigned controls weights that summed to 1.

Sensitivity Analyses

Our main results were relatively similar when we widened our washout period around the time of private equity acquisition (eTables 4 and 5 in the Supplement). The findings were relatively similar after removing case mix index and total beds as covariates (eTables 8 and 9 in the Supplement) and matching on preintervention outcomes (eTables 10 and 11 in the Supplement). When we included HRR and year interactions in the model (eTables 6 and 7 in the Supplement) as well as when we performed a fixed-effects model (eTables 12 and 13 in the Supplement), most of our estimates remained relatively similar, although with the Bonferroni adjustment, some of the corrected P values were larger. A joint F test to assess differences in preacquisition trends for hospital income and use measures as well as process quality measures did not show a significant difference for any of the 11 measures (eTable 14 in the Supplement).

HCA and Non-HCA Analysis

Baseline characteristics of HCA hospitals compared with non-HCA hospitals are given in eTable 15 in the Supplement. Prior to acquisition, HCA hospitals were almost entirely for-profit and located in the South, whereas about half of non-HCA hospitals were nonprofit and geographically dispersed. The HCA hospitals had more discharges annually than non-HCA hospitals.

In the subgroup analysis of HCA hospitals and matched controls, changes in income, use, and quality measures associated with the acquisition were generally similar to the main results, with most estimates larger in magnitude (eTables 16

Table 2. Changes in Hospital Income and Use Measures After Private Equity Acquisition

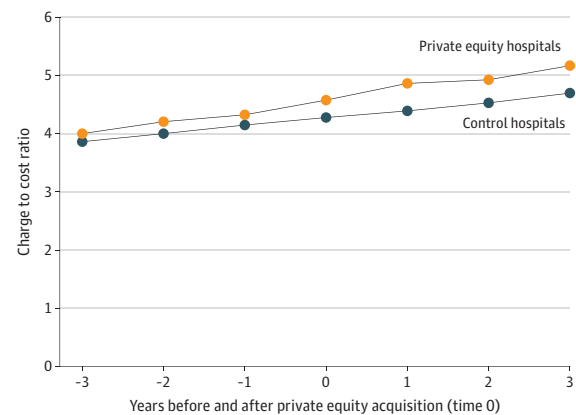
Measure	Hospitals				Differential change			
	Acquired hospitals (n = 204)		Control hospitals (n = 532)		Unadjusted, No. ^a	Adjusted, No. (%) [95% CI] ^b	P value	Corrected P value ^c
	Before private equity	After private equity	Before private equity	After private equity				
Net income per y, \$	8 527 119	12 861 680	7 655 125	10 092 820	1 896 866	2 302 391 (27.0) [956 660 to 3 648 123]	.001	.009
Total charge per inpatient day, \$	5789	7766	5583	6928	633	407 (7.0) [296 to 518]	<.001	<.001
Emergency charge to cost ratio	3.81	5.52	4.00	5.03	0.69	0.61 (16.0) [0.48 to 0.73]	<.001	<.001
Total charge to cost ratio	4.17	5.02	3.90	4.38	0.37	0.31 (7.4) [0.26 to 0.37]	<.001	<.001
Case mix index	1.42	1.47	1.36	1.41	0.00	0.02 (1.4) [0.01 to 0.02]	.001	.007
Medicare's share of discharges, %	40.3	36.8	39.1	37.1	-1.56	-0.96 (-2.4) [-1.45 to -0.46]	<.001	.002
Medicaid's share of discharges, %	13.2	12.2	15.2	14.3	-0.07	-0.16 (-1.2) [-0.86 to 0.53]	.64	>.99
Total discharges per y, No.	8948	9181	8504	8353	384	98 (1.1) [-54 to 250]	.21	>.99

^a Private equity–acquired hospitals were matched to controls at event time 0 (time of acquisition). R Package MatchIt was used to generate at most 8 controls per acquired hospital. We used nearest neighbor matching on total beds and exact matching on year, ownership, region (Northeast, Midwest, South, and West), and teaching hospital status. The unadjusted model refers to the mixed-effects model, which included a random intercept for the matched group and for the provider group, with no covariates. Values indicate means before and after private equity acquisition of acquired and control hospitals and were calculated using the unadjusted model.

^b The adjusted model included a random intercept term for the matched group and for the provider group and adjusted for calendar year, case mix index, and total hospital beds. Case mix index was not included as a covariate when evaluated as an outcome. Percentage differential change was calculated by dividing the adjusted differential change by the preacquisition mean among private equity–acquired hospitals.

^c Bonferroni correction used for multiple comparisons testing.

Figure. Total Charge to Cost Ratios Before and After Private Equity Acquisition



Weighted mean values at each event time. The mean values are calculated using weights derived from matching. Within matched groups, we weighted each target as 1 and assigned controls weights that summed to 1.

and 17 in the [Supplement](#)). In the analysis of non-HCA hospitals and matched controls, most hospital income and use outcomes did not change differentially after private equity acquisition, except emergency department charge to cost ratios, which increased, and Medicare's share of discharges, which slightly decreased (eTable 18 in the [Supplement](#)). The mean aggregate measure for heart failure decreased by 3.3 percentage points (95% CI, 1.3%-5.3%; $P = .01$) more among private equity–acquired hospitals than control hospitals (eTable 19 in the [Supplement](#)). The other quality measures did not change in a statistically significant manner among non-HCA hospitals relative to controls.

Discussion

Private equity has a substantial and growing presence in the US health care system, especially in the hospital sector. Although private equity firms may seek to create efficiencies in the delivery of care, their financial incentives, especially the pressure to sell acquired assets for a profit on a short time horizon, might conflict with parts of the mission and priorities of health care clinicians.³ Anecdotal reports suggest that private equity–owned health care organizations may be more likely to operate in ways that maximize margin in the near term.^{5,26,27} Payers may be appropriately concerned about the potential for increased health care spending that may be lower value. Most worrisome are suggestions of risk to patient safety and health equity.²⁸ Consequently, understanding the potential implications of private equity acquisitions of hospitals is important for patients, payers, and policy makers.

In this initial analysis of 204 hospitals acquired by private equity from 2005 to 2017, we found that relative to 532 control hospitals, private equity acquisition was associated with increases in annual net income, hospital charges, charge to cost ratios, and case mix index among hospitals. The proportion of

Table 3. Changes in Hospital Performance on Quality Measures After Private Equity Acquisition^a

Measure	Hospitals						Differential change			
	Acquired hospitals (n = 179)			Control hospitals (n = 404)			Unadjusted ^b	Adjusted, No. (%) [95% CI] ^c	P value	Corrected P value ^d
	Before private equity	After private equity	Change	Before private equity	After private equity	Change				
Heart failure ^e	75.2	93.6	18.4	76.7	89.4	12.7	5.7	1.3 (1.7) [−0.2 to 2.7]	.08	.92
Acute myocardial infarction ^f	89.3	97.5	8.2	89.8	93.6	3.8	4.4	3.3 (3.7) [1.6 to 5.0]	<.001	.002
Pneumonia ^g	73.7	95.4	21.7	77.2	91.4	14.2	7.5	2.9 (3.9) [1.8 to 3.9]	<.001	<.001

^a The aggregate quality measures are the weighted averages of individual measures within each condition category. Values correspond to the proportion (%) of eligible patients for a measure who met quality performance for the measure.

^b Private equity-acquired hospitals were matched to controls at time 0 (time of acquisition). R Package MatchIt was used to generate at most 8 controls per acquired hospital. We used nearest neighbor matching on total beds and exact matching on year, ownership, region (Northeast, Midwest, South, and West), and teaching hospital status. The unadjusted model refers to the mixed-effects model, which included a random intercept for the matched group and for the provider group, with no covariates. Values indicate means before and after private equity for acquired and control hospitals and were calculated using the unadjusted model.

^c The adjusted model included a random intercept term for the matched group and for the provider group and adjusted for calendar year, case mix index, and total hospital beds. Percentage differential change was calculated by dividing the adjusted differential change by the preacquisition mean among acquired hospitals.

^d Bonferroni correction for multiple comparisons testing.

^e Heart failure included Hf1 (2004-2014), Hf2 (2004-2015), and Hf3 (2004-2014); Hf1 represents patients with heart failure given discharge instructions; Hf2, patients with heart failure given an assessment of left ventricular function; and Hf3, patients with heart failure given an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker for left ventricular systolic dysfunction.

^f Acute myocardial infarction included Ami2 (2004-2014); Ami2 represents patients with an acute myocardial infarction given aspirin at discharge.

^g Pneumonia included Pn2 (2004-2011), Pn3 (2004-2012), Pn5 (2004-2011), and Pn6 (2004-2015); Pn2 represents patients with pneumonia assessed and given pneumococcal vaccination; Pn3, patients with pneumonia who received a blood culture performed prior to first antibiotic received in hospital; Pn5, patients with pneumonia given initial antibiotic(s) within 4 hours after arrival; and Pn6, patients with pneumonia given the most appropriate initial antibiotic(s).

patients discharged from hospitals acquired by private equity who were covered by Medicare decreased relative to control hospitals, whereas the proportion covered by Medicaid was unchanged, suggesting an increase in the share of discharges for patients who were privately insured or uninsured relative to controls. Patients who are privately insured typically garner higher reimbursements for hospitals than patients with Medicare or Medicaid.

Although the total hospital charge is the amount the hospital bills for care, it is typically not what insurers or patients pay the hospital (negotiated payment rates are less than the charge). Nevertheless, the charge represents the “asking price,” and is often the billed amount for patients paying out of pocket, including uninsured or out-of-network patients.^{29,30} Higher charges are also associated with greater payment among insured, in-network patients.³¹ The higher charge to cost ratio we observed may indicate that hospitals acquired by private equity firms began charging more for services, cutting operating costs, or both after the acquisition.

Increased charges following private equity acquisition provides insight into the strategic decisions made by fund managers or hospital leadership in response to new incentives hospitals face after an acquisition. Higher markups are associated with greater profitability.³² The increase in yearly case mix index suggests that hospitals saw reportedly sicker patients on average after acquisition. This could be due to selection effects if the composition of patients changed. However, it may also suggest that hospitals are engaging in more complete or aggressive coding. Upcoding can lead to higher diagnosis-related group payments for inpatient admissions and is another possible mechanism to increase net income.³³

In our main analysis, we observed greater improvements in process quality measures among private equity-acquired hospitals relative to controls, which may reflect better care for patients. However, it could also be consistent with better adherence to compliance standards or efforts to maximize opportunities for quality bonuses under pay-for-performance contracts.

Subgroup analyses showed that our aggregate results were driven by the subsample of HCA hospitals. Nevertheless, among non-HCA hospitals, the emergency department charge to cost ratios also increased relative to control. However, non-HCA hospitals showed a decline in 1 quality measure relative to control and no relative improvements in the others. These findings could reflect differences between HCA and non-HCA hospitals. For instance, HCA hospitals differed from non-HCA hospitals in location, ownership, and total discharges. Furthermore, HCA has focused on market power, volume, and performance on quality measures.³⁴⁻³⁷ That HCA hospitals saw improvements in quality measures whereas non-HCA hospitals did not could reflect different priorities across different private equity owners. Owing to the oversized influence of HCA hospitals in our sample, the results for non-HCA hospitals—reduction in a quality measure and increase in emergency department charge to cost ratio—may be more representative of private equity acquisitions in general.

Limitations

We highlight several limitations. First, the difference-in-differences design is vulnerable to unobserved confounding. This study did not capture potential differences in patient populations before and after acquisition. It is possible that hospitals acquired by private equity firms selected for certain pa-

tient populations after acquisition. Changes in charges may thus reflect changes in patient populations. Although we partially controlled for changes in patient population by including the case mix index as a covariate, it is limited by its focus on the Medicare population and there may be additional unobservable characteristics that changed differentially for private equity-acquired hospitals relative to controls.

Second, the preacquisition and postacquisition trends were relatively short given the data available, rendering it more difficult for statistical tests to detect significant differences. This could lead preintervention trends between groups to appear more similar, although, as far as the data would allow, a consistent lack of significant differences in preacquisition trends was found.

Third, the number of quality measures available was small, making it difficult to assess changes in quality measures

broadly. Moreover, no hospital-level health outcome measures were systematically available.

Conclusions

As private equity increasingly influences health care delivery in the US, this study offers an initial national assessment of changes in hospital-level economic and quality measures associated with private equity acquisition. Although further research is needed, our findings suggest that policy makers should consider monitoring or thoughtful oversight of changes in care delivery and billing practices in hospitals acquired by private equity firms to ensure proper stewardship of societal resources and the prioritization of patient interests.

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Author Contributions: Mr Bruch had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: All authors.

Acquisition, analysis, or interpretation of data: Bruch, Gondi.

Drafting of the manuscript: Bruch, Gondi.

Critical revision of the manuscript for important intellectual content: All authors.

Statistical analysis: Bruch, Song.

Obtained funding: Song.

Administrative, technical, or material support: Bruch, Song.

Supervision: Song.

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TRENDS FROM THE FIELD

Policies to Address Surprise Billing Can Affect Health Insurance Premiums

Erin L. Duffy, PhD, MPH; Bich Ly, BA; Loren Adler, MS; and Erin Trish, PhD

Surprise medical bills, which can occur in emergencies or when patients at in-network facilities are treated by out-of-network professionals, have drawn increasing public and policy attention. Although the main focus has been protecting patients from receiving these unfair—and potentially large—surprise bills, policies addressing surprise billing may affect health insurance premiums more broadly.

Most surprise bills are generated by emergency and ancillary providers, such as radiologists, anesthesiologists, pathologists, emergency physicians, emergency ground ambulances, and emergency outpatient facilities.^{1,2} Unlike most medical services, for which patients have an opportunity to seek in-network providers, patients generally are not able to choose these emergency and ancillary providers. As a result, these providers can often remain out of network without significantly reducing their patient volume. Not only can this lead to patients receiving surprise bills, but evidence suggests that the ability to surprise-bill creates leverage that enables these providers to obtain higher in-network payments.⁴⁻⁶ For example, in a letter to Congress, the CEO of TeamHealth, a large emergency physician staffing company, plainly acknowledged that “balance billing...is a contract leveraging tool.”⁷

The expense of these high in-network payments is passed on to consumers and taxpayers through the cost of health insurance premiums. Therefore, although the surprise bills themselves are burdensome to individual patients, the higher in-network payments resulting from this leverage have a broader impact on total health care spending for consumers.

A federal policy eliminating surprise bills would influence in-network payments for this subset of providers and, in turn, influence health insurance premiums. To assess the impact of a federal surprise billing law on premiums, it is critical to quantify the share of total health plan medical claims spending attributable to the subset of services most likely affected, for which only partial estimates are available in the existing literature (to our knowledge).⁷

In this study, we evaluate the proportion of total medical health plan spending on ancillary and emergency services with the highest prevalence of surprise billing. This includes services performed by

ABSTRACT

OBJECTIVES: To quantify the proportion of health plan spending on services for which surprise billing is common—provided by radiologists, anesthesiologists, pathologists, emergency physicians, emergency ground ambulances, and emergency outpatient facilities—and estimate the potential impact of proposed policies to address surprise billing on health insurance premiums.

STUDY DESIGN: Analysis of 2017 commercial claims data from the Health Care Cost Institute, comprising 568.5 million claims from 44.8 million covered lives in 3 large US insurers: UnitedHealthcare, Aetna, and Humana.

METHODS: We calculate the share of total health plan claims spending attributable to ancillary and emergency services. Next, we estimate the premium impact of proposed federal policies to address surprise billing, which, by removing provider leverage stemming from the ability to surprise-bill, could reduce in- and out-of-network payments for these services, in turn affecting premiums. Specifically, we model the premium impact of reducing payment for these services (1) by 15% and (2) to 150% of traditional Medicare payment rates.

RESULTS: More than 10% of health plan spending is attributable to ancillary and emergency services that commonly surprise-bill. Reducing payment for these services by 15% would reduce premiums by 1.6% (\$67 per member per year), and reducing average payment to 150% of traditional Medicare rates—the high end of payments to other specialists—would reduce premiums by 5.1% (\$212 per member per year). These savings would reduce aggregate premiums for the nation's commercially insured population by approximately \$12 billion and \$38 billion, respectively.

CONCLUSIONS: Addressing surprise billing could substantially affect commercial insurance premiums.

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TRENDS FROM THE FIELD

TAKEAWAY POINTS

Proposed surprise-billing legislation would not only protect patients from unexpected out-of-pocket expenses, but also likely affect negotiated payments for the ancillary and emergency services that generate most surprise bills.

- ▶ More than 10% of commercial health care spending is attributable to services for which surprise billing is common: those provided by radiologists, anesthesiologists, pathologists, emergency physicians, emergency ground ambulances, and emergency outpatient facilities.
- ▶ Eliminating provider leverage stemming from the ability to surprise-bill could reduce commercial insurance premiums by as much as 5.1%, or \$212 per member per year. This could reduce aggregate premiums by approximately \$38 billion for the nation's commercially insured population.

emergency medicine professionals, radiologists, anesthesiologists, and pathologists (ERAP), as well as emergency outpatient facilities and emergency ground ambulance services. Then, we estimate the impact that potential changes in payments for these services would have on health insurance premiums.

METHODS

We analyze 2017 commercial claims data from the Health Care Cost Institute (HCCI), comprising 568.5 million claims from 44.8 million covered lives (equating to 36 million member-years) in 3 of the 5 largest US insurers: UnitedHealthcare, Aetna, and Humana.⁸ More than 90% of observed claims were in network, although there is variation across these provider types ([eAppendix A](#) [eAppendices available at [ajmc.com](#)]). We compute total plan-paid spending on professional, facility, and pharmaceutical services per member per year. We then calculate plan-paid spending attributable to ERAP professional services, identified using 2 methods: (1) HCCI provider categories and (2) Current Procedural Terminology (CPT) codes generally billed by these specialties.⁹ We also calculate the share of total plan-paid spending per member per year on outpatient emergency facility claims and emergency ground ambulance services identified by CPT codes, as recent evidence suggests that these services would be affected by surprise-billing legislation.^{2,3} Then, we estimate the impact of 2 potential changes in payments for ERAP, outpatient emergency facility, and emergency ground ambulance services on insurance premiums. We assume a baseline medical loss ratio of 90% in these estimations to align with the average ratio among large group plans, and that nonmedical spending is unchanged by policies.¹⁰

First, we analyze the impact of a 15% reduction in average payments for these services, in line with the Congressional Budget Office–estimated effects of surprise-billing legislation proposed by the Senate Health, Education, Labor, and Pensions Committee.¹¹ This proposed legislation would prohibit surprise billing and require minimum out-of-network payments equal to a health plan's median in-network payments for similar services in the same geographic region.

Second, we estimate the effects of a policy that would have the

effect of reducing payment rates for ERAP professionals and emergency service providers to 150% of Medicare's reimbursement rates for the same service. We choose this level because it is roughly the upper bound of average markups for specialists not commonly involved in surprise billing.^{12–14} In contrast, multiple studies estimate average in-network payments at roughly 300% of Medicare for emergency physicians, 200% of Medicare for radiologists, and 350% of Medicare for both anesthesiologists and pathologists.^{7,12,15,16} Medicare payments are intended to reflect the relative cost of

providing care, and excess commercial markups observed among ERAP professionals and emergency service providers may be driven by their ability to surprise-bill. Therefore, we expect that a policy such as network matching¹⁷—by eliminating provider leverage stemming from the ability to surprise-bill—could result in negotiated payments with markups over Medicare more similar to these other types of specialists. Although it is impossible to predict the precise magnitude of prices resulting from these policies, we estimate the premium impact of reducing average payments for these services to 150% of Medicare payments.

In this analysis, we do not compute payments as a fraction of Medicare's payment rates for each service in our data but, rather, use estimates from the literature described previously. For example, we assume that such a policy would reduce spending on radiology services by one-fourth, from 200% to 150% of Medicare's rates. For emergency ground ambulance services, we estimate that commercial plans currently pay approximately 170% of Medicare's rates ([eAppendix B](#)). We assume that emergency facility payments would face the same reduction as emergency physician payments.

RESULTS

We find that ERAP professional services account for 7.0% to 8.6% of total plan spending in 2017, depending on the definition ([Table](#)). Outpatient emergency facility claims account for an additional 3.1% of plan spending, and emergency ground ambulance services comprise 0.3% of plan spending. Average annual plan spending per member-year is \$4161 among plans in our data set, with approximately \$290 to \$357 spent on ERAP professional services, \$127 spent on emergency facilities, and \$13 spent on emergency ground ambulances.

We estimate that a 15% reduction in payments to ERAP professionals corresponds to a 0.9% to 1.2% (approximately \$37–\$50 per member-year) reduction in annual premiums per enrollee ([Figure](#)). If average in-network payments for ERAP professionals declined to 150% of Medicare rates, premiums would decline by 3.1% to 3.6% (approximately \$129–\$150 per member-year), all else staying equal.

Including emergency facilities and emergency ground ambulance services, the estimated premium reduction would increase to 1.4% to

Premium Impact of Surprise Billing Policies

1.6% (approximately \$58-\$67 per member-year) under the 15% payment reduction scenario and 4.5% to 5.1% (approximately \$187-\$212 per member-year) if payments declined to 150% of Medicare. Applying these premium reductions to the US commercially insured population (approximately 177 million individuals),¹⁸ we estimate that 1.6% and 5.1% reductions in insurance premiums would yield a total savings of \$12 billion and \$38 billion, respectively.

DISCUSSION

The financial burden of surprise bills for individual patients has captured public attention, but this study illustrates that provider leverage derived from the ability to surprise-bill has broader effects on health care spending—resulting in commercial health insurance premiums as much as 5% higher than they otherwise would be in the absence of this market failure. Our estimates are roughly in line with others in the literature.^{7,11}

This growing body of research indicates that policies to address surprise billing would address an important market failure that has enabled emergency and ancillary services providers to command high payment rates. Removing the ability to surprise-bill patients reduces leverage for this subset of providers in their payment negotiations with health plans. Several federal proposals employ payment standards or arbitration processes that additionally require insurers to make a minimum payment to out-of-network providers. Other policy approaches would instead address surprise medical bills by imposing “network matching” requirements, whereby emergency, ancillary, and similar professional services delivered through in-network facilities could no longer be billed on an out-of-network basis; in turn, providers of such services would have to negotiate payment with the facility and/or health plans that the facility accepts, with the ability to surprise-bill now eliminated.¹⁷

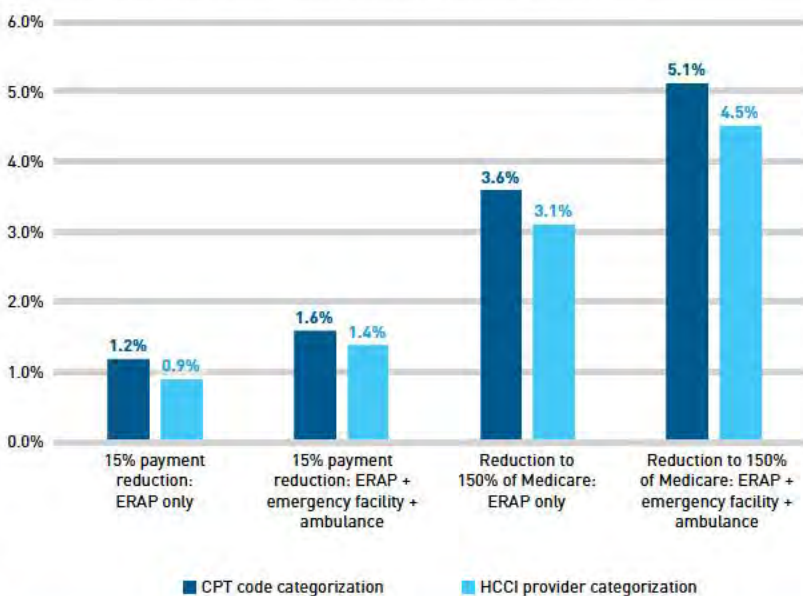
The net premium impact of any proposal would depend on the regulatory approach and generosity of any required minimum payments from health plans to out-of-network providers. If a policy were to base payment standards on something that is generally higher than payment rates today, such as provider charges, it could actually increase health insurance premiums.

TABLE. Share of Total Insurer Spending on ERAP Services Using 2 Identification Strategies

Provider category (CPT code categorization)	Share of total insurer spending	
	CPT code categorization	HCCI provider categorization
ERAP professionals		
Emergency medicine (99281-99285, 99291-99292)	1.5%	1.2%
Radiology (70010-79999, G6001-G6017, R0070-R0076)	2.3%	1.4%
Anesthesiology (00100-01999)	2.4%	2.4%
Pathology (80047-89398, P2028-P9615)	2.4%	2.0%
Sum of ERAP professional spending	8.6%	7.0%
Emergency outpatient facility		
Emergency outpatient facility (99281-99285, 99291-99292)		3.1%
Emergency ground ambulance		
Emergency ground ambulance (A0425, A0427, A0429, A0432-A0434)		0.3%
Total		
Total sum	12.0%	10.4%

CPT, Current Procedural Terminology; ERAP, emergency medicine professionals, radiologists, anesthesiologists, and pathologists; HCCI, Health Care Cost Institute.

FIGURE. Estimated Reductions in Insurance Premiums Associated With Changes in Payment for Ancillary and Emergency Services That Commonly Surprise-Bill



CPT, Current Procedural Terminology; ERAP, emergency medicine professionals, radiologists, anesthesiologists, and pathologists; HCCI, Health Care Cost Institute.

Limitations

These findings may not be generalizable beyond the 3 insurers we study, and we do not describe variation in effects across local markets. We may misattribute services to ERAP professionals, although consistent findings using 2 approaches suggest robustness. We analyze only 2 potential policy scenarios within a wider range of approaches.

TRENDS FROM THE FIELD

Although economic theory lends some intuition to the effect that different policies might have, the precise effects of different approaches on provider prices are highly uncertain and we do not account for potential secondary effects such as provider consolidation. There is also some uncertainty surrounding status quo commercial payment levels. Additional specialties may be affected by surprise-billing legislation, which would further magnify premium impacts. For example, legislation may affect inpatient facility spending incurred by patients admitted through the emergency department, but we conservatively exclude such spending from our calculations.

CONCLUSIONS

Providers affected by surprise-billing regulation—ERAPs, emergency outpatient facilities, and emergency ground ambulances—comprise more than 10% of total plan spending. Policies addressing surprise billing can meaningfully influence commercial insurance premiums. A well-designed policy to address this market failure could therefore reduce consumer health care spending. ■

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eAppendix A. Provider Network Status Summary

Provider Category (CPT Code Categorization)	CPT Code Categorization, % of claims in sample			HCCI Provider Categorization, % of claims in sample*		
	In- network	Out-of- network	Missing network	In- network	Out-of- network	Missing network
Emergency Medicine (99281-99285, 99291-99292)	74.2%	17.2%	8.6%	78.3%	14.2%	7.5%
Radiology (70010 – 79999, G6001 – G6017, R0070 – R0076)	93.5%	3.5%	3.0%	92.6%	4.7%	2.7%
Anesthesiology (00100 – 01999)	85.5%	8.5%	6.0%	87.1%	7.6%	5.3%
Pathology (80047 – 89398, P2028 - P9615)	94.4%	3.8%	1.8%	92.2%	5.6%	2.2%
Emergency Outpatient Facility (99281-99285, 99291-99292)	92.8%	5.0%	2.2%			
Emergency Ground Ambulance (A0425, A0427, A0429, A0432-A0434)	13.8%	42.5%	43.7%			
Total Sample	92.2%	4.9%	2.9%	90.2%	6.5%	3.3%

*Total sample network composition applying HCCI provider categorization includes the CPT-based definitions for emergency outpatient facility and emergency ground ambulance.

eAppendix B. Status Quo Emergency Ground Ambulance Commercial Payment to Medicare Payment Ratio

We were unable to identify recent estimates of the ratio of commercial allowed amounts to Medicare allowed amounts for emergency ground ambulance services, so we computed our own estimates using 2017 HCCI commercial claims and the Centers for Medicare and Medicaid Services' (CMS) *Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use Files* for calendar year 2017.¹ The following HCPCS Codes were included in the analysis:

1. A0427 – Advanced Life Support Level 1, emergency transport
2. A0429 – Basic Life Support, emergency transport
3. A0432 - Paramedic Intercept (PI), rural area transport furnished by a volunteer ambulance company
4. A0433 – Advanced Life Support Level 2
5. A0434 - Specialty Care Transport (SCT)

First, we computed the average ratio of allowed amounts to charges for both commercial and Medicare services using the HCCI and CMS data, weighting by claim volume. We calculated that the average Medicare allowed amount to charge ratio is 0.418 and the average commercial allowed amount to charge ratio is 0.710. In other words, on average, Medicare pays 41.8% of billed charges and commercial health plans pay 71.0% of billed charges for emergency ambulance services.

Then, applying these values, we estimated the ratio of commercial allowed amounts to Medicare allowed amounts as:

$$\begin{aligned} & (\text{commercial allowed amount/commercial charge})/(\text{Medicare allowed amount/Medicare charge}) \\ & = 0.710 / 0.418 \\ & = 1.70 \end{aligned}$$

We concluded that commercial health plans have allowed amounts roughly 170% of Medicare allowed amounts, and we employed this status quo value in our estimates of policy impact on insurance premiums.

¹ Medicare provider utilization and payment data: physician and other supplier. CMS. Updated November 19, 2019. Accessed January 10, 2020. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier>

COSTS & SPENDING

By Erin L. Duffy, Loren Adler, Paul B. Ginsburg, and Erin Trish

Prevalence And Characteristics Of Surprise Out-Of-Network Bills From Professionals In Ambulatory Surgery Centers

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ABSTRACT Patients treated at in-network facilities can involuntarily receive services from out-of-network providers, which may result in “surprise bills.” While several studies report the surprise billing prevalence in emergency department and inpatient settings, none document the prevalence in ambulatory surgery centers (ASCs). The extent to which health plans pay a portion or all of out-of-network providers’ bills in these situations is also unexplored. We analyzed 4.2 million ASC-based episodes of care in 2014–17, involving 3.3 million patients enrolled in UnitedHealth Group, Humana, and Aetna commercial plans. One in ten ASC episodes involved out-of-network ancillary providers at in-network ASC facilities. Insurers paid providers’ full billed charges in 24 percent of the cases, leaving no balance to bill patients. After we accounted for insurer payment, we found that there were potential surprise bills in 8 percent of the episodes at in-network ASCs. The average balance per episode increased by 81 percent, from \$819 in 2014 to \$1,483 in 2017. Anesthesiologists (44 percent), certified registered nurse anesthetists (25 percent), and independent laboratories (10 percent) generated most potential surprise bills. There is a need for federal policy to expand protection from surprise bills to patients enrolled in all commercial insurance plans.

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Patients treated at facilities in their insurer’s provider network can involuntarily receive services from out-of-network physicians and other service providers. In these scenarios, the out-of-network provider submits full billed charges to the patient’s insurer, and the insurer may allow all or part of the provider’s charges. Providers not paid in full by the insurer can send a bill to the patient for the balance. These bills, which are typically unexpected by patients, have been termed “surprise” out-of-network bills.

Previous studies have documented the prevalence of episodes that are likely to result in surprise bills in the emergency department (ED)

and inpatient settings, but their prevalence at ambulatory surgery centers (ASCs) is relatively unexplored.^{1–4} The number of ASC facilities in the United States increased from 1,000 in 1988 to 5,400 in 2015.⁵ The volume of services provided in ASCs has grown over time, as new facilities have entered the market.^{6–8} For example, the proportion of cataract surgeries performed in ASC facilities, in lieu of outpatient hospital settings, grew from 44 percent in 2001 to 73 percent in 2014.⁶ In our data set, 5 percent of commercially insured adults used ASC services each year—the same utilization rate as that for inpatient hospital services.⁹ Numerous studies have shown that for same-day elective services such as colonoscopies, cataract surgeries, arthroscopies, and up-

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per gastrointestinal procedures, ASCs are lower cost and more efficient than hospital outpatient departments.^{6,7,10,11} Moreover, many ASC procedures involve out-of-network ancillary providers whom patients generally do not choose and thus cannot avoid. Therefore, understanding patients' risk of surprise bills in this setting is important.

This study provides evidence of the prevalence and magnitude of potential surprise bills in ASCs, including variation across different types of clinicians, facilities, and insurance products. We also quantify health plan reimbursement to out-of-network providers. This reimbursement is an important factor in the likelihood of an individual plan member's receiving a surprise bill, as plans that pay out-of-network providers in full shield patients from surprise bills. However, a health plan's total expenditures are inflated when it reimburses out-of-network providers' full billed charges (which are typically much higher than negotiated rates), both directly and because doing so increases a provider's leverage to demand high in-network rates in the future. These inflated costs are then shared by all plan members through higher premiums. This is an understudied aspect of surprise medical bills, and our analysis provides important insights in this regard.

Study Data And Methods

DATA We evaluated Health Care Cost Institute commercial claims data for the period 2014–17, which comprised claims from three of the five largest US insurers: Aetna, Humana, and UnitedHealth Group. The data included more than forty million covered lives in each year.¹² Importantly, the claims data include a network status indicator for both facility and professional claims, actual prices paid for in- and out-of-network services (allowed amounts), provider charges, and patient cost-sharing information, which enabled us to determine the prevalence and magnitude of potential surprise out-of-network balance bills.

We included claims paid as primary in our analysis, because it is not possible to determine whether there was an unpaid balance when observing claims from a secondary insurer. We also included only commercial claims, because balance billing is largely prohibited in Medicare Advantage.¹³

ANALYTIC APPROACH We constructed episodes of care by matching ASC facility claims with all professional claims for the same patient on the same day. We excluded patients with another facility visit or physician office visit claim within one day of the ASC visit to prevent the overmatch-

ing of unrelated professional claims to an ASC visit.

We could not identify from the claims data whether out-of-network clinicians actually sent a surprise balance bill to patients, so we could not directly measure the prevalence of such bills. Instead, following prior work, we defined an episode as one that would be likely to lead to a surprise out-of-network bill if the patient was treated at an in-network ASC and seen involuntarily by one or more ancillary, or secondary, out-of-network providers.¹ (We considered a patient's out-of-network use voluntary if the facility or one or more of its lead professionals was out of network.) We defined lead and ancillary professionals based on the procedure codes billed (our categorization of procedure codes is described in online appendix 1).¹⁴

We further restricted our definition of potential surprise bill scenarios to the subset of scenarios in which the charges of out-of-network ancillary and secondary professionals exceeded the insurer's allowed amount, since when the charges are paid in full, there is no balance bill to the patient. Specifically, we determined whether there was a potential balance bill at the professional claim level by subtracting the sum of allowed amounts from the sum of billed charges separately for each professional who provided out-of-network services during an ASC visit. If the balance was zero, then the professional was paid in full, and there was no possible balance to bill. If the balance was greater than zero, we considered this a potential surprise billing scenario.

We calculated the prevalence of ASC episodes likely to generate surprise bills and the magnitude of the potential balances billed overall and for different types of providers and health plans. All dollar amounts are expressed in nominal dollars (unadjusted for inflation). We used chi-square tests to compare the percentages of involuntary out-of-network services paid in full between self-funded and fully insured health plans. Analyses were conducted using SAS, version 9.4.

LIMITATIONS Our study had several limitations. First, as described above, in the administrative insurance claims data, we could not observe balance bills sent directly from out-of-network professionals to patients. Moreover, providers may ultimately write off some or all unpaid balances. Our estimates therefore represent the prevalence and magnitude of potential rather than actual surprise bills. This inability to directly observe balance billing limits all claims-based studies of surprise medical billing prevalence and magnitude, and we are not aware of any comprehensive data set of actual balance bills sent to patients.

Potential surprise bills are in addition to any cost sharing that the patient would face.

Second, we did not directly observe whether patients voluntarily chose to receive care from an out-of-network provider. While most patients do not choose their ancillary providers, and we restricted our definition to include only those patients who did not also have an out-of-network lead provider, we still could not be sure that the use of out-of-network care was indeed involuntary.

Finally, while our data represent a sizable share of the commercially insured population in the US, our findings are not necessarily generalizable to the overall commercial market. Our comparisons of the prevalence of potential surprise bills across different insurance product characteristics (appendices 4 and 5)¹⁴ may reflect differences in the composition of plan design and market share among the three insurers that contributed to our data set, rather than the product types in and of themselves. Notably, point-of-service plans were overrepresented in our analytical sample, relative to the national composition of insurance plan types.¹⁵ Moreover, because we did not observe claims for all of the patients who were treated by a given professional or facility, our calculations of the proportions of specific providers' caseloads that yielded a potential surprise bill were limited to the commercially insured population in our analytical sample.

Study Results

The analytical sample included approximately 4.2 million ASC-based episodes of care in 2014–17 that involved 3.3 million unique patients. Many episodes of care included services provided by anesthesiologists (47 percent), certified registered nurse anesthetists (17 percent), gastroenterologists (31 percent), orthopedists (12 percent), pathologists (10 percent), and independent laboratories (12 percent) (data not shown). Common procedures included colonoscopies and other gastrointestinal procedures, cataract surgery, and orthopedic procedures such as arthroscopy.

Our sample included episodes of care for enrollees in point-of-service plans ($n = 3,046,915$

episodes), preferred provider organizations (PPOs) ($n = 454,837$), health maintenance organizations (HMOs) ($n = 409,405$), exclusive provider organizations ($n = 212,676$), indemnity plans ($n = 34,241$), and other products ($n = 26,544$). Seventy-two percent of these enrollees were in self-funded plans, while 28 percent were enrolled in fully insured plans (data not shown).

In 76 percent of the observed episodes, patients were treated at in-network ASC facilities and received only in-network professional services (appendix 2).¹⁴ We were unable to identify the facility network status in 3 percent of the observed episodes. In 5 percent of the episodes, the facility was in network and no out-of-network professionals were observed, but at least one professional service was missing network status information. Patients were treated at out-of-network facilities in 5 percent of the episodes, and we estimated that patients voluntarily received out-of-network professional services at in-network facilities in an additional 1 percent of the episodes.

In 10 percent ($n = 419,621$) of the episodes in our analytical sample, patients were treated at in-network ASCs but involuntarily received care from out-of-network professionals. In 24 percent ($n = 102,774$) of those episodes, the insurer allowed the out-of-network professionals' full billed charges, leaving no additional balance to bill. After accounting for insurer-allowed amounts (including any patient cost sharing for out-of-network services), we found that patients were subject to a potential surprise out-of-network bill in 8 percent ($n = 316,847$) of all episodes in our analytical sample. The prevalence of potential surprise bills remained stable at 8 percent over the four-year study period (data not shown). Observed rates of potential surprise bills in our analytic sample varied across states, with the highest rate (15 percent) observed in Texas (appendix 3).¹⁴

The average charges for out-of-network providers in potential surprise billing cases were \$1,912 per episode, and the average allowed amount—including insurer payment and patient cost sharing—was \$771 (data not shown). Thus, the average remaining patient liability for these potential surprise bills from out-of-network professionals was \$1,141 per episode. Over the four-year study period, the amount increased by 81 percent, from \$819 in 2014 to \$1,483 in 2017 (exhibit 1).

PROVIDER CHARACTERISTICS Among the potential surprise out-of-network professional bills at in-network ASCs, most were generated by anesthesiologists (44 percent) or certified registered nurse anesthetists (25 percent) (exhibit 2).

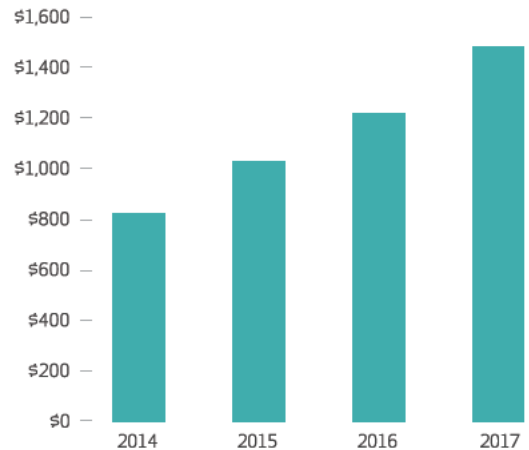
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Independent laboratories accounted for 10 percent of the bills, and pathologists accounted for an additional 3 percent. The provider type was not specified for 6 percent of professionals generating a potential surprise bill, as they were categorized as “unknown” (4 percent) and “other nonphysician provider” (2 percent). A smaller proportion of potential surprise bills were attributed to medical supply houses (2 percent), radiologists (1 percent), and family practice physicians (1 percent). All other specialties combined generated the remaining 8 percent of potential surprise bills.

The magnitude of average balances that could be billed to patients for their anesthesiologists and certified registered nurse anesthetists were \$946 and \$713, respectively (data not shown). The high share of potential surprise bills generated by these practitioners is due to both their high service volume in ASCs and their common out-of-network status. Anesthesiologists provided care in 46 percent of the episodes we observed at in-network ASCs and provided involuntary out-of-network services in 11 percent of these cases, generating possible surprise bills 8 percent of the time they provided care after we accounted for the 3 percent of instances in which insurers allowed amounts that equaled full billed charges (exhibit 3). Certified registered nurse anesthetists provided care in 17 percent of the observed episodes at in-network ASCs (data not shown), and they were involuntary out-of-network providers in 17 percent of these cases resulting in potential surprise bills in 13 percent of their cases at in-network ASC facilities, after

EXHIBIT 1

Mean potential surprise medical bill amounts incurred at ambulatory surgery centers, 2014–17

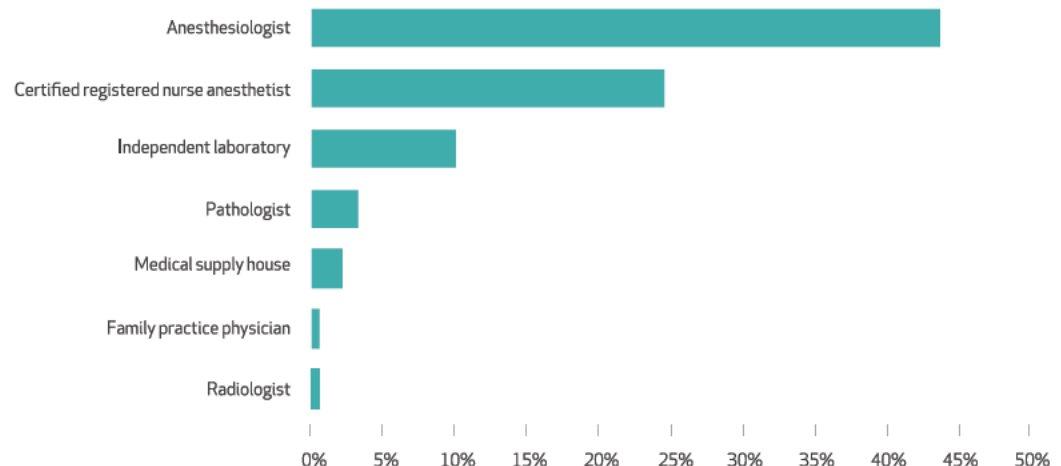


SOURCE Authors' analysis of commercial claims data for 2014–17 from the Health Care Cost Institute. **NOTE** Amounts are in nominal dollars.

we accounted for the 4 percent of instances where their charges were paid in full by the insurer (exhibit 3). Among the 12 percent of episodes at in-network ASCs that included independent lab services (data not shown), the lab was an involuntary out-of-network provider 10 percent of the time and yielded a potential surprise bill 7 percent of the time (exhibit 3). In contrast, both radiologists and pathologists generated a potential surprise bill in 3 percent of their observed cases at in-network ASCs.

EXHIBIT 2

Potential surprise medical bills incurred at ambulatory surgery centers, by provider type



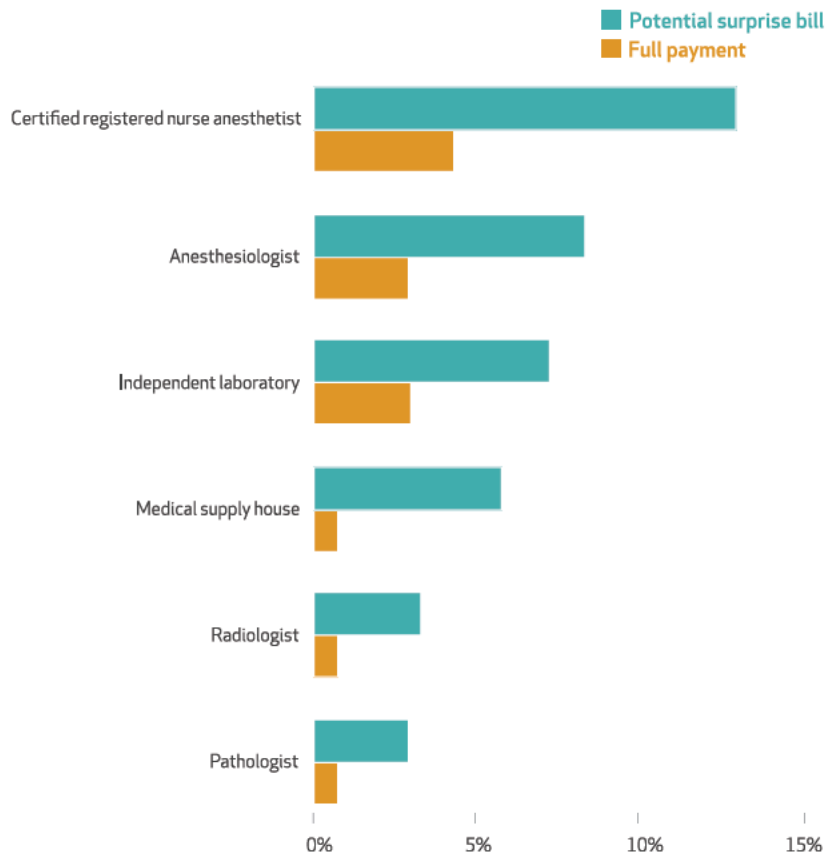
SOURCE Authors' analysis of commercial claims data for 2014–17 from the Health Care Cost Institute. **NOTE** Share of total potential surprise out of network professional bills at in-network ambulatory surgery centers generated by each provider type.

Most individual providers or provider groups, as identified by unique National Provider Identifiers (NPIs), did not generate any potential surprise bills. Twenty-one percent of potential surprise bills came from only 5 percent of NPIs, which performed only 3 percent of the ASC-based professional services we observed (data not shown). Seventy-five percent of anesthesiologist NPIs and sixty-eight percent of certified registered nurse anesthetist NPIs generated no potential surprise bills (exhibit 4). Eight percent of anesthesiologists generated a potential surprise bill more than half of the time when we observed them providing ASC-based care (exhibit 4), and these NPIs accounted for 38 percent of potential surprise bills from anesthesiologists but performed only 5 percent of the anesthesiology services (data not shown). Among certified registered nurse anesthetists, 11 percent of NPIs accounted for 43 percent of potential surprise bills for certified registered nurse anesthetist services and performed just 8 percent of those services. Similarly, out-of-network professionals practicing at in-network ASCs appeared to be concentrated in a small share of facilities. We observed no potential surprise billing scenarios in our four-year sample at 74 percent of ASC facility NPIs. Only 7 percent of ASCs generated a potential surprise bill in over half of the episodes we observed at them in our analytic sample: They accounted for just 2 percent of the episodes, but 19 percent of the potential surprise bills resulted from care at these facilities.

INSURER CHARACTERISTICS Involuntary exposure to out-of-network professional services at in-network ASCs was similar for patients enrolled in self-funded and fully insured plans. However, self-funded plans paid out-of-network professionals' full billed charges significantly more often than fully insured plans did (27 percent versus 18 percent; $p < 0.0001$) (appendix 4).¹⁴ Thus, after plan payments were accounted for, patients in self-funded plans experienced a lower rate of potential surprise bills (8 percent), compared to those in fully insured plans (9 percent). A higher rate of payment in full by self-funded plans was consistently observed across plan types (HMOs, PPOs, and point-of-service plans). Moreover, conditional on plan type, the average magnitude of the potential patient liability for a surprise bill—or the balance between charges and allowed amounts—was more than \$100 greater in fully insured plans than in self-funded plans. While we observed some variation in both the prevalence and the magnitude of potential surprise bills across plan types and market segments (appendix 5),¹⁴ we note that those differences may reflect the plans in our particular analytic sample and are not necessarily

EXHIBIT 3

Percent of in-network ambulatory surgery center episodes with a potential surprise medical bill and with full payment, by provider type



SOURCE Authors' analysis of commercial claims data for 2014–17 from the Health Care Cost Institute. **NOTES** For each provider type, percent is calculated using only the subset of in-network ambulatory surgery center episodes that involved care from that type of provider. Full payment means that out-of-network professionals used involuntarily by patients were paid in full by the insurer.

ily representative of those plan types in the broader market.

Discussion

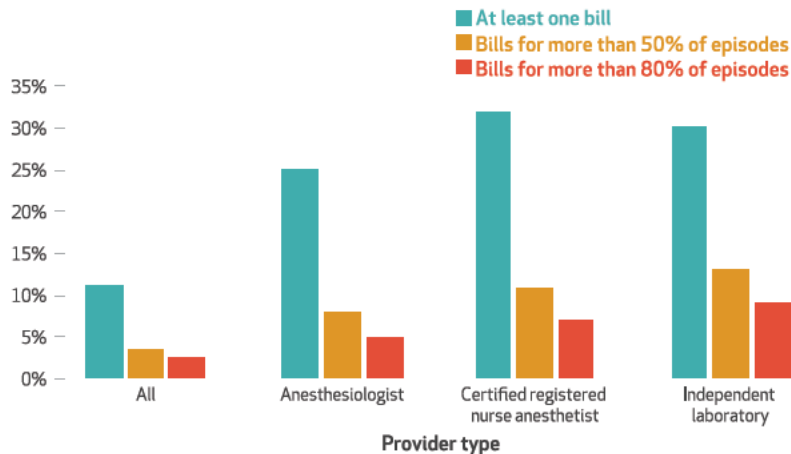
Patients who received care at in-network ambulatory surgery centers were involuntarily treated by out-of-network providers in one in ten episodes. However, in one-quarter of those cases, the insurer's allowed amount (what the insurer paid plus any patient cost sharing) was equal to the provider's full billed charges, thus eliminating the potential for a surprise bill. If the insurer allows providers' full billed charges and eliminates the potential for a surprise bill, those costs—which can be substantial, given the very high billed charges from ancillary clinicians—are then typically borne by all health plan enrollees through higher premiums.

After we accounted for the insurer's allowed amount, commercially insured patients ap-

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EXHIBIT 4

Percent of providers at ambulatory surgery centers with any potential surprise bills, by provider type and share of episodes with bills



SOURCE Authors' analysis of commercial claims data for 2014–17 from the Health Care Cost Institute. **NOTE** Unique providers were identified by National Provider Identifier, which may represent a single provider or a group of providers.

peared at risk of receiving a potential surprise bill in 8 percent of ASC-based episodes of care, predominantly from anesthesiologists and certified registered nurse anesthetists. Such patients could be liable for a balance bill with an average magnitude of \$1,141 over our four-year study period. The mean magnitude of potential surprise bills in our analytical sample increased by 81 percent over the study period, from \$819 in 2014 to \$1,483 in 2017. Over the same period, by comparison, the Health Care Cost Institute reports that total coinsurance, copayments, deductibles, and health plan payments per person for medical care and pharmaceuticals among the US population who were ages 0–64 and covered by employer-sponsored insurance grew by 13 percent, from \$4,974 in 2014 to \$5,641 in 2017.¹⁶ This finding indicates that there is a need for swift policy action to protect patients from surprise billing.

Moreover, potential surprise bills are in addition to any cost sharing that the patient would face, which can be a high percentage of the insurer's allowed amount—particularly for out-of-network services. Unexpected medical bills of these magnitudes would be a financial hardship for most US households. The 2016 Survey of Consumer Finances found that 26 percent of multiperson households and 36 percent of single-person households do not have sufficient liquid assets to cover an unexpected \$1,000 expense.¹⁷

Several previous studies of commercial claims data have measured the prevalence of potential

surprise bills in emergency and inpatient settings, and their findings provide reference points for considering the relative risk of possible surprise bills across care settings. Christopher Garmon and Benjamin Chartock used Truven Health MarketScan data for 2007–14 to estimate that involuntary out-of-network services were provided at in-network facilities in 9 percent of elective inpatient admissions, 14 percent of outpatient emergency visits, and 20 percent of inpatient admissions originating in the ED.¹ Zack Cooper and Fiona Scott Morton reported that one in five ED visits in 2014–15 by beneficiaries of a single large insurer involved out-of-network physicians at in-network facilities, with average potential surprise bills of \$623.² A 2019 analysis by the Health Care Cost Institute also found that 15 percent of inpatient admissions involved an out-of-network professional at an in-network facility, although some of these professionals may have been selected voluntarily by the patient.³

Our finding that 10 percent of ASC episodes involved an involuntary out-of-network provider is similar to the 9 percent prevalence of involuntary out-of-network providers in elective inpatient episodes reported by Garmon and Chartock.¹ Both of these estimates, which are generally for elective procedures, are somewhat lower than the prevalence of potential surprise bills in ED and inpatient admissions originating in the ED, which are more likely to be non-elective, urgent, or emergent care. The average magnitude of the potential patient liability for a surprise bill that we observed in ASCs in 2014–17 (\$1,141) is nearly double the average balance documented for emergency physician services by Cooper and Scott Morton, although that estimate appears to include only emergency physician charges (rather than all out-of-network professional charges incurred during the emergency episode), and the potential balance was calculated in a different way.¹⁸ Our finding that most potential surprise bills were generated by a small share of providers was consistent with a previous study of out-of-network billing for emergency services.¹⁹

To our knowledge, the impact of health plan reimbursement for out-of-network professional services on mitigating the potential for surprise bills has not previously been systematically analyzed. Our finding that billed charges are paid in full for one-quarter of the episodes involving out-of-network professionals at in-network ASCs suggests that it is not uncommon for health plans to pay providers' charges in full (with patient cost sharing included), potentially as a way to protect patients from surprise bills. Our finding that self-funded plans tend to pay full billed

There is a need for federal policy to expand protection from surprise bills to all states and to enrollees in all commercial insurance plans.

charges more frequently than fully insured plans do suggests that this strategy may be more common among self-funded employers. As a result, people in fully insured plans face a higher risk of possible surprise billing. While enrollees in self-funded plans are at lower risk of potential surprise billing, they are collectively sharing the cost of paying out-of-network providers' full billed charges in their premiums.

Some patients may also be protected from surprise bills by state policies that prohibit them—although these policies generally apply only to fully insured plans, because states cannot regulate self-funded plans as a result of preemption under the Employee Retirement Income Security Act (ERISA) of 1974. In the first year of our study, only Colorado, Illinois, and New Jersey had policies in place to protect patients from surprise

bills in ASCs (appendix 6).¹⁴ Five additional states (California, Connecticut, Florida, New York, and Oregon) implemented such policies during the remainder of our study period.

We estimate that in 2019, state policies addressing surprise bills at ASCs protected 18 percent of the nation's commercially insured population. There is a need for federal policy to expand protection from surprise bills to all states and to patients enrolled in all commercial insurance plans. Our finding that the prevalence of potential surprise bills in ASCs is similar to that in elective outpatient settings demonstrates the importance of including ASC-based care in the scope of services protected by future policies. Furthermore, our observation that the mean magnitude of potential surprise bills increased by 81 percent from 2014 to 2017 indicates that this form of out-of-pocket health care spending liability is growing rapidly, and there is an urgent need for policy action.

Conclusion

Among a large national sample of commercially insured patients, one in twelve patients who received care at an in-network ambulatory surgery center were at risk of receiving a surprise out-of-network professional bill. The average magnitude of potential surprise bills increased by 81 percent in the period 2014–17, reaching an average potential patient liability of \$1,483. Most potential surprise bills at ASCs were generated by anesthesiologists or certified registered nurse anesthetists and were concentrated among a minority of physicians and facilities. Federal policy is needed to address surprise billing and help protect patients from large surprise bills. ■

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2019, and the Annual Conference of the Association for Public Policy Analysis and Management in Denver, Colorado,

November 8, 2019. This research was funded by Arnold Ventures. [Published online April 15, 2020.]

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HOSPITALS

By Zack Cooper, Hao Nguyen, Nathan Shekita, and Fiona Scott Morton

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Out-Of-Network Billing And Negotiated Payments For Hospital-Based Physicians

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ABSTRACT When physicians whom patients do not choose and cannot avoid can bill out of network for care delivered within in-network hospitals, it exposes patients to financial risk and undercuts the functioning of health care markets. Using data for 2015 from a large commercial insurer, we found that at in-network hospitals, 11.8 percent of anesthesiology care, 12.3 percent of care involving a pathologist, 5.6 percent of claims for radiologists, and 11.3 percent of cases involving an assistant surgeon were billed out of network. The ability to bill out of network allows these specialists to negotiate artificially high in-network rates. Out-of-network billing is more prevalent at hospitals in concentrated hospital and insurance markets and at for-profit hospitals. Our estimates show that if these specialists were not able to bill out of network, it would lower physician payments for privately insured patients by 13.4 percent and reduce health care spending for people with employer-sponsored insurance by 3.4 percent (approximately \$40 billion annually).

Hospitals and physicians independently negotiate payment terms and network participation agreements with private insurers. As a result, it is possible for a commercially insured patient to be treated at an in-network hospital by a physician who is out of network with the patient's insurer. Various types of physicians work at hospitals and are not chosen and therefore cannot reasonably be avoided by patients, such as emergency department (ED) physicians, anesthesiologists, pathologists, radiologists, and assistant surgeons. When these physicians can bill out of network and cannot be avoided by patients, it undercuts the functioning of health care markets, raises health care costs, and exposes patients to significant financial risk.

A few states have enacted meaningful legislation to address out-of-network billing, other states are currently pursuing such legislation,

and several relevant bills are circulating in Congress.¹ However, more research is needed to understand how out-of-network billing is affecting consumers, where it is occurring, and the extent to which it is influencing the bargaining process between physicians and insurers.

Researchers have shown that more than 20 percent of in-network ED visits involve care from an out-of-network physician.^{2,3} While most observers focus on the impact of out-of-network billing on patients' out-of-pocket spending, Zack Cooper and colleagues (three of this article's coauthors) observed that the ability to bill out of network allows ED physicians to be paid in-network rates that are significantly higher than those paid to other specialists who cannot readily bill out of network.⁴ These higher payments get passed along to all consumers (including those who do not even access care) in the form of higher insurance premiums.

However, ED physicians are by no means the

only category of practitioners who face inelastic demand in the short run for their services (meaning that demand for their services does not vary with price). In this study we used data from a large commercial insurer that covers tens of millions of lives to explore the rates that anesthesiologists, pathologists, radiologists, and assistant surgeons bill out of network. Previous work in *Health Affairs* has identified the frequency with which patients receive out-of-network bills in these specialties.² We extended that analysis by analyzing whether out-of-network billing is concentrated in certain groups of hospitals, observing the conditional correlates of the rates of out-of-network billing at hospitals, and identifying the influence of the ability to bill out of network on in-network payments and total health care spending. We also describe the arguments for and against four policy options to address out-of-network billing.

Why would hospitals allow physicians who bill out of network to work inside their facilities when it likely exposes patients to financial risk and produces reputational harm? Cooper and coauthors⁴ found evidence that out-of-network providers offer transfers that bring economic benefits to hospitals that offset the hospitals' costs. These transfers can include waiving staffing fees or engaging in clinical behavior, such as ordering more imaging studies, that raises facility spending. As a result, a hospital can gain monetarily from allowing surprise billing. Given that, theory predicts that for-profit hospitals will be more likely than nonprofit or government hospitals to have providers who bill out of network working within their facilities.⁴ Compared to nonprofits, for-profit hospitals likely put a higher value on profits relative to patient welfare.⁵ In addition, hospitals in concentrated markets will presumably be less exposed to reputational harm generated by out-of-network billing (because patients have few alternative locations for care). As recent press accounts illustrate, the reputational harm physicians receive from out-of-network billing can be substantial.^{6,7} We explored these hypotheses.

Study Data And Methods

CONSTRUCTION OF ANALYTIC SAMPLE We analyzed data for 2015 provided by a large commercial insurer that covers tens of millions of lives, collectively, in all fifty states and the District of Columbia. We focused on insurance claims for people younger than age sixty-five with employer-sponsored coverage in fully insured and administrative services only (ASO) plans (plans in which the insurer administers the plan but does not bear financial risk). We analyzed care deliv-

ered at in-network hospitals that involved services rendered by anesthesiologists, pathologists, radiologists, or assistant surgeons, which we identified using the clinical codes on each physician claim (details about the codes are in online appendix A).⁸ We chose these specialties because, along with ED physicians (which we have studied), these are physicians who are hospital based and not chosen by patients.

Our data set included a flag for whether the services on a physician claim were rendered by an out-of-network provider. We identified physicians' in-network payments as the sum of the patient and negotiated insurer contributions (the allowed amounts). Unfortunately, consistent with previous research in this area, we did not have data on what physicians were able to collect from patients beyond the usual cost sharing (for example, we did not observe whether patients were sent or paid a balance bill).

ANALYSIS We present physician charges and in-network payments as percentages of Medicare Part B physician payments. We compared private prices to Medicare payments because the latter are designed by the Centers for Medicare and Medicaid Services (CMS) to approximate the costs of providing care across regions (although CMS's calculations may be imperfect). Our calculation of payments as a percentage of Medicare Part B payments considered the geographic location where care was delivered and adjusted for the work relative value unit (RVU) of each service, the practice expenses RVU, and the malpractice insurance RVU that were specific to a provider's address. All payments were adjusted using the geographic practice cost indexes and the relevant conversion factor, based on the CMS payment rules for 2015.⁹ We measured patients' potential balance bill as the difference between physician charges and median in-network payments (as a percentage of Medicare payments).

We limited our analysis to cases of care delivered at in-network hospitals that were registered with the American Hospital Association, had delivered more than ten cases per specialty in our study, and were not critical access hospitals. We defined a case as the span of time from hospital entry to exit. To avoid idiosyncratically expensive or inexpensive observations, we winsorized the top and bottom 1 percent of physician charges and physician in-network payments (although our results were robust to not winsorizing). We also excluded cases whose claims did not have both facility and physician payments, observations in which patients had coordinated medical benefits, and cases in which the same physician billed as both in and out of network.

We also examined the conditional correlates of the share of out-of-network care delivered at each

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hospital. To do this, we carried out ordinary least squares regression in which the dependent variable was the share of out-of-network cases by hospital. We merged data on hospital concentration used by Cooper and coauthors;¹⁰ insurer market concentration from Decision Resources Group's Managed Market Surveyor Suite database;¹¹ and local area characteristics from Opportunity Insights,¹² the Census Bureau, and the Area Health Resources Files of the Health Resources and Services Administration. We measured hospital concentration by creating indicator variables for whether a hospital was in a monopoly, duopoly, or triopoly market (based on the count of hospitals within a fifteen-mile circular area drawn around each hospital). We measured Herfindahl-Hirschman Indexes to capture insurance market concentration by county.¹³

The standard errors in our regression were clustered around hospitals. The continuous independent variables were scaled so that they had a mean of 0 and a standard deviation of 1. As a result, the point estimates on continuous variables show the effect of a one-standard-deviation change in those variables.

This project was deemed exempt by the Yale University Social Sciences Institutional Review Board.

LIMITATIONS There were four core limitations to this work. First, we analyzed data from a single large commercial insurer. As a result, we were analyzing a sample of privately insured claims. However, previous analyses of the frequency of out-of-network billing by ED physicians using this database (for example, that by Cooper and Fiona Scott Morton)³ produced results that were very similar to those of a later analysis by Christopher Garmon and Benjamin Chartock² that was carried out on wholly separate data.

Second, we did not observe whether patients received balance bills directly from the out-of-network physicians who treated them. As a result, while we could estimate patients' potential out-of-pocket spending exposure, we could not know precisely what costs patients were exposed to when they were treated by an out-of-network provider. To our knowledge, there are no data sets that systematically capture the amounts of patients' balance bills.

Third, we estimated the associations between hospital and local area characteristics and the frequency with which hospitals had out-of-network specialists working from their facilities. These results should not be read as causal.

Fourth, for our policy counterfactuals, we assumed that the driver of differentially high in-network prices for the four groups of physicians we studied was their ability to bill out of network. This is consistent with the empirical work and

theory developed by Cooper and coauthors.⁴ However, there could be other drivers of these differences—for example, supply-side characteristics such as physicians per capita.

Study Results

Our analytic data set, described in appendix exhibit 1,⁸ included 606,128 hospital-based cases involving anesthesia services, 420,800 cases involving pathology services, 2,890,017 cases that included a radiologist claim, and 37,252 cases that involved an assistant surgeon. More than 99.5 percent of the cases in our data set with care delivered at a hospital involved care that was delivered at an in-network hospital. Approximately 73.2 percent of cases involved a beneficiary enrolled in an ASO insurance plan.

In exhibit 1 we show the distribution of cases delivered at in-network hospitals that involved an out-of-network anesthesiologist, pathologist, radiologist, assistant surgeon, or orthopedist performing knee replacements. Orthopedists performing knee replacements can generally be chosen (or avoided) in advance by patients, so they served as the reference specialty in this analysis. The mean share of cases involving an out-of-network physician were 11.8 percent for anesthesiologists, 12.3 percent for pathologists, 5.6 percent for radiologists, and 11.3 percent for assistant surgeons. By contrast, the mean share of cases where out-of-network orthopedists performed knee replacements from in-network hospitals was less than 1 percent.

A key finding from our analysis is that out-of-network billing was concentrated in a minority of hospitals. Indeed, for anesthesiologists, 46.2 percent of patients at hospitals in the ninetyth percentile of the out-of-network billing distribution were treated by an out-of-network anesthesiologist. The analogous numbers were 50.0 percent for pathologists, 13.2 percent for radiologists, and 35.7 percent for assistant surgeons. By contrast, hospitals with less than 2 percent out-of-network billing for anesthesiologists, for example, made up 64 percent of the hospitals in our sample (data not shown).

Physicians with the ability to bill out of network without losing patient volume are able to negotiate significantly higher in-network payments from insurers, compared to physicians without a strong outside option. For example, on average, orthopedists performing knee replacements were paid 164 percent of Medicare rates (exhibit 1). By contrast, in-network rates were 367 percent of Medicare rates for anesthesiologists, 343 percent for pathologists, 195 percent for radiologists, and 176 percent for assistant surgeons.

EXHIBIT 1**Out-of-network billing frequency, in-network physician payments, out-of-network physician charges, and potential balance bills, by physician specialty, 2015**

	Mean	SD	Percentile			
			25th	50th	75th	90th
Frequency of out-of-network billing at in-network hospitals (%)						
Anesthesiologists	11.8	24.4	0.0	0.0	9.4	46.2
Pathologists	12.3	25.6	0.0	0.0	8.8	50.0
Radiologists	5.6	17.7	0.0	0.0	0.9	13.2
Assistant surgeons	11.3	18.2	0.0	2.8	15.8	35.7
Orthopedists performing knee replacements ^a	0.9	4.5	0.0	0.0	0.0	0.0
In-network physician payments (% of Medicare payments)						
Anesthesiologists	367	166	271	327	430	532
Pathologists	343	399	133	212	399	698
Radiologists	195	98	132	175	225	312
Assistant surgeons	176	244	106	132	180	274
Orthopedists performing knee replacements ^a	164	80	120	147	189	257
Out-of-network physician charges (% of Medicare payments)						
Anesthesiologists	802	560	478	638	903	1,408
Pathologists	562	576	211	384	699	1,203
Radiologists	452	251	313	398	528	732
Assistant surgeons	2,652	3,519	659	1,561	3,091	6,219
Potential balance bills from seeing an out-of-network physician (\$) ^b						
Anesthesiologists	1,171	1,551	321	648	1,336	2,979
Pathologists	177	317	0	69	195	469
Radiologists	115	158	24	58	133	303
Assistant surgeons	7,420	10,578	1,028	3,134	8,562	23,419

SOURCE Authors' analysis of data for 2015 from a large commercial insurer. **NOTES** The percentiles are those of the distribution of the variable in the row. Bills are calculated at the hospital level for frequency of out of network billing at in network hospitals and at the case level (defined in the text) in the rest of the exhibit. SD is standard deviation. ^aPrices for orthopedists represent the average in network rates for knee replacements, expressed as a percentage of Medicare rates under Part B. ^bDifference between physician charges and median in network payments.

In the event that a patient's insurer does not cover care delivered by an out-of-network provider, physicians will seek to collect their charges directly from patients. Mean out-of-network physician charges were 802 percent of Medicare payments for anesthesiologists, 562 percent for pathologists, 452 percent for radiologists, and 2,652 percent for assistant surgeons (exhibit 1)—or \$2,130, \$311, \$194, and \$7,889, respectively (data not shown).

Recall that we calculated a potential balance bill as the difference between physician charges and median in-network payments (164 percent of Medicare payments). Based on these calculations, balance bills can be substantial. We estimated that the mean potential balance bills for anesthesiologists, pathologists, radiologists, and assistant surgeons were \$1,171, \$177, \$115, and \$7,420, respectively.

Appendix exhibit 2 contains maps with the share of out-of-network billing physicians per hospital referral region, by specialty.⁸ As the maps illustrate, there was heterogeneity in the frequency of out-of-network billing by specialty across regions. However, across all specialties, the share of out-of-network billing was highest in

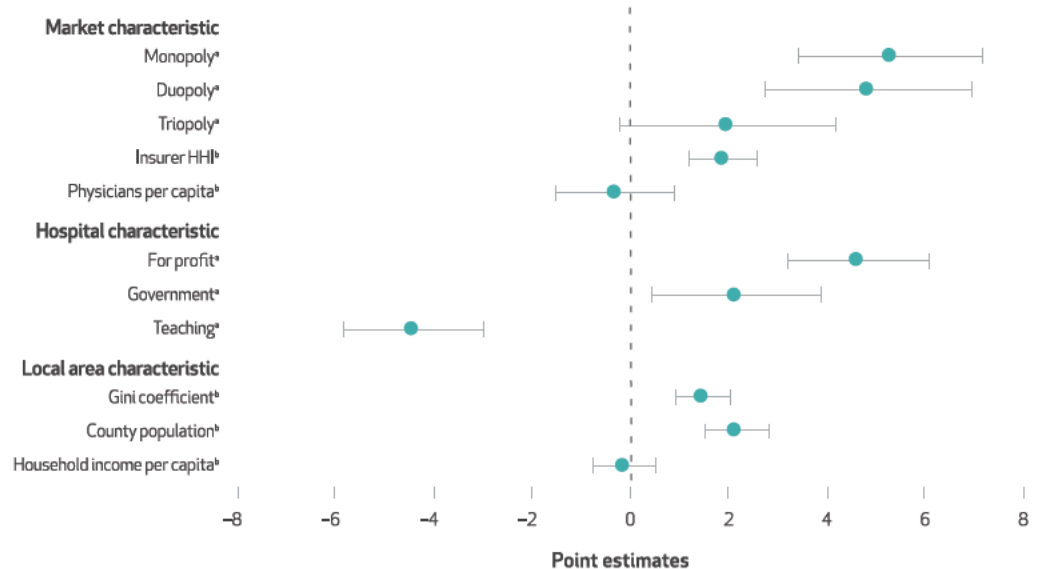
Alabama, Idaho, Mississippi, and Montana.

Exhibit 2 shows the conditional correlates of the share of out-of-network physicians per hospital. Descriptive statistics for each variable in the regression are in appendix exhibit 3.⁸ Relative to hospitals in quadropoly or less concentrated markets, hospitals in monopoly and duopoly markets had a higher share of out-of-network providers. Indeed, the share of out-of-network billing increased monotonically as hospital concentration increased. Across the hospital-based out-of-network specialists we studied, the mean hospital had 10.1 percent of specialists that were out of network (appendix exhibit 3).⁸ The prevalence of out-of-network specialist billing at monopoly hospitals was 5.3 percentage points higher than it was at hospitals in quadropoly markets (exhibit 2). By contrast, we observed that the share of out-of-network billing at hospitals increased as insurance market concentration increased. These results were robust to measuring hospital concentration using Herfindahl-Hirschman Indexes calculated in hospital markets defined using fixed and variable radii, following the approach described in appendix C1 of Cooper and coauthors.¹⁰ These results were

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EXHIBIT 2

Correlations between hospitals' selected characteristics and frequency of out-of-network billing



SOURCE Authors' analysis of data for 2015 from a large commercial insurer. **NOTES** The exhibit shows the point estimates from an ordinary least squares regression of the frequency of hospital level out of network billing on key variables. Each observation is the hospital specialty frequency of out of network billing. The standard errors are clustered around hospitals. The error bars indicate 95% confidence intervals. For hospital concentration (monopoly, duopoly, and triopoly), the reference category is quadropoly or more concentrated markets. (As a point of reference, the mean hospital in our study had 10.1 percent of specialists that were out of network.) For for-profit and government hospitals, the reference category is nongovernment nonprofit hospitals. HHI is Herfindahl Hirschman Index. ^aBinary variables. The point estimate illustrates the impact of having the variable take a value of 1. ^bContinuous variables. The point estimates can be interpreted as the percentage point change in out of network billing for an increase in the explanatory variable of one standard deviation.

also robust when we looked at the unconditional correlations.

Consistent with our predictions, relative to nonprofit hospitals, for-profit hospitals had 4.6 percentage points more out-of-network providers, from a base of 10.1 percent (exhibit 2). For-profit hospitals have an incentive to take a share of the profits earned from physicians' surprise billing. We also observed that hospitals located in areas with more economic inequality, measured using Gini coefficients (which measure the dispersion of income in an area, with a higher coefficient implying greater inequality), had higher shares of out-of-network providers.¹⁴

To give a rough estimate of the savings that could be achieved by eliminating the ability of these four types of specialists to readily bill out of network, we simulated what would happen if all of these specialists received the same average payments as orthopedic surgeons did (164 percent of Medicare rates). An important caveat is that this simulation ignored general equilibrium effects. For example, lowering physician payments could affect the amount of care provided or the number of physicians per capita. Also, setting physician payment rates below market

rates could cause an offsetting increase in insurers' payments to facilities.

Spending on anesthesiologists, pathologists, radiologists, and assistant surgeons in our data accounted for 6.8 percent, 14.0 percent, 16.3 percent, and 0.8 percent of total physician spending, respectively (data not shown). We estimated that if these physicians were paid the same average rate as orthopedists for all of the services that they delivered in our sample, spending would be lowered on anesthesiologists by 53.5 percent, on pathologists by 47.4 percent, on radiologists by 16.3 percent, and on assistant surgeons by 46.2 percent (details about how to calculate these numbers are in appendix C).⁸ Therefore, a policy change that affected these four specialties and reduced their in-network payments to 164 percent of Medicare rates would result in a total reduction in physician spending of 13.4 percent. Given that physician spending accounts for approximately 25 percent of total health care spending,¹⁵ savings of this magnitude would lower total spending for people with employer-sponsored insurance by approximately 3.4 percent (or approximately \$40 billion annually).¹⁶ Paying these specialists 150 percent of Medicare

rates would reduce physician spending by 15.5 percent.

Discussion

Patients receiving care at in-network hospitals have a significant risk of being treated by out-of-network anesthesiologists, pathologists, radiologists, or assistant surgeons. Because these physicians have a strong outside option in negotiations, they are able to negotiate high in-network payments with insurers. We found that for-profit hospitals and hospitals located in concentrated markets had a higher incidence of out-of-network providers.

There are three potential outcomes when a patient is treated by an out-of-network provider. First, the insurer can refuse to cover the physician's bill in its entirety. As we illustrated, if patients are exposed to the entirety of physician charges, this can mean bills of hundreds or thousands of dollars. Indeed, the median charge for an assistant surgeon in our data was \$3,134. Second, the insurer can pay the out-of-network policyholder some standard rate (for example, its median in-network rate). Above, we showed that even if insurers paid physicians their median in-network payment, physicians could balance bill patients for significant amounts of money (the median potential balance bill for patients treated by an out-of-network anesthesiologist was \$648). Finally, the insurer can cover an out-of-network physician's charges in their entirety. However, these higher payments will likely be passed along to all consumers in the form of higher insurance premiums.

Most of the attention on out-of-network billing has been focused on patients' exposure to large, unexpected out-of-pocket spending.¹⁷ While this attention is warranted, the impact of out-of-network billing on total health care spending is also problematic. When physicians whom patients do not choose and cannot avoid can bill out of network while working within hospitals that are in network with their patients' insurers, it strengthens physicians' outside options in negotiations with insurers and raises in-network payment rates. These higher in-network payments get passed along to all consumers in the form of higher insurance premiums.

To illustrate the scale of the increase in total spending created by the ability of certain physician specialists to bill out of network, we estimated the savings that would be produced if anesthesiologists, pathologists, radiologists, and assistant surgeons were paid the same in-network rates (as a percentage of what Medicare pays for their services) as orthopedic surgeons were paid for performing in-network knee re-

placement. We estimated that if policies were introduced that precluded these four physician specialties from billing out of network and thus lowered their in-network payments to 164 percent of Medicare payments, the savings would equal 13.4 percent of physician spending and 3.4 percent of spending for people with employer-sponsored insurance. For reference, it has been estimated that approximately \$1.2 trillion was spent on people with commercial health insurance in 2017.¹⁶ As a result, this would amount to approximately \$40 billion in savings annually.

To succeed, any policy to address out-of-network billing must achieve two aims. First, it must protect patients from financial harm in the event that they are treated by an out-of-network physician whom they could not reasonably avoid. Second, it must introduce a competitively set price for physician services or identify the amount insurers must pay providers if a policyholder is treated by an out-of-network physician.

Protecting patients from financial harm is fairly straightforward. Most existing state legislation includes a "hold harmless" provision that stipulates that if a patient is treated by an out-of-network provider who could not be avoided, the patient is liable for only the cost sharing they would have paid had the physician been in network.^{18 20} Early evidence from recent efforts in New York State suggest that this provision has been successful.²¹

The harder problem for policy makers is determining how an out-of-network physician should be paid for delivering care when they are working from an in-network hospital. In general, there are four options.

First, policy makers could set a regulated price for out-of-network providers. This rate would be used as the reimbursement for physicians and would apply anytime a patient was treated at an in-network hospital by a physician who was out of network with the patient's insurer. For example, the regulated price could be set as a percentage of Medicare payment rates or as the median in-network payment. This is the type of approach that has been taken in New Jersey and California and in some early Senate proposals.^{22 24}

The upside of this approach is that it is fairly straightforward to legislate and easily understood by stakeholders. However, there are significant downsides. First, regulated rates would be subject to vigorous and ongoing lobbying by providers and insurers. Second, regulated prices could be set too high or too low. A regulated price that was too high or too low would inevitably create significant distortions in behavior. For example, if the regulated out-of-network payments were set too low, insurers would be reluctant to form networks, since they would save

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money by falling back on the regulated payments. Likewise, in the extreme, a regulated payment that was set too low could lead to physician shortages, which hospitals might try to overcome by raising their subsidies to physicians (and seeking to recoup this money from insurers). By contrast, if the regulated payments were set too high, physicians would be unwilling to join networks, since they could make more money by refusing to participate in networks, and it could also lead to a surplus of physicians.

In the second option, policy makers could introduce arbitration for out-of-network physicians and insurers. If physicians and insurers were unable to reach an agreement about a fair compensation rate for an individual bill, they could seek a ruling from an approved arbitrator designated by the state or federal government. In New York State, policy makers introduced “baseball rules” arbitration in 2014, according to which the arbitrator must select a payment from one of two options: the physician’s initial charge or the insurer’s initial offer.

Early evidence from the New York arbitration process has been positive. Work by Cooper and coauthors⁴ showed that this program reduced the frequency of out-of-network billing by 6.8 percent. In addition, by weakening physicians’ outside option, the program also reduced in-network payment rates by 13 percent.

However, there are challenges with introducing arbitration to address out-of-network bills. First, when introduced at the state level, these rules apply only to people enrolled in fully insured plans. Second, arbitrators could be overwhelmed, particularly in regions where physicians who bill out of network are prevalent.²⁵ Third, while an arbitration process may be present, consumers are often unaware that one exists, and thus they might not avail themselves of its protections. Fourth, most arbitration policies apply only to bills over a certain amount (for example, more than \$500). Fifth, the outcome of the arbitration process will depend on how the process is designed. For example, instructing arbitrators to consider how physician and insurer payments were related to the eightieth percentile of charges could lead to higher in-network payments and create perverse incentives for physicians to game the process and artificially inflate their charges.

A third option would be to require physicians to participate in the same insurance networks as the hospitals where they work. This has two distinct advantages. First, it would prevent a patient from ever going to an in-network hospital and seeing an out-of-network provider (and subsequently receiving an unexpected bill) without requiring any behavioral changes by the patient.

Second, the policy is straightforward to implement and easily understood. However, this approach would give more bargaining leverage to insurers in negotiations with physicians. An insurer that had a contract with a hospital would know it could offer local physicians a low rate, because otherwise they could not work in their local hospital. This concern could be addressed by creating an arbitration process that would be initiated by physicians to settle disputes between physician groups and insurers. Likewise, it is possible that hospitals could make up any shortfall in physician payments.

A fourth option would be to regulate the contracts of physicians who work in hospitals and are not chosen by patients. This is our preferred policy approach. Under this policy, hospitals would be required to sell a bundled package of services that included the fees for ED physicians, anesthesiologists, pathologists, radiologists, and assistant surgeons. As a result, for example, hospitals would bill for anesthesiology services and then be responsible for recruiting anesthesiology providers to work in their facilities. Those anesthesiologists could be employees of the hospital or independent contractors and could bargain over compensation with the hospital.

There are several upsides to this type of policy. First, it would eliminate the possibility of patients seeing an out-of-network provider at an in-network hospital. Moreover, unlike arbitration, it would protect patients without requiring them to take action. Second, it would restore a competitively set rate for physicians who are not chosen by the patient. Absent an intervention, these physician specialties face inelastic demand. Under this bundled care approach, physicians would compete to offer their services on the basis of price and quality. Hospitals would compete with one another on the price and quality of their care, including the services provided by the physicians they recruited. Hospitals would also need to compete to retain physicians.

This approach would require a shift in how certain physician specialties contract with hospitals. However, given the dysfunction in these particular physician markets and the harm that is causing to patients, a mild change of this type seems warranted. In addition, it is likely to be superior to setting prices by regulation. Moreover, these sorts of policies are not without precedent. Numerous professionals—for example, nurses and custodial staff—do not separately bill patients for their services.

Conclusion

When physicians whom patients cannot avoid can work out of network from in-network hos-

pitals, it exposes patients to significant financial risk and raises physicians' in-network payments. Anesthesiologists, pathologists, radiologists, and assistant surgeons are out of network in approximately 10 percent of cases. We estimated that these specialists' ability to bill out of network raises total health care spending for people

with employer-sponsored insurance by approximately 3.4 percent (\$40 billion). Our proposed policy solution—requiring hospitals to sell a package of facility and physician services—would protect patients, restore a competitively determined price for physician services, and lower commercial health spending. ■

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Research

JAMA | Original Investigation

Out-of-Network Bills for Privately Insured Patients Undergoing Elective Surgery With In-Network Primary Surgeons and Facilities

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IMPORTANCE Privately insured patients who receive care from in-network physicians may receive unexpected out-of-network bills ("surprise bills") from out-of-network clinicians they did not choose. In elective surgery, this can occur if patients choose in-network surgeons and hospitals but receive out-of-network bills from other involved clinicians.

OBJECTIVE To evaluate out-of-network billing across common elective operations performed with in-network primary surgeons and facilities.

DESIGN, SETTING, AND PARTICIPANTS Retrospective analysis of claims data from a large US commercial insurer, representing 347 356 patients who had undergone 1 of 7 common elective operations (arthroscopic meniscal repair [116 749]; laparoscopic cholecystectomy [82 372]; hysterectomy [67 452]; total knee replacement [42 313]; breast lumpectomy [18 018]; colectomy [14 074]; coronary artery bypass graft surgery [6378]) by an in-network primary surgeon at an in-network facility between January 1, 2012, and September 30, 2017. Follow-up ended November 8, 2017.

EXPOSURE Patient, clinician, and insurance factors potentially related to out-of-network bills.

MAIN OUTCOMES AND MEASURES The primary outcome was the proportion of episodes with out-of-network bills. The secondary outcome was the estimated potential balance bill associated with out-of-network bills from each surgical procedure, calculated as total out-of-network charges less the typical in-network price for the same service.

RESULTS Among 347 356 patients (mean age, 48 [SD, 11] years; 66% women) who underwent surgery with in-network primary surgeons and facilities, 20.5% of episodes (95% CI, 19.4%-21.7%) had an out-of-network bill. In these episodes, the mean potential balance bill per episode was \$2011 (95% CI, \$1866-\$2157) when present. Out-of-network bills were associated with surgical assistants in 37% of these episodes; when present, the mean potential balance bill was \$3633 (95% CI, \$3384-\$3883). Out-of-network bills were associated with anesthesiologists in 37% of episodes; when present, the mean potential balance bill was \$1219 (95% CI, \$1049-\$1388). Membership in health insurance exchange plans, compared with nonexchange plans, was associated with a significantly higher risk of out-of-network bills (27% vs 20%, respectively; risk difference, 6% [95% CI, 3.9%-8.9%]; $P < .001$). Surgical complications were associated with a significantly higher risk of out-of-network bills, compared with episodes with no complications (28% vs 20%, respectively; risk difference, 7% [95% CI, 5.8%-8.8%]; $P < .001$). Among 83 021 procedures performed at ambulatory surgery centers with in-network primary surgeons, 6.7% (95% CI, 5.8%-7.7%) included an out-of-network facility bill and 17.2% (95% CI, 15.7%-18.8%) included an out-of-network professional bill.

CONCLUSIONS AND RELEVANCE In this retrospective analysis of commercially insured patients who had undergone elective surgery at in-network facilities with in-network primary surgeons, a substantial proportion of operations were associated with out-of-network bills.

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In 2019, lawmakers in both the Senate and House of Representatives proposed multiple bills to end unexpected (ie, "surprise") medical billing.^{1,2} These bills occur when patients obtain care from physicians and hospitals that participate in their insurance network ("in network") but receive separate and often unexpected bills from a clinician who does not participate in their insurance network ("out of network"). Out-of-network clinicians charge patients what they believe they should be paid and may be reimbursed for the entire amount charged, a fraction of it, or none at all. "Balance billing" occurs when out-of-network clinicians are paid less by the insurance plan than they charged and send the patient a "balance bill" for the difference between their charges and the plan payment. Balance bills from out-of-network clinicians can amount to thousands of dollars, without the usual limits on out-of-pocket obligations (eg, deductibles, out-of-pocket maximums).³⁻⁶ Out-of-network billing can also increase health care costs for patients who do not receive balance bills, as many insurance plans require higher cost-sharing (deductibles, co-insurance, co-pays) for out-of-network care, and the option for clinicians to go out of network may increase their ability to negotiate higher in-network prices.^{7,8}

Most prior studies on unexpected out-of-network billing have involved emergency department care or general inpatient care.^{4,8-12} Unlike those settings, in elective surgery, patients can usually choose in-network surgeons and facilities. However, they can rarely choose other involved clinicians (eg, assistants, anesthesiologists, pathologists). The extent to which each of these clinical specialties accounts for out-of-network bills is unclear.

To better understand the factors associated with out-of-network billing in surgical episodes, this study evaluated out-of-network billing for elective surgical episodes using claims data from a large commercial insurer. This study also examined variation in the rates of out-of-network billing associated with patient, physician, and insurance characteristics, and across geographic regions in the United States.

Methods

Data Source

The data source for this study was the Clinformatics DataMart (Eden Prairie, Minnesota), which contains insurance claims from a large national insurer. The study was deemed "not regulated" by the University of Michigan Institutional Review Board because it represented a secondary analysis of deidentified data.

Cohort Selection

The study cohort consisted of commercially insured patients aged 18 to 64 years who had undergone 1 of 7 operations between 2012 and 2017. The operations were chosen to represent some of the most common surgical procedures undergone by commercially insured patients,¹³ as well as a diverse range of acuity levels, surgical subspecialties, and surgical settings: laparoscopic cholecystectomy, total knee replacement, arthroscopic meniscal repair, coronary artery bypass graft

Key Points

Question How often are patients undergoing elective surgery with in-network primary surgeons at in-network facilities at risk for receiving out-of-network bills?

Findings In this retrospective analysis of 347 356 surgical episodes among commercially insured patients who had undergone elective surgery with in-network primary surgeons and facilities, 20% of episodes involved out-of-network charges.

Meaning Patients undergoing elective surgery with in-network primary surgeons and facilities may be at risk of receiving out-of-network bills.

(CABG) surgery, colectomy, hysterectomy, and breast lumpectomy (see eAppendix eTable 1 in the [Supplement](#) for procedure codes).

We included only elective cases, as defined in the database. We restricted the analysis to cases in which the facility and primary surgeon were in-network. We identified primary surgeons as the surgeons whose *Current Procedural Terminology* code matched the principal procedure and who did not submit a modifier code identifying themselves as assistants or co-surgeons. Surgical assistants included those with assistant surgeon or co-surgeon modifier codes, as well as other clinicians providing a surgical type of service any time during the hospitalization. We excluded cases with missing facility identifiers or missing patient-level information. (See the eAppendix in the [Supplement](#) for a flow diagram, full description of exclusion criteria, and details on how primary surgeons and other clinician specialties were identified.)

We identified Elixhauser comorbidities based on *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* and *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Clinical Modification (ICD-10-CM)* diagnosis codes documented in the 3 months before the surgical episode.¹⁴ We also used *ICD-9-CM* and *ICD-10-CM* codes to identify postoperative complications documented in the inpatient setting based on the diagnosis codes previously described to have the greatest sensitivity and specificity.¹⁵

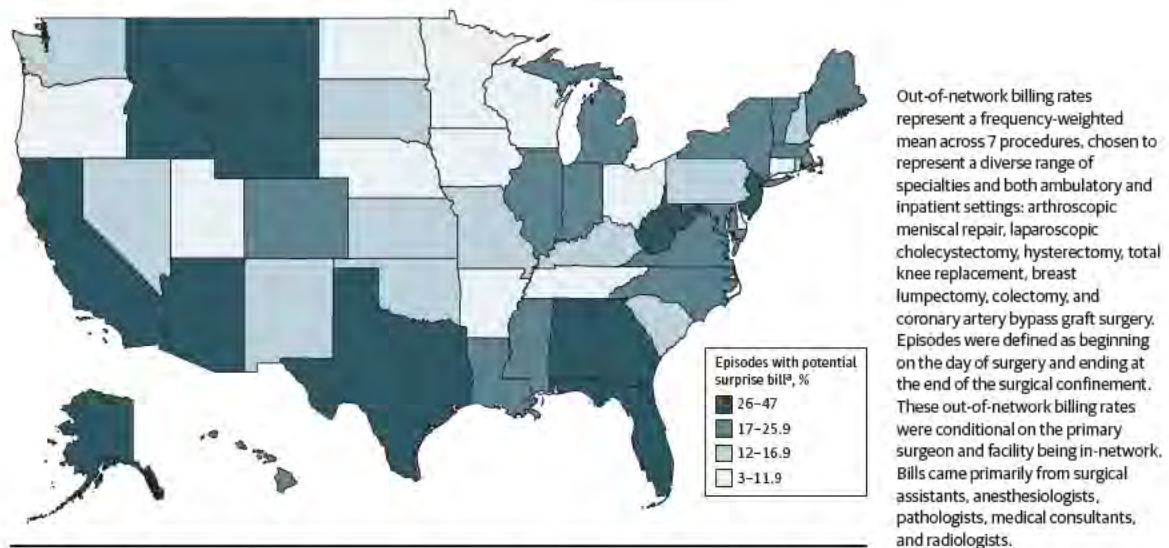
Outcomes

We identified out-of-network claims using the "participating provider" variable in the data set, which indicated whether the clinician or facility associated with a claim has a contract with the payer to provide services at negotiated payment rates (ie, is "in-network").

Because patients seeking elective surgery can generally choose in-network hospitals and surgeons, we specifically identified out-of-network bills in which the facility and primary surgeon were in-network, but other clinicians were out-of-network. The primary outcome was the proportion of elective surgical episodes involving an out-of-network bill.

The secondary outcome was the estimated potential balance bill, which was calculated for each episode as the total of out-of-network charges less the standardized payment (ie, typical in-network price) for each out-of-network charge,

Figure. Geographic Variation in Rates of Out-of-Network Bills, by State



in line with prior research.¹² The potential balance bill excludes expected sources of cost-sharing, such as deductibles and co-insurance. We also reported total out-of-network charges, total episode charges, standardized payments, and out-of-pocket cost-sharing. All charges and payments were winsorized to the 1st and 99th percentiles of charges and payments within each procedure.

Statistical Analysis

We calculated the percentage of out-of-network bills for each procedure by dividing the number of episodes with any out-of-network bill by the total number of episodes of each procedure. We calculated the percentage of out-of-network bills from each specialty by dividing the number of episodes with an out-of-network bill from that specialty by the number of episodes with any out-of-network bill. Episodes with missing data were excluded (see eFigure in the Supplement).

To assess factors associated with out-of-network bills, we constructed a logistic regression at the surgical episode level, with the presence of an out-of-network bill as the outcome variable. Explanatory variables included patient factors such as age, sex, comorbidities (modeled with indicators for 0, 1, 2, or ≥ 3 comorbidities), and surgical complications (modeled with indicators for 0, 1, 2, or ≥ 3 complications); location of service (hospital inpatient, hospital outpatient, or ambulatory surgery center [ASC]); insurance plan characteristics (self-insured or fully insured; health insurance exchange vs nonexchange), procedure, geographic region, and year. Model fit was assessed using receiver operating characteristic curves. We estimated adjusted risk differences by calculating population-averaged marginal effects at each value of the explanatory variables. Because of the potential for type I error due to multiple comparisons, the findings of this secondary analysis should be interpreted as exploratory.

Since prior research has focused on out-of-network billing in the inpatient setting, we also separately calculated the

proportion of episodes with in-network primary surgeons involving out-of-network bills at ASCs. To specifically measure the proportion of episodes at ASCs with out-of-network facility fees, having an in-network facility was not an inclusion criterion for this analysis.

All statistical testing was conducted at the 5% significance level with 2-sided tests, accounting for clustering at the facility level. SAS version 9.4 (SAS Institute Inc) was used for cohort preparation and descriptive analyses; Stata version 14.2 (StataCorp) was used for regression models.

Results

Among 347 356 patients who had undergone elective surgery with in-network primary surgeons at in-network facilities, the mean age was 48 (SD, 11) years; 66% were women; 116 749 (34%) underwent arthroscopic meniscal repair; 82 372 (24%) underwent laparoscopic cholecystectomy; 67 452 (19%) underwent hysterectomy; 42 313 (12%) underwent total knee replacement; 18 018 (5%) underwent breast lumpectomy; 14 074 (4%) underwent colectomy; and 6378 (2%) underwent CABG surgery (eTable 2 in the Supplement). After applying exclusion criteria (eFigure in the Supplement), there were no missing data.

The prevalence of out-of-network bills varied by state, from 3% (Nebraska) to 46% (Alaska) (Figure). High prevalences were common in parts of the South and Northwest, whereas low prevalences were common in the Midwest.

Among 347 356 identified episodes, an out-of-network bill was present in 20.5% of episodes (95% CI, 19.4% to 21.7%) when the primary surgeon and facility were in-network (Table 1).

The presence of an out-of-network bill was associated with significantly higher total charges (\$48 383 vs \$34 300; difference, \$14 083 [95% CI, \$12 883 to \$15 281]), standardized payments (\$21 656 vs \$16 200; difference, \$5456 [95% CI, \$5029 to \$5886]), and out-of-pocket cost-sharing (\$1768 vs \$1444;

Mean (95% CI)						
No. (total)	All	Arthroscopic Meniscal Repair	Laparoscopic Cholecystectomy	Hysterectomy	Total Knee Replacement	Breast Lumpectomy
347 356	116 749	82 372	67 452	42 313	18 018	14 074
When All Clinicians Are In-Network						
No.	276 128	101 588	62 334	50 193	31 797	15 265
Total charge, \$ ^a	34 300 (33 577-35 024)	20 948 (20 377-21 520)	24 068 (23 591-24 544)	43 370 (42 261-44 478)	60 201 (59 094-61 308)	26 645 (25 770-27 520)
Plan payment, \$ ^b	16 200 (15 928-16 472)	9803 (9590-10 015)	12 648 (12 429-12 867)	20 350 (19 961-20 740)	28 602 (28 280-28 925)	13 616 (13 241-13 990)
Plan out-of-pocket cost share, \$ ^c	1444 (1422-1466)	1276 (1252-1300)	1490 (1464-1515)	1799 (1763-1834)	1673 (1632-1714)	862 (830-894)
Episodes With Out-of-Network Bill						
Percent of total (95% CI)	20.5 (19.4-21.7)	13.0 (11.9-14.1)	24.3 (22.8-25.9)	25.6 (23.5-27.6)	24.9 (22.9-26.8)	15.3 (13.6-17.0)
When Out-of-Network Bill Is Present						
No.	71 228	15 161	20 038	17 259	10 516	2753
Total charge, \$ ^a	48 383 (47 073-49 693)	29 862 (28 519-31 204)	29 664 (28 786-30 542)	52 256 (50 690-53 821)	70 208 (67 996-72 420)	33 709 (31 752-35 665)
Plan payment, \$ ^b	21 656 (21 197-22 115)	13 330 (12 850-13 810)	14 978 (14 618-15 338)	23 888 (23 270-24 505)	31 910 (31 352-32 468)	16 574 (15 840-17 309)
Out-of-network charge, \$ ^d	3606 (3403-3809)	2838 (2613-3064)	2471 (2234-2709)	3800 (3497-4103)	5110 (4582-5638)	4442 (3553-5332)
Plan out-of-pocket cost share, \$ ^e	1768 (1736-1799)	1638 (1576-1699)	1705 (1670-1740)	2046 (2000-2093)	1826 (1771-1881)	1176 (1106-1245)
Potential balance bill, \$ ^e	2011 (1866-2157)	1591 (1407-1774)	1255 (1078-1432)	2174 (1974-2373)	2881 (2506-3255)	2786 (2067-3504)
Abbreviation: CABG, coronary artery bypass graft.						
^a Sum of the reimbursements requested by all clinicians and facilities involved in the surgical episode.						
^b Reflects the typical amount that would be paid if the services were provided in-network.						
^c Sum of all deductible, co-insurance, and co-pays expected of the patient under his or her benefit structure, excluding any potential balance bills.						
^d Sum of all reimbursements requested on an out-of-network basis throughout the episode.						
^e Calculated as the difference between total out-of-network charges and standardized plan payments, reflecting the ability of an out-of-network clinician to balance bill the patient for the difference between charges and plan payments. This does not include plan cost-sharing (see "out-of-pocket cost share" above).						

difference, \$324 [95% CI, \$292 to \$355]) relative to cases with all bills in-network ($P < .001$ for all). The secondary outcome of potential balance bills (difference between charges and standardized payments) ranged from \$1255 (95% CI, \$1078 to \$1432) for laparoscopic cholecystectomy to \$3449 (95% CI, \$2947 to \$3950) for CABG surgery.

Of 71 228 episodes with out-of-network bills, anesthesiologists and surgical assistants were both associated with out-of-network claims in 37% of episodes (Table 2). The mean potential balance bill from surgical assistants was \$3633 (95% CI, \$3384 to \$3883) and from anesthesiologists was \$1219 (95% CI, \$1049 to \$1388). Out-of-network surgical assistants were most commonly physician assistants (26% of all out-of-network surgical assistant claims), registered nurses (24%), certified surgical assistants (19%), and other surgeons (6%-27%, depending on the procedure) (eTable 3 in the Supplement). In procedures commonly requiring surgical pathology review (colectomy, hysterectomy, cholecystectomy, breast lumpectomy), the proportion of out-of-network bills involving pathologists ranged from 25% to 43% of episodes.

When potential balance bills were present, the mean charges for medical consultants were \$708 (95% CI, \$599 to \$816); for pathologists, \$284 (95% CI, \$257 to \$311); for radiologists, \$321 (95% CI, \$103 to \$539); and for other clinicians, \$754 (95% CI, \$673 to \$835). The most common clinician types categorized as "other" are listed in eTable 4 in the Supplement.

In a separate analysis of 83 021 operations performed at ASCs, 6.7% (95% CI, 5.8% to 7.7%) of episodes involved out-of-network facility bills, and 17.2% (95% CI, 15.7% to 18.8%) involved out-of-network professional bills (Table 3). Although fewer episodes involved out-of-network facility bills, the potential balance bills from out-of-network facility charges were significantly higher than those from out-of-network professional charges (\$12 624 vs \$6872, respectively; difference, \$5752 [95% CI, \$4849 to \$6656]; $P < .001$).

In multivariable analysis (Table 4), self-insured plan membership was associated with a significantly lower risk of out-of-network bills, compared with fully insured plan membership (19% vs 22%, respectively; risk difference, -3% [95% CI, -3.3% to -1.9%], $P < .001$). Exchange plan membership was associated with a significantly higher risk when compared with nonexchange plans (27% vs 20%, respectively; risk difference, 6% [95% CI, 3.9% to 8.9%]; $P < .001$). The occurrence of surgical complications was also associated with a significantly higher risk of out-of-network bills, compared with episodes with no complications (28% vs 20%, respectively; risk difference, 7% [95% CI, 5.8% to 8.8%]; $P < .001$). Complications were significantly associated with out-of-network bills from radiologists, medical consultants, and "other" clinicians (eTable 5 in the Supplement). Surgery at an ASC or in the hospital outpatient setting was associated with a significantly lower risk of out-of-network bills (20% and 18%, respectively) relative to the hospital inpatient setting (24%, $P < .001$ for both). However, the difference between ASCs and the hospital outpatient setting was not statistically significant (difference, 1.1%; [95% CI, -0.9% to 3.1%]; $P = .26$). The prevalence of out-of-network bills was not significantly different between 2012 and 2017.

Discussion

In this analysis of commercially insured patients who had undergone elective surgery with an in-network surgeon at an in-network facility, approximately 1 in 5 received an out-of-network bill, with a mean potential balance bill of \$2011.

The patterns of out-of-network bills varied with the clinical scenario. Simpler ambulatory procedures that tend to involve 1 surgeon (arthroscopic meniscal repair, breast lumpectomy) had fewer out-of-network bills (13%-15% of cases), whereas inpatient procedures (hysterectomy, knee replacement, colectomy, CABG surgery) had more frequent out-of-network bills (24%-33% of cases). These more complex procedures were also associated with larger potential balance bills, in the range of \$2000 to \$4000.

Prior studies have estimated that the rate of out-of-network bills in general inpatient care is between 10% and 40%.^{10,12} By focusing on a granular set of elective surgical procedures, the current study was able to more precisely estimate the risk of an out-of-network bill as approximately 20%. Prior estimates have also suggested that anesthesiology was involved in 8% to 22% of out-of-network bills in general inpatient admissions overall,^{7,10,12,16} but the current study found that in surgical care, anesthesiology was involved in 37%. This study also found that episodes with out-of-network bills were associated with significantly higher overall charges, payments, and cost sharing than episodes without any out-of-network bills.

Although anesthesiologists are often cited as the most common source of out-of-network bills in surgery, the current analysis found that out-of-network bills from surgical assistants had a similar frequency (37% of episodes) and were significantly larger than those from anesthesiologists (\$3633 vs \$1219). Skilled assistance is often required in surgical care for a variety of reasons,^{17,18} and in the complex inpatient procedures analyzed in the current study, claims from assistants were present in the majority of episodes. Assistants may participate intraoperatively or perioperatively and may manage the care of admitted patients on behalf of the primary surgeon. At teaching hospitals, trainees often provide surgical assistance. However, when qualified trainees are unavailable, surgeons may rely on other surgeons or allied professionals (eg, nurses, physician assistants, certified surgical assistants) to assist, and these clinicians may bill the patient separately from the primary surgeon. As surgeons are often able to choose their assistants, choosing assistants who will be in-network would seem a logical opportunity for reducing financial risk to patients. However, there have been reports of surgeons billing as out-of-network assistants as an intentional billing tactic.¹⁹

In addition, this analysis found that the risk of out-of-network bills was not significantly different for patients who had undergone the same operation in an ASC vs in a hospital as an outpatient, if both the facility and primary surgeon were in-network. The subanalysis of cases at ASCs with in-network primary surgeons found that out-of-network facility claims were less frequent compared with out-of-network professional claims (6.7% of episodes vs 17.2% of episodes, respectively), even though ASCs are less tightly regulated than hospitals.²⁰ However,

Table 2. Sources of Out-of-Network Bills in Elective Surgery, by Specialty, for Patients Undergoing Elective Surgery With In-Network Primary Surgeons and Facilities^a

	All	Arthroscopic Meniscal Repair	Laparoscopic Cholecystectomy	Hysterectomy	Total Knee Replacement	Breast Lumpectomy	Colectomy	CABG Surgery
No. of cases with out-of-network bills	71 228	15 161	20 038	17 259	10 516	27 53	3405	2096
% of out-of-network bills involving specialty								
Surgical assistant	37	18	38	54	41	25	40	27
Anesthesiologist	37	64	32	28	30	37	28	23
Pathologist	22	5	30	25	16	43	30	18
Radiologist	7	3	8	3	9	14	9	32
Medical consultants	3	0	2	1	12	0	9	13
Other ^b	13	19	11	5	16	5	14	34
Potential balance bill from specialty (when present), mean (95% CI), \$								
Surgical assistant	3633 (3384-3883)	5250 (4800-5700)	2346 (1967-2725)	3033 (2730-3336)	4774 (4210-5338)	8078 (5563-10 593)	5580 (4529-6630)	4174 (3201-5147)
Anesthesiologist	1219 (1049-1388)	818 (672-963)	726 (561-892)	1524 (1240-1808)	1953 (1639-2266)	937 (629-1246)	2750 (2172-3328)	5593 (4413-6772)
Pathologist	284 (257-311)	164 (108-221)	121 (114-129)	301 (263-340)	185 (162-208)	970 (809-1131)	545 (449-641)	497 (402-593)
Radiologist	321 (103-539)	161 (81-242)	101 (86-115)	86 (62-110)	1101 (12-2190)	136 (100-172)	218 (146-291)	171 (142-199)
Medical consultants	708 (599-816)	632 (-71 to 1336)	814 (653-975)	449 (350-547)	519 (389-650)	319 (97-542)	1261 (890-1631)	969 (699-1239)
Other ^b	754 (673-835)	556 (433-679)	679 (595-764)	617 (374-860)	791 (604-977)	369 (198-540)	1269 (783-1755)	1592 (1096-2088)

Abbreviation: CABG, coronary artery bypass graft.

^a The share of out-of-network billing by specialty is calculated by dividing the number of episodes with an out-of-network bill from that specialty by the number of episodes with an out-of-network bill. Values do not sum to 100% because many episodes contained out-of-network claims from multiple specialties.^b Included durable medical equipment providers, ambulances, nurse practitioners, and physician assistants. Please refer to e Table 4 in the Supplement for a detailed list of the most common "other" clinicians.

Table 3. Prevalence and Magnitude of Out-of-Network Bills at Ambulatory Surgery Centers for Patients Undergoing Elective Surgery With In-Network Primary Surgeons

	All	Arthroscopic Meniscal Repair	Laparoscopic Cholecystectomy	Breast Lumpectomy	Total Knee Replacement
When All Clinicians Are In-Network					
No.	65 541	53 631	8311	2674	925
Total facility charges (95% CI), \$	12 300 (11 831-12 768)	11 870 (11 370-12 369)	11 892 (11 303-12 480)	12 863 (11 761-13 965)	39 290 (30 779-47 801)
Total professional charges (95% CI), \$	7133 (6854-7411)	7325 (7006-7644)	5010 (4780-5240)	7326 (6893-7760)	14 480 (11 518-17 442)
When Primary Surgeon Is In-Network					
No.	83 021	66 519	11 821	3316	1365
Episodes with out-of-network claim, % (95% CI) ^a					
Facility	6.7 (5.8-7.7)	7.0 (5.9-8.1)	4.5 (3.5-5.6)	3.2 (1.9-4.4)	21.8 (13.1-30.5)
Professional	17.2 (15.7-18.8)	15.3 (13.6-17.0)	27.6 (24.6-30.5)	17.3 (14.3-20.3)	20.4 (12.9-28.0)
Total charges when out-of-network claim present (95% CI), \$					
Facility	19 620 (18 638-20 602)	19 470 (18 414-20 526)	14 861 (13 592-16 131)	17 164 (15 218-19 109)	65 561 (58 977-72 144)
Professional	11 164 (10 509-11 819)	11 809 (10 990-12 628)	7917 (7266-8568)	10 900 (9189-12 610)	18 565 (16 393-20 738)
Potential balance bill, mean (95% CI), \$ ^b					
Facility	12 624 (11 789-13 459)	11 375 (10 609-12 140)	11 562 (9604-13 520)	9483 (6539-12 428)	35 231 (31 033-39 428)
Professional	6872 (6328-7416)	7611 (6933-8290)	3953 (3436-4470)	5039 (3712-6366)	11 169 (9298-13 041)

^a Proportions of out-of-network claims were calculated conditional on the primary surgeon being in-network. Unlike other analyses in this article, this analysis included episodes in which the facility was out-of-network. This analysis was also restricted to procedures that are commonly performed in the ambulatory setting.

^b Calculated as the difference between total out-of-network charges and standardized plan payments, reflecting the ability of an out-of-network clinician to balance-bill the patient for the difference between charges and plan payments. This does not include plan cost-sharing.

out-of-network facility charges were significantly larger than out-of-network professional charges and thus may still be driving up costs for insurance plans and patients.

This analysis also examined out-of-network bills in several policy-relevant subgroups. First, self-insured plans, in which the employer takes on full responsibility for members' health care expenses and the insurer provides administrative services (eg, billing, reimbursement) only, cover the majority of US residents with employer-sponsored insurance.²¹ The Employee Retirement Income Security Act (ERISA) preempts states from regulating these plans.²²⁻²⁴ As such, states are thought to be unable to protect self-insured patients from unexpected out-of-network bills. This analysis found that the risk of out-of-network bills was slightly lower in self-insured plans, perhaps because large self-insured employers may offer plans with broader clinician networks. However, self-insured plan members remain a large share of the commercially insured who are not being protected by current state policy.

Second, health insurance exchange plans are commonly purchased by individuals not offered employer-sponsored insurance. Exchange plans are known to have narrower networks than employer-sponsored plans (in exchange for lower premiums).²⁵⁻²⁷ This analysis found that members of these plans have a 6-percentage-point higher risk of out-of-network bills than members of nonexchange plans.

Third, this analysis also found that the prevalence of out-of-network bills varied widely across states. Various states (CA, CT, FL, IL, MA, MD, MS, NY) have enacted policies that protect

patients from out-of-network billing at in-network facilities^{22,23}; however, in this analysis, those states all had proportions of out-of-network bills above the national median. This suggests several hypotheses, including that these states may have been responding to endemic surprise billing problems, and that these policies may not have been completely effective. Although a formal evaluation of state policy was outside the scope of this analysis, future studies will need to account for this endogeneity and for variation in state policy designs.

Fourth, these findings suggest that, in surgical settings, the problem of out-of-network billing is not restricted to a single specialty or setting. Surgical care is inherently multidisciplinary and requires a team of clinicians with payer contracts that are rarely intentionally coordinated. This is in contrast to prior research on emergency care, which pointed toward a subset of emergency departments staffed by private equity-backed medical groups as the primary source of out-of-network billing.⁹

Limitations

This study has several limitations. First, the Clinformatics database only contains claims from 1 insurer. However, this insurer is present in all 50 states, in the individual, small-group, and large-group markets, and offers both self- and fully-insured plans, thereby reflecting the diversity of commercial insurance plans available today. Regarding the prevalence of out-of-network bills, previous studies of out-of-network billing involving a single insurer^{4,8,9,12} were consistent with studies of multipayer data sets.^{7,10}

Table 4. Risk Factors for Out-of-Network Bills Among Patients Undergoing Elective Surgery With In-Network Primary Surgeons and Facilities

	Change in Risk of Out-of-Network Bill, % Points (95% CI) ^a	P Value
Patient characteristics		
Age (per 1 y)	-0.05 (-0.1 to 0.0)	<.001
Men (vs women)	0.1 (-0.3 to 0.5)	.55
Comorbidity count (Elixhauser)		
0	Reference	
1	0 (-0.5 to 0.3)	.59
2	0 (-0.3 to 0.7)	.44
≥3	1 (0.6 to 2.0)	<.001
Complication count		
0	Reference	
1	7 (5.8 to 8.8)	<.001
2	18 (14.5 to 21.9)	<.001
≥3	26 (18.2 to 34.3)	<.001
Insurance characteristics		
Self-insured plan (ASO), vs fully insured ^b	-3 (-3.3 to -1.9)	<.001
Health insurance exchange plan, vs nonexchange ^c	6 (3.9 to 8.9)	<.001
Facility characteristics		
Procedure at ambulatory surgery center, vs hospital inpatient	-4 (-6.3 to -2.1)	<.001
Procedure at hospital outpatient, vs hospital inpatient	-5 (-6.5 to -4.1)	<.001
Operation		
Arthroscopic meniscal repair	Reference	
Laparoscopic cholecystectomy	11 (9.4 to 12.4)	<.001
Hysterectomy	9 (7.3 to 11.3)	<.001
Total knee replacement	8 (6.6 to 10.3)	<.001
Breast lumpectomy	2 (0.5 to 4.1)	.01
Colectomy	6 (3.6 to 7.6)	<.001
CABG surgery	10 (7.2 to 12.9)	<.001
Year		
2012	Reference	
2013	0 (-0.4 to 1.0)	.45
2014	1 (-0.4 to 1.7)	.23
2015	0 (-0.8 to 1.4)	.59
2016	0 (-1.6 to 0.7)	.45
2017	-1 (-2.4 to 0.0)	.06
Region		
Northeast	8 (4.4 to 12.1)	<.001
Midwest	Reference	
South	14 (12.1 to 16.7)	<.001
West	14 (10.9 to 16.8)	<.001

Abbreviations: ASO, administrative services only; CABG, coronary artery bypass graft.

^a Estimates reflect population-average absolute marginal effects at each value of the independent variables. Estimates are derived from a single-level logistic regression model using robust standard errors to account for clustering at the facility level. Model fit was assessed using receiver operating characteristic curves; the model had a C statistic of 0.67. Counts of patients with and without out-of-network bills in each of the table categories are presented in eTable 2 in the Supplement.

^b "Self-insured" (administrative services only) plans are defined as those in which employers contract with the insurer solely to administer health benefits for their employees. The insurance plan is not financially accountable for their health care service utilization.

^c "Health insurance exchange plan" includes any individual or group insurance plan sold in a state or federal insurance marketplace.

Second, claims data do not indicate whether patients were balance-billed, nor whether they were aware of their out-of-network status. This limitation is common to most studies of out-of-network medical billing. However, prior analyses indicate that the majority of out-of-network contacts at inpatient facilities are involuntary.¹¹

Third, the data set used in this study did not indicate how much the insurance plan paid for out-of-network care. The payments in the data set were adjusted to the typical in-network price for each service across the United States. Thus, this study's calculations of potential balance bills reflected an estimate of the dollar amount patients could be balance-billed

but not the actual amount that was balance-billed. If an insurance plan does not have out-of-network benefits, its members would be responsible for all out-of-network charges; the approach used in this study would underestimate the potential balance bill in this scenario. On the other hand, plans with out-of-network benefits often reimburse out-of-network clinicians at a "usual and customary rate," which may exceed the typical in-network payment. In this case, the approach used in this study would overestimate the potential balance bill. Since the study data did not indicate whether patients' insurance plans had out-of-network benefits, this analysis used methods previously published to estimate potential financial

liability within the same data set.^{4,12} This is likely a conservative estimate because it excludes expected sources of cost-sharing such as deductibles, co-insurance, and co-pays.

Fourth, many factors influencing out-of-network billing cannot be observed using claims data. For instance, it is well-known that insurance network directories are sometimes inaccurate,²⁷⁻²⁹ but their role could not be measured in this study.

Conclusions

In this retrospective analysis of commercially insured patients who had undergone elective surgery at in-network facilities with in-network primary surgeons, a substantial proportion of operations were associated with out-of-network bills.

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Concept and design: Chhabra, Sheetz, Ryan, Dimick. **Acquisition, analysis, or interpretation of data:** Chhabra, Sheetz, Nuliyalu, Dekhne, Dimick. **Drafting of the manuscript:** Chhabra, Sheetz, Dekhne, Dimick.

Critical revision of the manuscript for important intellectual content: Chhabra, Nuliyalu, Dekhne, Ryan, Dimick.

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Editor's Note

Surprise Billing in Surgery—Time for Action

Karen E. Joynt Maddox, MD, MPH; Edward Livingston, MD

"Surprise" billing occurs when patients with health insurance receive care from a clinician or facility included in their insurer's network ("in-network") but unexpectedly receive "surprise" bills from other clinicians involved in their care who are not in the patient's insurer's network ("out-of-network") and therefore not covered

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by their insurance. In this issue of the *JAMA*, Chhabra and colleagues¹ present a thorough analysis of out-of-network billing for elective operations and find the practice to be both common and potentially financially devastating. Based on their analysis of 347 356 patients who had undergone 1 of 7 common elective operations with in-network surgeons at in-network facilities, the authors report that 20.5% of these surgical episodes also had an associated out-of-network bill, with a mean potential financial liability of more than \$2000. The most common sources of the out-of-network bills were surgical assistants and anesthesiologists.

The evidence provided by Chhabra et al¹ adds to an increasing literature on the prevalence and size of these "surprise" bills for privately insured patients.^{2,3} Such billing practices are particularly pernicious because patients usually have no knowledge that they will occur, and no way to avoid them.

Clinicians and policy makers alike should act to end this practice. First, surgeons have an ethical responsibility to speak out against surprise billing. Patients generally select sur-

geons because they have faith that the surgeon they choose will provide them with the best possible care. This crucial trust between patient and physician will be eroded if patients discover after an operation that they must pay large sums of money to other clinicians the surgeon has involved in their care. When feasible, surgeons should ensure that all the personnel involved in the care team that they are leading accept the same insurance plans and should consider refusing to work in facilities that allow surprise billing.

Second, Congress needs to act to eliminate surprise billing. While some states have enacted surprise billing legislation, Chhabra et al¹ found no relationship between states' surprise billing policies and patients' financial liability resulting from these out-of-network bills, suggesting broader change is necessary. In 2019, the US Senate proposed the Lower Health Care Costs Act⁴ and the House proposed the No Surprises Act,⁵ which would require patients to pay only the in-network cost-sharing amount (ie, deductibles or co-insurance) for out-of-network care provided at in-network facilities without the patient's informed consent. There has been pushback from physician groups, particularly those backed by private equity firms, who argue that such legislation will have potentially negative consequences for clinicians by reducing their leverage to negotiate fair reimbursement.⁶ While it is important that legislation take these issues into account, it is crucial that patients' interests remain paramount.

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On December 27, 2020, tucked into the year-end coronavirus relief package and spending [bill](#), Congress passed the [No Surprises Act](#), largely ending the practice of [surprise out-of-network medical bills](#). In a win for patients, the law applies to air ambulance operators as well as out-

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of-network providers and facilities that provide emergency and non-emergency health services. Nevertheless, the law's consumer protections don't go far enough to protect patients from the financial risks of an air ambulance transport.

Effective January 1, 2022, the No Surprises Act [generally prohibits](#) out-of-network providers in emergencies and at in-network facilities from billing patients for more than their in-network cost-sharing amounts (eliminating patient balance-billing) and sets up a dispute resolution process to determine the amount the patient's health plan will pay for the out-of-network care.

If the out-of-network provider and the payer cannot agree on a rate through negotiation, the parties can pursue "baseball-style" arbitration and submit their final proposed rates to the arbitrator, who must then select one of the proposed rates. The arbitrator is directed to consider certain factors to select the winning rate, including the median in-network rates for the services in the area, the acuity of the case, and prior contracted rates or attempts to contract between the parties. In addition to these factors, the arbitrator can consider the air ambulance vehicle type (for example, fixed or rotary wing), the vehicle's clinical capacity, and the population density of the pick-up site. Either party can present any other information they wish, with the important exception that the arbitrator is prohibited from considering both the provider's billed or usual and customary charges and public payer rates, such as those paid by Medicare, Medicaid, or the Children's Health Insurance Program.

The Arbitration Guidelines May Not Work For Air Ambulances

While protecting patients from surprise bills for air ambulance rides—particularly at [the federal level](#)—is a welcome able step forward, the No Surprises Act alone is unlikely to rationalize the air ambulance market. Out-of-network air ambulance bills are a particularly pernicious form of surprise medical bill, and the market distortions are even more pronounced than in other specialties. Arbitration that looks to previously negotiated rates for air ambulances will be higher than genuine market rates for three reasons: current negotiated rates are inflated by the threat of surprise billing; the [highly concentrated](#) air ambulance market means negotiated prices are further inflated by market power; and the paucity of in-network transports makes in-network data unreliable.

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The standard insurer-provider negotiation model does not function properly for emergency air ambulance services, both because providers must pick up any patient regardless of payment and insurers have no ability to steer patients to preferred providers. Air ambulance transports are also rare and, even with high per-transport costs, make up only a [tiny portion](#) of health insurance spending. Thus, insurers may continue paying inflated charges for the rare air ambulance bills that do occur rather than investing substantial resources to bring these providers in network at a reasonable rate.

Given these realities, median in-network rates—which arbitrators are directed to consider—are unlikely to be a meaningful measure of efficient prices for these services. Instead, payers agreed to these rates largely to avoid surprise out-of-network liability for patients, which [averaged about \\$20,000](#) over the 2016–17 period. Likely due to the infrequency of air ambulance services and the very high costs, many insurers appear to place a high value on preventing enrollee surprise bills, with [one study](#) finding that insurers allowed out-of-network air ambulances' full charges for about half of transports, without any clear relation to the magnitude of the charge. In turn, this creates an incentive for air ambulance operators to continuously raise charges and remain out of network unless offered very high payment. Furthermore, the national market for air ambulance services is highly consolidated, with private-equity firms that appear to [set their charges more aggressively](#) controlling a large share of the market.

It is unsurprising, then, that about three-quarters of air ambulance transports (estimates range from [70 percent](#) to [77 percent](#)) of commercially insured patients were out of network, compared with about one in five inpatient admissions from the [emergency department](#) or [elective surgeries](#) that involved an out-of-network provider. Median charges for a rotary-wing air ambulance transport spiked over the past decade, [nearly tripling](#) from \$12,500 to \$35,900 between 2008 and 2017, while median in-network rates increased [128 percent](#) over the same period.

The No Surprises Act's guidelines for arbitrators to determine out-of-network rates—referring to median in-network rates and prior contracted rates—thus do not represent anything approaching a “market price” for air ambulance services. Moreover, to a greater extent than other services, air ambulance operators have historically used out-of-network billing as a [revenue strategy](#), and there are few in-network rates to guide arbitrators.

Arbitration cannot fix the market failures, consolidation, and unequal bargaining power that [characterize](#) the air ambulance market. Bringing market forces to the air ambulance industry would likely involve setting up a competitive bidding process, as some of us have [recommended](#). The alternative is to pursue price regulation in this market, but due to the myriad problems described above, arbitration based on median in-network rates is the wrong way to go about this. Instead, Congress should re-evaluate and update Medicare prices for

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air ambulance services (which were created via negotiated rulemaking in 2002) to better approximate efficient prices, and then use Medicare prices (or some multiple thereof) to determine out-of-network payment requirements for commercial insurers or to guide arbitrator decisions. Yet, under the act, arbitrators are prohibited from considering Medicare rates.

The No Surprises Act requires health insurance plans and air ambulance operators to submit cost and claim data to the secretary of the Department of Health and Human Services, who will then publish a report analyzing trends in the costs, use, service capacity, competition, and unfair consumer practices of air ambulance industry. This reporting and analysis can be helpful but only if Congress uses this information to improve upon the current arbitration process and to re-evaluate Medicare payment rates. Otherwise, the challenges in implementation of the act's consumer protections and arbitration process mean that monitoring the pricing and contracting trends in air ambulance market will be critical—and insufficient.

Making matters worse, unlike surprise medical bills for services at health facilities, out-of-network bills from air ambulances have been largely shielded from state regulation by [judicial interpretations](#) that such state laws are preempted by the Airline Deregulation Act. This means that despite the fact that the No Surprises Act permits more comprehensive state laws to supersede the federal out-of-network payment methodology, states may not have the ability to apply such laws to the air ambulance market.

What Else Is Needed?

Beyond the balance billing protections in the No Surprises Act, Congress should amend the Airline Deregulation Act to clarify that it [does not preempt](#) state consumer protection laws, or the Department of Transportation and courts should correct their [contrary interpretations](#) of the Airline Deregulation Act to the same end. In the absence of a functioning market, we rely on consumer protection laws, particularly [state laws](#), to address the market manipulation and consumer exploitation at work in the air ambulance market.

Barring balance billing is just one consumer protection. Private-equity and profit-seeking investors will continue to find ways to exploit legal loopholes to the detriment of consumers, including through the sale of dubious air ambulance “[membership](#)” programs, challenges to state efforts to create [preferred call lists](#) for emergency management dispatchers to direct calls to in-network air ambulance providers, and challenges to states' application of [workers' compensation fee schedules](#) or automobile insurance regulations to air ambulance transports.

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Recently, the 8th Circuit Court of Appeals [struck down](#) North Dakota's ban on air ambulance balance billing and regulation of membership programs as preempted by the Airline Deregulation Act—erroneously in our view. Such rulings are products of an excessively literal reading of narrow provisions in the Airline Deregulation Act, and their invalidation of state consumer protection laws undermine central state authorities. These judicial errors will hopefully be corrected by other courts, but in the alternative, the Department of Transportation should [regulate abuses](#) by the air ambulance industry via its [consumer protection authority](#) or Congress should amend the Airline Deregulation Act.

States have always served as the front lines of consumer protection, so it doesn't make sense to carve out air ambulances from these state laws by treating them more like commercial airlines than ground ambulances under an overly broad reading of the Airline Deregulation Act. Nor does it make sense to place consumer protection for patients who are transported via air ambulances solely in the hands of the federal Department of Transportation, as the current laws [provide](#).

Lessons For The Broader Health Care Market

Policy makers must recognize that when markets break down, exploitive practices soon follow. Surprise medical billing, whether by air ambulance operators or other providers, stemmed from aggregation of market power and abuse of that market power through nefarious contracting practices. Given the opportunity to exploit legal loopholes to raise revenues, certain [provider groups](#) (particularly those controlled by [private equity](#)) rushed in and drove up health care costs. This pattern exists throughout the health care system and should inform many areas of health policy, including hospital monopolies, patent evergreening, pharmaceutical price gouging, and unwarranted outpatient facility fees. Ending surprise bills is important, but health policy requires a more comprehensive approach to [making markets work](#).

In short, the air ambulance problem points to other problems, and solving the worst abuses with narrow solutions might only prompt minor changes in a policy whack-a-mole while avoiding a broader remedy. The No Surprises Act is an important response to this abusive use of an out-of-network billing strategy, but it does not solve other market failures or health care consumer woes.

We need to sharpen available legal tools to address the problems of consolidation and anticompetitive and unfair practices in health care, including strengthening antitrust and consumer protection laws. Although a positive step forward, the No Surprises Act does not go far enough to correct either.

Authors' Note

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Erin Fuse Brown, Erin Trish, and Loren Adler received support from grants from Arnold Ventures to study surprise medical bills and air ambulance bills. Erin Fuse Brown reports consulting fees from the National Academy for State Health Policy. Erin Trish reports consulting fees from the Blue Cross Blue Shield Association and Cedars-Sinai Health System.

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Original Scholarship

Out-of-Network Air Ambulance Bills: Prevalence, Magnitude, and Policy Solutions

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Policy Points:

- Out-of-network air ambulance bills are a type of surprise medical bill and are driven by many of the same market failures behind other surprise medical bills, including patients' inability to choose in-network providers in an emergency or to avoid potential balance billing by out-of-network providers.
- The financial risk to consumers is high because more than three-quarters of air ambulances are out-of-network and their prices are high and rising. Consumers facing out-of-network air ambulance bills have few legal protections owing to the Airline Deregulation Act's federal preemption of state laws.
- Any federal policies for surprise medical bills should also address surprise air ambulance bills and should incorporate substantive consumer protections—not just billing transparency—and correct the market distortions for air ambulances.

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Context: Out-of-network air ambulance bills are a growing problem for consumers. Because most air ambulance transports are out-of-network and prices are rising, patients are at risk of receiving large unexpected bills. This article estimates the prevalence and magnitude of privately insured persons' out-of-network air ambulance bills, describes the legal barriers to curtailing surprise air ambulance bills, and proposes policies to protect consumers from out-of-network air ambulance bills.

Methods: We used the Health Care Cost Institute's 2014-2017 data from three large national insurers to evaluate the share of air ambulance claims that are out-of-network and the prevalence and magnitude of potential surprise balance bills, focusing on rotary-wing transports. We estimated the magnitude of potential balance bills for out-of-network air ambulance services by calculating the difference between the provider's billed charges and the insurer's out-of-network allowed amount, including the patient's cost-sharing. For in-network air ambulance transports, we calculated the average charges and allowed amounts, both in absolute magnitude and as a multiple of the rate that Medicare pays for the same service.

Findings: We found that less than one-quarter of air ambulance transports of commercially insured patients were in-network. Two-in-five transports resulted in a potential balance bill, averaging \$19,851. In the latter years of our data, in-network rates for transports by independent (non-hospital-based) carriers averaged \$20,822, or 369% of the Medicare rate for the same service.

Conclusions: Because the states' efforts to curtail air ambulance balance billing have been preempted by the Airline Deregulation Act, a federal solution is needed. Owing to the failure of market forces to discipline either prices or supply, out-of-network air ambulance rates should be benchmarked to a multiple of Medicare rates or, alternatively, air ambulance services could be delivered and financed through an approach that combines competitive bidding and public utility regulation.

Keywords: air ambulances, out-of-network, surprise medical bills, balance bills.

EXORBITANT OUT-OF-NETWORK AIR AMBULANCE BILLS ARE A serious and growing problem facing health care consumers. Air ambulances, which provide rapid medical transport for acutely ill or injured patients to reach higher-level health care facilities, may be either rotary (helicopter) or fixed-wing (airplane) transports. In urgent situations, patients are unable to select an in-network air ambulance

provider or even to decline the services. As a result, they can end up unexpectedly transported by an air ambulance provider not in their health plan's network, in which case the air ambulance provider may bill the patient for the difference between its full charges and the amount paid by the patient's insurance plan.

Out-of-network air ambulance bills are a type of surprise medical bill, those generated by the involuntary and unavoidable use of an out-of-network provider. Air ambulance bills share many of the same features of other surprise medical bills, such as consumers' inability to choose in-network providers in an emergency and to avoid the potentially higher cost-sharing and balance billing by out-of-network providers. To an even greater extent than ordinary surprise medical bills, however, states are unable to regulate air ambulance providers' billing practices because of the federal Airline Deregulation Act's preemption of state laws. And even though Medicare and Medicaid generally prohibit balance billing, there are no protections against balance billing commercially insured patients for air ambulance services. Thus, despite some bold efforts by the states to address the problem, a federal solution is required.

Previous research has found that most air ambulance transports of commercially insured patients are provided out-of-network. The Government Accountability Office (GAO) reported that in 2017, 69% of air ambulance transports were out-of-network, and Garmon and Chartock found that between 2007 and 2014, 52% to 69% of air or water ambulances were out-of-network.^{1,2} Bai and colleagues found that the amounts charged to out-of-network patients—the provider's "list price" before any discounts—are far higher than Medicare's payment rates and have been growing rapidly.³ Moreover, recent evidence indicates that average in-network prices have also risen rapidly over the past decade.⁴ These large charge and price increases have followed changes in the air ambulance industry, including greater private equity ownership and rising costs per transport driven by growing numbers of bases and vehicles and relatively flat demand.^{1,5}

Unexplored, however, are the magnitudes of commercial insurers' payments to air ambulance providers and patients' financial liability, for both in- and out-of-network air ambulance transports. Such data are necessary to provide a more complete picture of spending on air ambulance services, its growth over time, and the size of patients' potential out-of-network bills. We also have few data detailing the breakdown of rural versus urban air ambulance utilization or the share of air

ambulance transports that cross state lines, which is important in order to understand the value of uniform federal protections.

In this article, we use a large nationwide data set of commercial medical claims to examine the prevalence and magnitude of out-of-network air ambulance bills, in-network payment rates, and patients' liability for rotary-wing services. Focusing on interfacility transports, we also describe the commercial air ambulance rates' markup over Medicare's rates and the share of air ambulance transports originating in urban versus rural areas. Next, we explain the market failures that have resulted in increasing spending on air ambulances. Finally, we describe the legal barriers to the states' regulation of air ambulance billing practices and propose two federal solutions to protect consumers from excessive out-of-network air ambulance bills. One would combine a prohibition on balance billing with minimum insurer out-of-network payments based on Medicare's rates. The other proposed solution would entail a regional competitive bidding framework.

Data and Methods

We evaluated Health Care Cost Institute (HCCI) commercial claims data from 2014 through 2017, which comprise claims from Aetna, Humana, and UnitedHealthcare (including more than 40 million covered lives in each year). The data include a network status indicator, the actual prices that insurers allow for in- and out-of-network services (allowed amounts), providers' charges, and patients' cost-sharing information.

We first looked at the share of air ambulance claims in- (versus out-of-) network. Next, in order to estimate the prevalence and magnitude of potential balance bills for out-of-network rotary-wing air ambulance services, we calculated the difference between the providers' billed charges and the insurers' out-of-network allowed amount (including any cost-sharing by patients). Because our data do not include any information on the magnitude of actual balance bills sent to patients, this calculation represents the *potential* liability that such a patient could face.

We then calculated the average and median charges and allowed amounts for in-network air ambulance services, both in absolute magnitude and, when possible, as a multiple of the rate that Medicare pays for the same service. Payments for air ambulance services generally have two components: a base rate and an additional per-mile rate.⁶ For

Table 1. Shares of Air Ambulance Claims by Network Status, 2014-2017^a

	In-Network	Out-of-Network ^b	Total
Rotary-Wing Claims	7,250	24,965	32,215
% of Rotary-Wing Claims	23%	77%	89%
Fixed-Wing Claims	1,213	2,884	4,097
% of Fixed-Wing Claims	30%	70%	11%
Total Air Ambulance Claims	8,463	27,849	36,312
% of Total Claims	23%	77%	100%

^aAnalysis of 2014-2017 Health Care Cost Institute commercial claims data.^bClaims with missing network status are assumed to be out-of-network.

transports from rural areas, Medicare pays an additional 50% for both the base and the mileage rates. Thus, to compare commercial payment rates with Medicare's rates, it is necessary to know whether the pickup was in a rural or an urban area. Because the HCCI data do not include a geographic indicator for where an air ambulance pickup occurred, for this analysis we restricted the data to a subset of interfacility transfers for which we can identify the location of the facility from which the patient was transferred.

Finally, among this subset of interfacility transfers, we determined the share of air ambulance transports that crossed state lines.

Results

Our analytic sample was made up of 36,312 air ambulance claims over the four-year study period. Of these claims, 77% were out-of-network (including those missing a network status) (Table 1). In total, 36% of the claims were missing a network status. They did, however, appear to be out-of-network claims delivered by hospital-based providers. Tables 2, 3, and 4 describe the characteristics of those claims missing a network status that led us to believe that they were out-of-network claims. Of these 36,312 claims, 89% were for rotary-wing services, and the remaining 11% were for fixed-wing services. Accordingly, the rest of our analyses focus on rotary-wing services, of which 77% were also provided

Table 2. Shares of Air Ambulance Claims by Network Status, 2014-2017 ^a							
Network Status	Metric	2014	2015	2016	2017	2014-2017	
Rotary-Wing Claims Hospital-Based In-Network	# of Claims	1,137	835	1,116	1,491	4,579	
	% of Rotary-Wing Claims	15%	11%	12%	18%	14%	
	# of Claims	2,603	2,965	3,411	2,562	11,541	
	% of Rotary-Wing Claims	35%	40%	38%	31%	36%	
Non-Hospital-Based In-Network	# of Claims	448	446	1,265	512	2,671	
	% of Rotary-Wing Claims	6%	6%	14%	6%	8%	
	# of Claims	3,274	3,215	3,264	3,671	13,424	
	% of Rotary-Wing Claims	44%	43%	36%	45%	42%	
Out-of-Network^b	# of Claims	7,462	7,461	9,056	8,236	32,215	
Total Rotary-Wing Claims							
Fixed-Wing Claims Hospital-Based In-Network	# of Claims	142	119	142	152	555	
	% of Fixed-Wing Claims	15%	12%	12%	15%	14%	

Continued

Table 2. Continued

Network Status	Metric	2014	2015	2016	2017	2014-2017
Missing Network ^b	# of Claims	337	327	400	328	1,392
	% of Fixed-Wing Claims	36%	33%	35%	32%	34%
Non-Hospital-Based In-Network	# of Claims	116	164	252	126	658
	% of Fixed-Wing Claims	12%	16%	22%	12%	16%
Out-of-Network ^b	# of Claims	350	388	343	411	1,492
	% of Fixed-Wing Claims	37%	39%	30%	40%	36%
Total Fixed-Wing Claims	# of Claims	945	998	1,137	1,017	4,097

^a Analysis of 2014-2017 Health Care Cost Institute commercial claims data.^b Our data sample had no out-of-network claims for hospital-based providers and no missing network status claims for non-hospital-based providers.

Table 3. Counts of Rotary-Wing Air Ambulance Claims Paid in Full by Network Status and Year, 2014-2017^a

Network Status	Metric	2014	2015	2016	2017	2014-2017
In-Network	# of Claims Paid in Full	72	32	374	27	505
	% of In-Network Claims	5%	2%	16%	1%	7%
Out-of-Network ^b	# of Claims Paid in Full	1,676	1,698	1,607	1,499	6,480
	% of Out-of-Network Claims	51%	53%	49%	41%	48%
Missing Network ^b	# of Claims Paid in Full	1,282	1,472	1,745	1,025	5,524
	% of Missing Network Claims	49%	50%	51%	40%	48%
All Network Status	# of Claims Paid in Full	3,030	3,202	3,726	2,551	12,509
	% of Total Claims	41%	43%	41%	31%	39%
Potential Balance Bill: Out-of-Network ^b		1,598	1,517	1,657	2,172	6,944
Potential Balance Bill: Missing Network Status ^b		1,321	1,493	1,666	1,537	6,017
% of Claims with Potential Balance Bill						
Out-of-Network Only ^b						
		21%	20%	18%	26%	22%
Out-of-Network and Missing Network Status ^b		39%	40%	37%	45%	40%

^a Analysis of 2014-2017 Health Care Cost Institute commercial claims data.^b Our data sample had no out-of-network claims for hospital-based providers and no missing network status claims for non-hospital-based providers.

Table 4. Prevalence and Magnitude of Rotary-Wing Air Ambulance Claims Not Paid in Full and Out-of-Network and Missing Network Status Claims, 2014-2017^a

	Out-of-Network (Non-Hospital- Based) ^b		Missing Network Status (Hospital-Based) ^b	
	Paid in Full	Not Paid in Full	Paid in Full	Not Paid in Full
Number of Claims	6,480	6,944	5,524	6,017
% of Claims	48%	52%	48%	52%
Mean Amounts ^c				
Charge	\$34,493	\$37,025	\$37,188	\$37,747
Allowed Amount	\$34,493	\$17,471	\$37,188	\$17,552
Balance	\$0	\$19,554	\$0	\$20,194
Insurer Payment	\$33,804	\$16,717	\$37,103	\$17,214
Patient	\$689	\$754	\$85	\$338
Cost-Sharing				
Median Amounts ^c				
Charge	\$34,919	\$36,698	\$37,672	\$37,909
Allowed Amount	\$34,919	\$8,538	\$37,672	\$14,489
Balance	\$0	\$15,172	\$0	\$18,187
Insurer Payment	\$34,189	\$7,712	\$37,631	\$14,236
Patient	\$0	\$0	\$0	\$0
Cost-Sharing				

^aAnalysis of 2014-2017 Health Care Cost Institute commercial claims data.

^bOur data sample had no out-of-network claims for hospital-based providers and no missing network status claims for non-hospital-based providers.

^cCharge and allowed amount include the base rate and mileage.

out-of-network (see Table 1). Our finding that 77% of air ambulance transports were out-of-network is higher than prior estimates from the GAO (69%, using FAIR Health data) and Garmon and Chartock (52% to 69%, using MarketScan data), which may reflect differences in the plans, market segments, and years included in the data sources, as well as the fact that the GAO restricted its analysis to claims that did have a network status.

Table 5. Prevalence and Magnitude of Rotary-Wing Air Ambulance Claims Not Paid in Full, 2014-2017^a

	Paid in Full	Not Paid in Full
Number of Claims		
Number of In-Network Claims	505	6,745
% of In-Network Claims	7%	93% ^b
Number of Out-of-Network Claims ^c	12,004	12,961
% of Out-of-Network Claims	48%	52%
Total Rotary-Wing Claims	12,509	19,706
% of Claims Resulting in a Potential Balance Bill		40%
Mean Amounts for Out-of-Network Claims^{c,d}		
Charge	\$35,733	\$37,360
Allowed Amount	\$35,733	\$17,509
Balance	\$0	\$19,851
Insurer Payment	\$35,323	\$16,948
Patient Cost-Sharing	\$411	\$561

^a Analysis of 2014-2017 Health Care Cost Institute commercial claims data.

^b Includes in-network claims whose in-network contracted rates were less than full charges and whose in-network providers are prohibited from sending patients a balance bill.

^c Claims with missing network status are assumed to be out-of-network.

^d Charge and allowed amount include the base rate and mileage.

Among out-of-network rotary-wing claims, the insurer paid the air ambulance provider's full billed charges 48% of the time—at an average of \$35,733—meaning that there was no potential balance to bill the patient (beyond any normal cost-sharing by the patient) (Table 5). (We found that insurers paid the in-network air ambulance providers their billed charges in full 7% of the time, even though in-network providers are prohibited from sending their patients a balance bill.) The vast majority of these approved charges for out-of-network providers were paid by the insurer, and for these cases, the patient's cost-sharing averaged \$411. Payers may be approving the air ambulance providers' full billed charges to protect plan members from balance billing. Moreover, we found that this practice may be more common among self-insured plans. While the prevalence of and mean charges for out-of-network claims

were similar, self-insured plans paid these out-of-network claims in full 50% of the time, whereas fully insured plans did so 38% of the time.

Of those out-of-network services that were not paid in full (across all plan types), patients were liable for a potential balance bill for 40% of all helicopter air ambulance rides, with an average potential surprise bill of \$19,851, in addition to standard out-of-network cost-sharing, which averaged \$561 (see Table 5). The average charges were similar for out-of-network air ambulance providers whose charges both were and were not paid in full (see Table 5), suggesting that such behavior represents the insurers' or the employers' policy rather than the providers' billing practice.

The average allowed amount for in-network services (\$23,821) was 80% of the average billed charges (\$29,679), suggesting that insurers receive only modest in-network discounts off charges in their negotiations with air ambulance providers (Table 6). The average total charges grew by 28% from 2014 to 2017 (across all network types), with a similar growth in charges by both in- and out-of-network providers. The average total allowed amounts for in-network providers increased by 28% over the study period, while the average total out-of-network allowed amounts rose by 12% (see Table 6).

Overall, approximately half the claims we analyzed were provided by air ambulance providers who appeared to be affiliated with a hospital's outpatient department (defined by the place of service code on the claim), and the other half appeared to be independent, non-hospital-based air ambulance providers (Figure 1). Hospital-based providers have a higher share of in-network claims (28%) than do non-hospital-based providers (17%), which may indicate that air ambulances' network participation is more likely when part of a broader contract negotiation with one or more facilities. However, both the average charges and allowed amounts are higher for hospital-based air ambulance providers than for non-hospital-based providers, particularly for in-network services (see Figure 1), suggesting again that insurers are unable to gain much cost advantage by bringing these services in-network.

To compare commercial charges and allowed amounts with Medicare's reimbursement rates, we looked at the subset of 2016 through 2017 interfacility transfer claims for which we can identify whether the pickup was in an urban or a rural area. Interfacility transfers comprised 59% of all rotary-wing air ambulance claims during this time period, including 51% for which we could identify the associated pickup facility

Table 6. Mean and Median Charges and Allowed Amounts for Rotary-Wing Air Ambulance Claims by Network Status and Year, 2014-2017^a

Year	In-Network			Out-of-Network ^b			All Network Status		
	# of Claims	Amount	Change %	# of Claims	Amount	Change %	# of Claims	Amount	Change %
Mean Charge^c									
2014	1,585	\$24,938		5,877	\$31,974		7,462	\$30,480	
2015	1,281	\$26,055	4%	6,180	\$34,971	9%	7,461	\$33,440	10%
2016	2,381	\$32,236	24%	6,675	\$37,770	8%	9,056	\$36,315	9%
2017	2,003	\$32,708	1%	6,233	\$41,230	9%	8,236	\$39,158	8%
2014-2017	7,250	\$29,679	31%	24,965	\$36,577	29%	32,215	\$35,024	28%
Median Charge^c									
2014	1,585	\$24,014		5,877	\$31,893		7,462	\$30,566	
2015	1,281	\$24,911	4%	6,180	\$35,350	11%	7,461	\$33,611	10%
2016	2,381	\$31,590	27%	6,675	\$38,790	10%	9,056	\$37,164	11%
2017	2,003	\$30,878	-2%	6,233	\$42,006	8%	8,236	\$39,653	7%
2014-2017	7,250	\$28,683	29%	24,965	\$36,774	32%	32,215	\$34,842	30%

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Out-of-Network Air Ambulance Bills

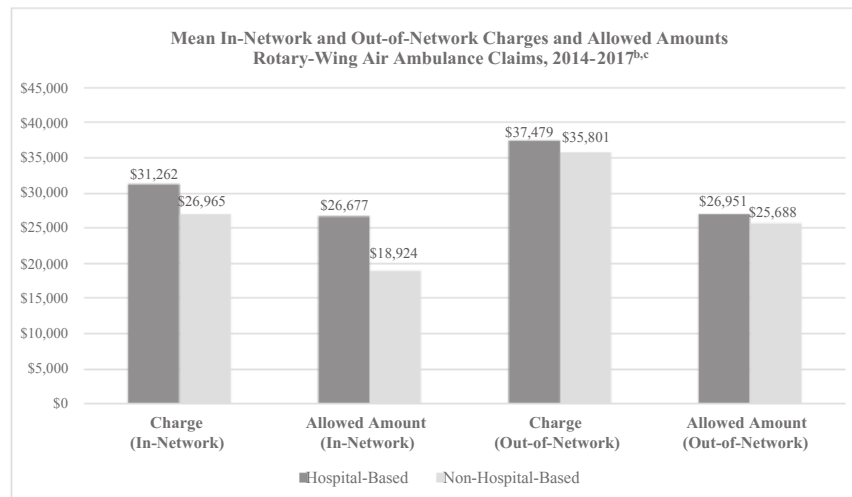
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Table 6. Continued

Year	In-Network			Out-of-Network ^b			All Network Status		
	# of Claims	Amount	% Change	# of Claims	Amount	% Change	# of Claims	Amount	% Change
Mean Allowed Amount ^c									
2014	1,585	\$21,385		5,877	\$24,299		7,462	\$23,680	
2015	1,281	\$21,553	1%	6,180	\$26,039	7%	7,461	\$25,269	7%
2016	2,381	\$23,662	10%	6,675	\$27,233	5%	9,056	\$26,294	4%
2017	2,003	\$27,387	16%	6,233	\$27,333	0%	8,236	\$27,346	4%
2014-2017	7,250	\$23,821	28%	24,965	\$26,272	12%	32,215	\$25,720	15%
Median Allowed Amount ^c									
2014	1,585	\$20,297		5,877	\$26,227		7,462	\$24,785	
2015	1,281	\$18,872	7%	6,180	\$27,730	9%	7,461	\$26,214	9%
2016	2,381	\$22,440	19%	6,675	\$27,909	1%	9,056	\$26,000	1%
2017	2,003	\$24,800	11%	6,233	\$25,975	-7%	8,236	\$25,494	-2%
2014-2017	7,250	\$22,207	22%	24,965	\$27,037	-1%	32,215	\$25,628	3%

^a Analysis of 2014-2017 Health Care Cost Institute commercial claims data.^b Claims with missing network status are assumed to be out-of-network.^c Charge and allowed amount include the base rate and mileage.

Figure 1. Charges, Allowed Amounts, and Shares of Rotary-Wing Air Ambulance Claims for Hospital-Based and Non-Hospital-Based Providers, 2014-2017^a



Shares of Rotary-Wing Air Ambulance Claims by Network Status, 2014-2017

	In-Network	Out-of-Network ^e	Total
Hospital-Based	4,579	11,541	16,120
% of Hospital-Based Claims	28%	72%	50%
Non-Hospital-Based	2,671	13,424	16,095
% of Non-Hospital-Based Claims	17%	83%	50%
Total Claims	7,250	24,965	32,215
% of Total Claims	23%	77%	100%

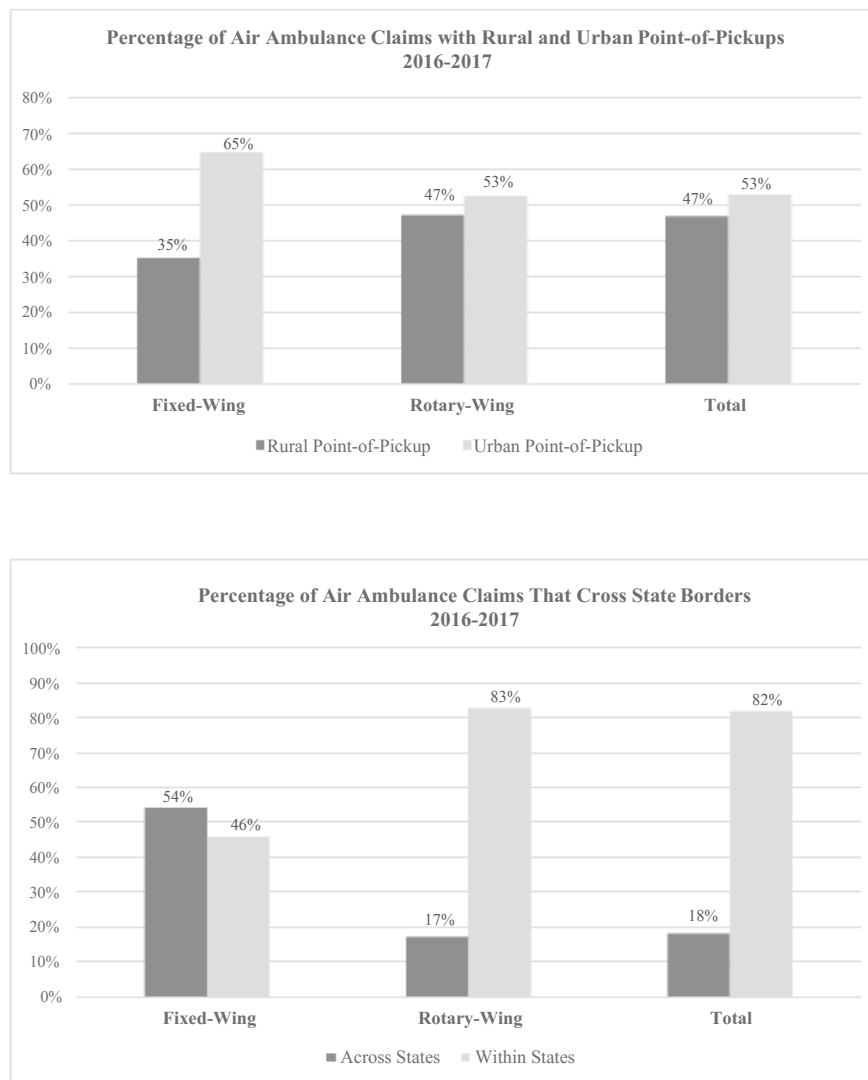
^a Analysis of 2014-2017 Health Care Cost Institute commercial claims data.

^b Charge and allowed amounts include the base rate and mileage.

^c Claims with missing network status are assumed to be out-of-network.

claim. Of these pickups, 53% originated in urban areas, with the remaining 47% originating in rural areas (Figure 2). For these claims, the average total in-network allowed amounts were \$27,688 and \$20,822 for hospital-based and non-hospital-based air ambulance providers,

Figure 2. Percentage of Air Ambulance Claims with Rural and Urban Point-of-Pickups and Cross State Borders, 2016-2017^a

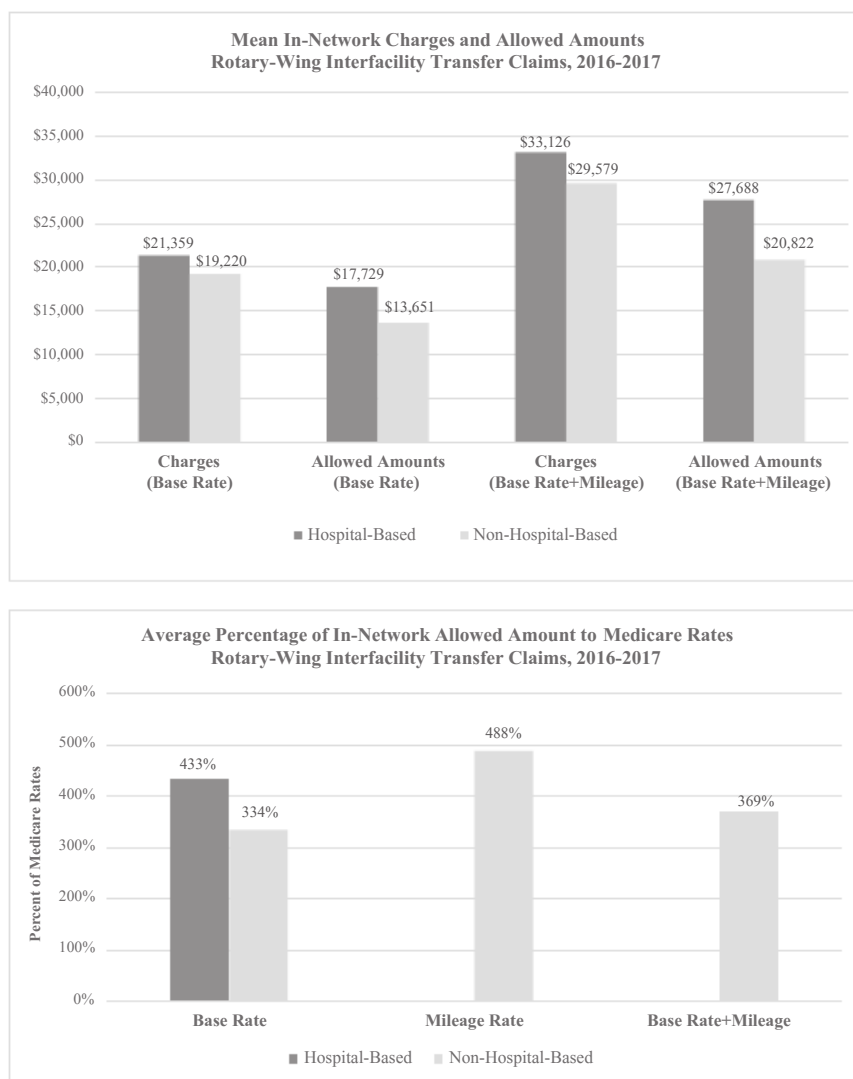


^aAnalysis of 2016-2017 Health Care Cost Institute commercial claims data.

respectively (Figure 3), which are roughly similar to the average in-network allowed amounts for the overall sample (Figure 4).

Data also allow Medicare comparisons for independent (non-hospital-based) air ambulance providers. For them, the average in-network

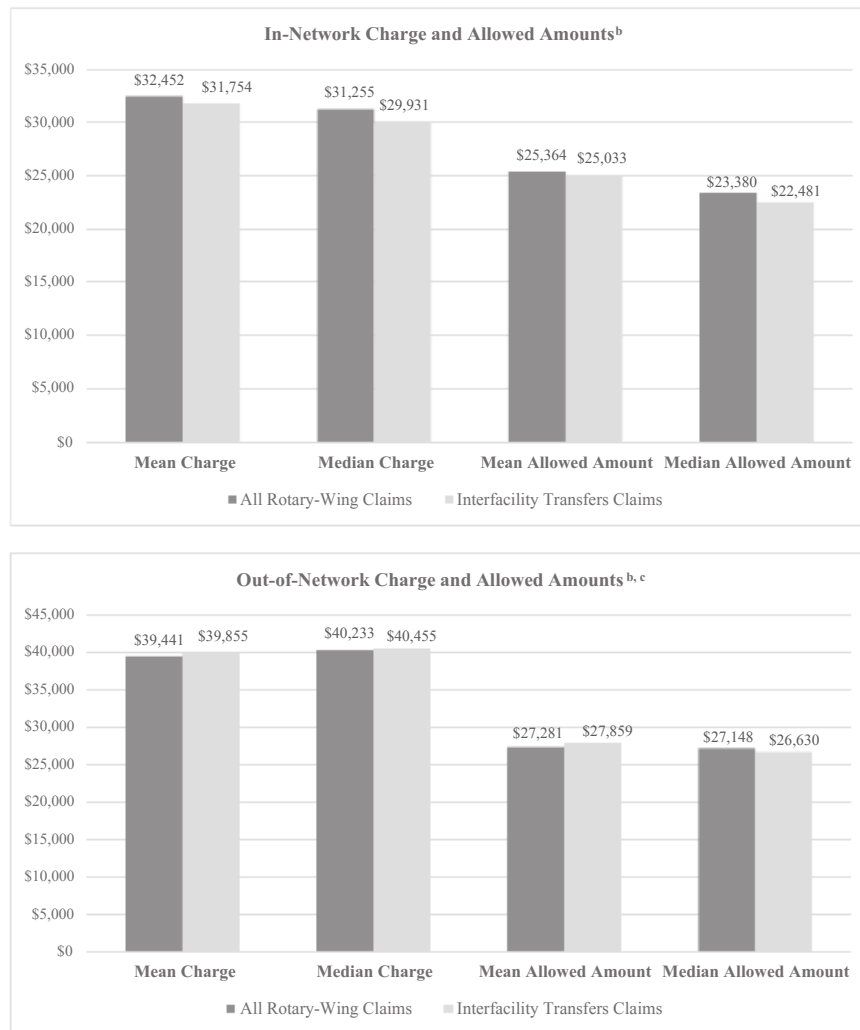
Figure 3. In-Network Charges and Allowed Amounts for Rotary-Wing Interfacility Transfer Claims, 2016-2017^a



^a Analysis of 2016-2017 Health Care Cost Institute commercial claims data.

allowed amounts were 369% of Medicare's reimbursement rate for the same service. We found that the markup over Medicare was higher for the mileage rate (488%) than the base rate (334%). We could not compute the equivalent metric for hospital-based providers because these

Figure 4. Comparison of Charges and Allowed Amounts for Rotary-Wing Interfacility Transfers Claims with All Rotary-Wing Claims, 2016-2017^a



^aAnalysis of 2016-2017 Health Care Cost Institute commercial claims data.

^bCharge and allowed amount include the base rate and mileage.

^cClaims with missing network status are assumed to be out-of-network.

claims do not include mileage units in our data, but the base rate for these claims—which averages \$17,729—was 433% of Medicare's base rate (see Figure 3).

Finally, among this subset of interfacility transfers, 18% of them crossed state lines (see Figure 2).

Discussion

Out-of-network air ambulance bills exhibit the hallmarks of unfair surprise medical bills, and the market is characterized by high and fast-growing spending. The remainder of this article discusses why a federal regulatory solution is needed to fix the market for air ambulance services and how a federal solution should be crafted.

The Dysfunctional Market for Air Ambulance Service

For most medical services, patients almost always select providers that are in-network with their insurance plan, as doing so generally comes with lower cost-sharing. But given the urgent nature of air ambulance services, patients are typically unable to choose the operator to transport them and therefore can end up serviced by an out-of-network air ambulance. We found that more than three-quarters of air ambulance transports are out-of-network. In this situation, about half the time the commercial insurer pays the air ambulance's billed charges in full. We did find, however, potential balance bills for air ambulances in 40% of cases, averaging nearly \$20,000.

Without the ability to steer service volume, it may be difficult for insurers to contract with or secure much of a discount from air ambulance providers. The low volume of air ambulance services likely also contributes to the lack of price constraints. As a result, it is not surprising to see such high and rising charges from air ambulance companies, relative to Medicare's rates, in addition to the infusion of private equity into the industry.⁷ Moreover, providers can use the threat of balance billing patients to demand higher contracted rates from payers, which may help explain the high in-network rates relative to what Medicare pays and why in-network discounts are relatively modest.

The Legal Landscape

We might expect the states to be the first line of defense against air ambulance surprise billing, as states are the primary regulators of both health care services and health insurance. Air ambulance providers, however, have repeatedly used federal preemption to beat back state regulations. Beyond the broad ERISA preemption that stymies many state efforts to regulate health plans,⁸ here the primary source of preemption is even more sweeping: the Airline Deregulation Act of 1978 (ADA).⁹

For decades before 1978, the federal government regulated all commercial air transport services (scheduled or otherwise) essentially as public utilities, setting both fares and schedules. The Airline Deregulation Act eliminated this government oversight in favor of market competition, based on the premise that doing so would better serve consumers' interests. To ensure that states did not step into the breach, the ADA has a sweeping preemption provision: "a state ... may not enact or enforce a law, regulation, or other provision ... related to a price, route, or service of an air carrier" (49 U.S.C. § 41713 [1997]).

Unlike normal commercial air service, market competition has not worked well for medical transport. Deregulation produced a sharp drop in commercial air fares,¹⁰ in contrast with the rapidly rising prices for air medical transport. The air ambulance service was so new in 1978 that we have no data concerning the prevailing charges at the time that deregulation was adopted.¹¹ An industry survey in 1982, however, reported that air ambulance charges averaged about \$500, which is equivalent to about \$1,350 now.¹² The average charges of \$35,024 between 2014 and 2017 (see Table 6) represent a more than 25-fold escalation in charges since shortly after the deregulation era began. This failure of the market has prompted a half dozen states to attempt some form of rate oversight of air ambulances.¹³ But courts have firmly rejected all of these state efforts, ruling that these state laws are preempted by the ADA.¹⁴

States have sought creative ways to avoid preemption by, for instance, giving priority in assigning 911 response calls to companies that voluntarily comply with a fee schedule, but courts have also struck down these voluntary approaches.¹⁵ Indeed, courts have gone as far as ruling that states may not set air ambulance fee schedules even for their own government employee health plans or under their state-administered worker compensation funds.¹⁵ Nor may states apply generic consumer

protection laws, or even long-standing common law contract doctrine, to claims of excessive air ambulance billing.¹⁶

Courts have enforced this absolute preemption even though the air ambulance industry did not exist when Congress enacted the ADA,^{10,17} and the act's fundamental premise about the suitability of unregulated market forces does not apply to these services.¹⁸ As the Tenth Circuit explained:

There is certainly some persuasive force to the ... [argument that] states have been unable to “prevent air ambulance service providers ... from imposing exorbitant fees on patients who wrongly assume their insurance will cover the charges and are not in a position to discover otherwise” or engaging in other unscrupulous pricing behaviors that would not be sustainable in a true free market but are easily perpetuated in the warped market of air-ambulance services, ... [and so] surely Congress did not anticipate or intend such a result... . [Nevertheless] any deficiency in the plain language of the statute or the scope of its coverage must be corrected by Congress.¹⁹

States continue to search for creative ways to circumvent this seemingly impenetrable preemption barrier. Wyoming, for instance, recently issued a proposal (in the form of a Medicaid Section 1115 waiver) to pay for all air ambulance services in the state through Medicaid, including services to the privately insured, in order to receive federal permission to regulate the industry as a public utility.²⁰ Although CMS rejected the plan, Wyoming had proposed to set up a call center to dispatch air ambulances and solicit bids from air ambulance providers to service the state in exchange for a fixed monthly payment. For the privately insured, the state would recoup payments from private insurers and employer-based plans through its Medicaid “pay and chase” authority. CMS denied Wyoming’s waiver application, stating that Section 1115 waivers could not be used to circumvent the ADA and that the proposal was not budget neutral, as required.²¹ Even if such an approach were approved, because a substantial number of air ambulance transports cross state lines (18% in our data sample of interfacility transports), a uniform federal solution would still offer advantages.

Responding to widespread sentiment that federal law is frustrating much needed consumer protection, Congress, in its FAA Reauthorization Act of 2018,²² called for the creation of an advisory committee to study air ambulance billing, but the committee’s charge appears to center on developing proposals relating to price transparency

rather than on preventing, or limiting the size of, unfair out-of-network billing.²³

Although we believe that a federal solution to out-of-network air ambulance bills is preferable, in the absence of a substantive federal solution, Congress should at least carve out air ambulance bills from the Airline Deregulation Act's preemption to allow states to apply their own solutions.

Policy Solutions

Any solution to out-of-network air ambulance bills should protect consumers from out-of-network balance billing and counter the market distortions that have failed to discipline high and rising prices. In this section, we describe two policy options that would achieve these goals.

The market failures causing different types of unfair out-of-network bills are similar, and thus similar approaches proposed to address hospital and physician surprise medical bills can be fashioned for the air ambulance market.²⁴ The consumer protections typically proposed for surprise medical bills should apply to out-of-network air ambulances: patients should be held harmless from owing more than the in-network cost-sharing amount; air ambulance providers should be prohibited from balance billing patients; and any cost-sharing the patient owes should be counted toward the patient's in-network deductible and cost-sharing limits.

As with policies to address surprise medical bills in other settings, the most contentious aspect is how to determine the amount that private health plans owe the out-of-network air ambulance provider. In the context of the air ambulance market, it is critical to get the out-of-network benchmark "right" (ie, approximating an efficient market rate).

Billing Regulation Benchmarked to Medicare Rates. The goal of an out-of-network benchmark for reimbursement is to replicate a "market rate" to which the parties would agree in the absence of the ability to collect an out-of-network balance bill. But no market-based reference point is available in the absence of a functioning market.

Federal legislative proposals to address surprise medical bills and air ambulance bills have proposed out-of-network payment methodologies based on median in-network rates.^{25,26} The preponderance of out-of-network air ambulance services (77% in our data) and the resulting

distortion of in-network rates point to the weakness of this approach. Payment methodologies based on median in-network contracted rates bake in the already excessive rates resulting from the very market failure that consumer protections are attempting to correct.²⁷ Similarly, methods relying on arbitration to determine payment rates often direct arbitrators to consider in-network contracted rates or even charges, thus replicating the same problems with the added unpredictability and administrative costs of arbitration.²⁸ That private payers are unable to secure significant discounts for network participation suggests they lack the bargaining power to resist air ambulance providers' price demands.

Accordingly, a better approach would benchmark out-of-network reimbursement rates for air ambulances to a national payment standard—a rate based on a multiple of the Medicare rate for the service provided—determined with the goal of replicating an efficient market rate. Although serious disagreement persists regarding the adequacy of the Medicare rates, the problem is less that the Medicare air ambulance fee schedule is too low than that the private market has failed to discipline rising prices, excess capacity, or discriminatory pricing.

One reaction that many would have to government rate regulation is that the government might set the rate too low to maintain adequate service. We believe, however, that the government would maintain a close eye on the industry after the implementation of rate regulation to gauge whether access issues arise, in which case the agency would be authorized to increase payment rates. One good indicator of whether rate increases are needed is whether, for hospital-based carriers, hospitals find it necessary to subsidize air ambulances beyond the allowed rates. The GAO could continue to report on air ambulance services, rates, network status, market entry or exit, and access, to inform regulatory modifications if the GAO report finds evidence of under- or overpayment or access issues.

Like other health care services, Medicare in the past paid hospital-operated air ambulance providers based on their costs. In 2002, Medicare switched to a prospective fee schedule for air ambulance services, established through negotiated rule-making.²⁹ The air ambulance base rate was set in 2002 to approximate costs at that time (67 Fed. Reg. 9100, 9117–9118 [2002]) and is adjusted annually based on the Consumer Price Index for All Urban Consumers (CPI-U) and a modest “productivity adjustment” (67 Fed. Reg. 9100, 9125 [2002]). The benefits

of using Medicare rates as a benchmark are administrative simplicity and the fact that Medicare already contains plausible adjustments for appropriate factors such as geography, rural versus urban origination, distance, and level of service.³⁰ These Medicare adjustments would be reflected in the benchmark multiplier and updated over time.

Just as Medicare's ambulance rates (for both ground and air) were initially set through negotiated rule-making with representatives of various stakeholders affected by the regulation, negotiated rule-making could be used to set the appropriate multiplier of these Medicare rates for private payers for out-of-network reimbursement, with the secretary of Health and Human Services given authority to make a final determination. Negotiated rule-making is an administrative process that a variety of federal agencies have successfully used to gather input from relevant interest groups to develop proposed rules that the agency then revises and adopts through the standard, public notice, and comment process.³¹ The negotiation could start using a multiple currently existing in a reasonably functioning geographic market, in which a larger share of air ambulance providers are in-network for historical or structural reasons and in which private rates are more closely related to efficient costs. The process of determining the multiplier would be contentious and would need to be calibrated to strike a balance between affordability and access, avoiding both agency-capture and widespread provider exit. We acknowledge the difficulty of this approach but believe it is worth exploring.

The lack in most areas of a functioning market for air ambulance services that is not distorted by balance billing requires the adoption of some type of benchmark for out-of-network rates. An objective benchmark unrelated to charges would strongly encourage insurers and air ambulance providers to establish a contracted rate or else default to a benchmark based on objective measures. Using median in-network rates or databases of commercial rates as a benchmark or resorting to arbitration, albeit preferable to a totally unregulated market, risks ossifying the current above-market rates resulting from a distorted market. Without a functioning market, some multiple of Medicare rates would likely be our best benchmark on which to base out-of-network air ambulance bills.

Competitive Bidding/Public Utility Regulation. An alternative approach would seek to create a functioning market for air ambulance services building on the model recently proposed by Wyoming.¹⁹ This approach resembles both a competitive bidding system and a public utility regulation model.

The federal government would determine the quantity, standards, and features of the air ambulance services needed to service different regions of the country. The air ambulance companies would then competitively bid for contracts to provide up to a certain quantity of services in a given region in exchange for a fixed monthly payment from the government. Multiple companies could be selected to service a given region to ensure adequate capacity, to allow smaller companies and new entrants to maintain a market presence, and to maintain competition in subsequent years' competitive bidding. Administering separate bidding processes for different regions in the country (possibly state-by-state) also would help maintain competition over the longer term by allowing different companies to win contracts. Call centers would be established to dispatch air ambulance calls to the winning bidders in a given region.

Air ambulance services for all US residents, including the uninsured, would be financed through this new competitive bidding program. Some amount of patient cost-sharing, based on income and program eligibility, could also help fund the benefit; no cost-sharing would be required of patients enrolled in Medicaid or other programs without cost-sharing requirements. While monthly payments would be made through the federal government, all payers—public and private—would contribute their per capita share of the air ambulance costs to the program.

Limiting the air medical transport market to selected providers is a form of public utility regulation, which the health care industry as a whole generally resists.³² It would also represent a significant departure from the status quo. However, a key feature and potential advantage of this proposed approach is that it avoids the difficulty of the government having to decide the “right” price for air ambulance services, instead utilizing a competitive bidding mechanism to establish prices. It also allows quicker price responses to changing market dynamics. This competitive bidding approach for air ambulance services is feasible because of the existence of a relatively large number of air ambulance service providers and their geographic mobility. Nonetheless, regulators need to remain vigilant to ensure that such competition remains in the market over time. Without competition, this approach would fail to constrain prices.

Conclusion

Whichever approach is taken, out-of-network air ambulance bills are created by the same market failures as other types of surprise medical bills. Thus, any federal policies to address surprise medical bills should also address out-of-network air ambulance bills. A federal solution is critical because the states are unable to protect patients under the Airline Deregulation Act. The best policy approaches incorporate substantive consumer protections—not just transparency—and correct the market distortions for air ambulances.

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SURPRISE! OUT-OF-NETWORK BILLING FOR EMERGENCY CARE IN THE
UNITED STATES

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Surprise! Out-of-Network Billing for Emergency Care in the United States
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ABSTRACT

Hospitals and physicians independently negotiate contracts with insurers. As a result, a privately insured individual can attend an in-network hospital emergency department, but receive care and potentially a large, unexpected bill from an out-of-network emergency physician working at that hospital. Because patients do not choose their emergency physician, emergency physicians can remain out-of-network and charge high prices without losing patient volume. As we illustrate, this strong outside option improves emergency physicians' bargaining power with insurers. We then analyze a New York State law that introduced binding arbitration between emergency physicians and insurers and therefore weakened physicians' outside option in negotiations. We observe that the New York law reduced out-of-network billing by 34 percent and lowered in-network emergency physician payments by 9 percent.

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1 Introduction

The prices of health care services delivered to privately insured individuals in the US are set via bilateral negotiations between health care providers and health insurers. Each year, there are 41.9 emergency department (ED) visits per 100 people in the United States (US) (Rui, Kang, and M 2013). When patients access EDs, they are consuming an indivisible package of care that includes hospital and physician services. However, what most privately insured patients do not realize is that hospitals and physicians in the US independently negotiate contracts with insurers. As a result, it is possible for a patient to choose a hospital ED that is in-network with his insurer, but receive care and a subsequent large bill from an unavoidable ED physician working at the hospital who is out-of-network with her insurer. A fundamental problem in emergency medicine in the US, which we describe, is that ED physicians face inelastic demand from patients when they are practicing inside in-network hospital EDs. As a result, they need not set their prices in response to market forces. Ultimately, the practice of out-of-network billing from inside in-network hospitals undercuts the functioning of health care labor markets, exposes patients to significant financial risk, and reduces social welfare. In this paper, we describe where out-of-network billing occurs, why it persists, and explore policy options to address the issue. Out-of-network billing is both an immediate policy concern and provides an illuminating demonstration of the economics of insurer physician bargaining. In particular, this paper illustrates how shifting a physician's outside option and disagreement payoff changes the negotiated payments they receive from insurers.

The financial harm patients face when they are treated by an out-of-network physician can be substantial. When a physician is out-of-network, she bills for and attempts to collect her "charges," which are not competitively determined. In many instances, when a patient is treated by an out-of-network physician, insurers will only pay physicians a portion of their out-of-network charges. This leaves the physician to attempt to collect the difference between her charges and the insurer's payment (the balance) from the patient (so-called balance or surprise billing). These balance bills can be hundreds or thousands of dollars and have been well documented in the popular press (see, for example, Rosenthal 2014a; Rosenthal 2014b; Sanger-Katz and Abelson 2016). Moreover, even in instances when an insurer pays the entirety of a physician's out-of-network charges, those higher payments will be passed onto consumers through higher premiums and cost sharing. Given that nearly half of individuals in the US do

not have the liquidity to pay an unexpected \$400 expense without taking on debt, these out-of-network bills can be financially devastating to a large share of the population and should be a major policy concern (Board of the Governors of the Federal Reserve System 2016).

ED physicians' ability to bill out-of-network also has the potential to raise the costs of in-network care. The incentives facing ED physicians to join insurers' networks differ markedly from the incentives facing most other non-ED physicians. Traditionally, physicians (e.g. orthopedic surgeons and internists) face a price-volume tradeoff when deciding whether to join an insurer's network. An orthopedic surgeon can, for example, refuse to join all insurers' networks and bill her patients for her charges. However, many patients will not seek treatment from a physician who is out-of-network because of the additional cost they would incur. Alternatively, the orthopedic surgeon could join insurers' networks, which will increase the physician's demand, but in exchange for that demand, the insurers will require a price concession. In this way, physicians in high demand or with few substitutes are able to command higher prices, a characteristic of functioning labor markets. By contrast, because they are part of a wider bundle of hospital care and cannot be avoided once the hospital choice is made, ED physicians (and other specialist physicians like radiologists, pathologists, and radiologists) face inelastic demand from patients and will not see a reduction in their patient volume if they fail to negotiate contracts with insurers.

The ability to stay out-of-network and charge high prices with no impact on quantity might suggest that we should observe zero in-network ED physicians. However, as we discuss, physicians can incur significant costs when bill out-of-network. Theory predicts that the availability of a lucrative outside option will give ED physicians bargaining leverage that will allow them to obtain higher in-network payment rates (which also allows all sides to avoid the transaction costs of out-of-network billing, discussed further below).¹ As a result, physicians can use the threat of out-of-network billing to raise their in-network payments and avoid the added costs of being out-of-network. These higher payment rates, caused not by supply or demand, but rather by the ability to "ambush" the patient represent a transfer from consumers to physicians and, because ED care is so common, raise overall health spending.

In this paper, we analyze data from a large insurer that covers tens of millions of lives annually to study where and why out-of-network ED billing occurs. We

¹For a description of this result, see Osborne and Rubinstein (1990)

also use our analysis of ED billing in the US to illustrate how a strong outside option improves a party's negotiating power. Finally, we explore policy options for protecting consumers and restoring a competitively set price for ED physician care. While doing so, we test empirically whether a policy pursued in New York state that limits ED physicians' ability to bill out-of-network (and hence lowers their disagreement payoff) reduces the frequency of out-of-network billing and lowers ED physicians' average in-network payments.

We begin by assessing the distribution of out-of-network billing for ED care across hospitals in the US. Previous work has found that approximately a fifth of privately insured patients treated at in-network hospital EDs were treated by out-of-network ED physicians (Cooper and Scott Morton 2016; Garmon and Chartock 2016). However, we illustrate that looking at national or regional averages of out-of-network is uninformative because out-of-network billing is concentrated in a small number of hospitals: 50 percent of hospitals have out-of-network billing rates below two percent while 15 percent of hospitals have out-of-network billing rates above 80 percent. Out-of-network physicians in our data charge, on average, 637 percent of what the Medicare program would pay for identical services, which is 2.4 times higher than in-network payment rates. Consistent with predictions that a strong outside option should give ED physicians stronger negotiating power over in-network rates, we find that ED physicians in our data are paid in-network rates of 266 percent of Medicare payments, which is higher than most other specialists (for reference, in our data, in-network orthopedic surgeons are paid 178 percent of Medicare rates to perform hip replacements).

Approximately two-thirds of hospitals in the US outsource the staffing of their EDs to physician management firms that hire and manage physicians, manage ED operations, and take care of billing (Deutsche Bank 2013). We analyze the behavior of the two largest ED outsourcing firms in the US – TeamHealth and EmCare – to understand how each for-profit firm uses the strong outside option ED physicians possess to influence their negotiations with insurers. We find that both firms use the power of their outside option to raise revenues when they take over new contracts with hospitals, albeit in very different ways. When EmCare enters into a new contract to manage a hospital's ED services, they immediately exit networks, bill as out-of-network providers, and seek to collect their charges (which they also raise by 96 percent relative to the charges billed by the prior physician group in that hospital). By contrast, when TeamHealth receives a new hospital contract, physicians working for the firm go out-of-network for

several months and then rejoin networks while using the now credible threat of out-of-network status to secure higher in-network payments. As we discuss, differences in how the two firms use out-of-network billing to raise revenue are interesting in their own right. In addition, their respective strategies offer insight into the economics of bargaining between physicians and insurers.

When physicians bill out-of-network for services they deliver while working from inside in-network EDs, it exposes patients to financial risk and creates reputational harm for the hospitals where they work. What hospitals would allow physician groups working inside their facilities to engage in an out-of-network billing strategy given that it exposes patients to financial risk and exposes the hospital to reputational harm? Newhouse (1970) posited that hospitals trade off patient and community benefit with profits. Since a hospital ultimately controls which physician groups staff their EDs, hospitals that allow ED physician practices that bill out-of-network to work from inside their facilities must put more weight on profit relative to patient welfare than hospitals that do not. Likewise, hospitals that allow ED practices that bill out-of-network to operate from their facilities must also receive transfers of value from those ED physician practices that offset the reputational costs the hospitals incur from out-of-network billing occurring.

Consistent with these predictions, we find that for-profit hospitals are significantly more likely to contract with EmCare physicians. Moreover, we find evidence that EmCare physicians compensate hospitals in kind for allowing them to engage in an out-of-network strategy from inside their facilities. Recall that physicians order hospital services (e.g. imaging studies) that are billed by and paid to the hospital rather than the doctor. After EmCare physicians took over EDs at the hospitals in our data, facility payments rise by 11 percent, which were driven, in part, by increases in the rates patients received imaging studies ordered by EmCare. We also observe that patients were 23 percent more likely to be admitted to the hospital after EmCare took over ED staffing. This is notable because hospitals earn significantly higher profits on emergency care when a patient is admitted to the hospital rather than being discharged (Wilson and Cutler 2014). These changes in hospital behavior are not a function of changes in the case mix of patients after EmCare took over hospital EDs.

Out-of-network bills are irksome for consumers (historically, they have been the number one health insurance complaint to the New York Department of Financial Services), expose patients to financial risk, and raise the total cost of health care services (New York State Department of Financial Services 2012).

We finish by exploring policy options for state and federal officials to address the issue. Effective policy should aim to protect consumers from financial risk and restore a competitively set price for ED physicians' payments. At present, only six states have meaningful laws to protect consumers from surprise bills (Lucia, Hoadley, and A. Williams 2017). Of those six states, all include a hold harmless provision to protect patients from financial risks (e.g., these laws stipulate that patients cannot be charged more than their usual in-network cost sharing during emergencies and cannot be balance billed). The harder problem for states is determining how to fill the "missing" price when there is no contract between physicians and insurers. Half of states with surprise billing laws and a recent bi-partisan proposal from the Senate seek to fill the "missing" price via regulating the payment insurers must make to providers (Lucia, Hoadley, and A. Williams 2017).² However, as we describe, it is extremely unlikely that a regulated price will approximate the true market price for any given insurer-physician pair in a particular year. As a result, as soon as the regulated price set by states or the federal government differs from the market price, either the insurer or the physician will take advantage of a regulated price that favors them (e.g., insurers will cease to build networks or physicians will cease to join networks) and insurance networks for ED care will be not develop.

In lieu of regulating the 'missing' price, we explore two alternative strategies states or the federal government could pursue to restore a competitively set price for ED physicians. The first is a baseball rules arbitration process where an arbitrator chooses between the original offer made by the insurer and the original bill sent by the physician. The second is a policy that would require hospitals to sell, and insurers to purchase, an "ED package" that includes both physician and hospital services. As we describe, both policies would introduce a competitively set ED physician price and curtail physicians' outside option, which should reduce physicians' in-network payments. We then test the impact of a 2014 law in New York that introduced baseball rules arbitration to settle the out-of-network billing disputes between physicians and insurers. We show that the New York state policy reduced out-of-network billing by 34 percent and lowered in-network ED physician payments in the state by 9 percent via shifting the disagreement payoff to ED physicians who bill out-of-network.

Ultimately, this paper makes two contributions to the literature. First, we

²U.S. Congress. Senate. *To Prohibit Surprise Medical Billing of Patients of 2018*. TAM18B37. <https://www.cassidy.senate.gov/imo/media/doc/Draft-%20Protecting%20Patients%20from%20Surprise%20Medical%20Bills%20Act.pdf>

analyze the drivers of out-of-network billing in the US, quantify the extent the issue raises total health care costs and harms consumers, test one state's efforts to address the issue, and make economically grounded recommendations to restore a competitively-set price for ED physician services. Second, we demonstrate how the strength of a party's outside options influences negotiations. We show three pieces of evidence which illustrate that improving physicians' outside options and disagreement payoffs in their negotiations with insurers lead to higher in-network payments. These results are therefore informative about broader physician/insurer bargaining.

Going forward, this paper is structured as follows. Section 2 gives background on ED care in the US and describes the impact of surprise out-of-network billing on patients. In Section 3, we outline the incentives of physicians and hospitals to engage in out-of-network billing. We describe our data and analytic approach in Section 4. In Section 5, we identify the factors associated with out-of-network billing and analyze the impact of the entry of EmCare and TeamHealth on out-of-network billing rates, physician prices, out-of-pocket costs, and hospital behavior. We explore policy options to address out-of-network billing in Section 6 and conclude in Section 7.

2 Background

2.1 The Evolution of Emergency Medicine in the United States

From the 1970s through the 1990s, care in hospital-based EDs shifted from being provided on an ad hoc basis by community physicians to being delivered, round-the-clock, by doctors who often completed emergency medicine residencies and obtained board-certification in the specialty (Institute of Medicine 2006).³ At present, there are more than 4,500 EDs in the US and approximately 40,000 physicians who staff them nationwide (Hsia, Kellermann, and Shen 2011; Morganti et al. 2013). The use of EDs has risen dramatically over time. From 1993 to 2003, the U.S. population grew by 12 percent, hospitalizations increased by 12 percent, and ED visits increased by 26 percent (Institute of Medicine 2006). From 2001 through 2008, the use of EDs increased 1.9 percent each year—60

³Many EDs are not staffed by board-certified ED physicians. Approximately a third of emergency care is provided by family physicians. In rural states, the share of family physicians delivering emergency care is higher than 50% (Wadman et al. 2005; Groth et al. 2013; McGirr, J. M. Williams, and Prescott 1998).

percent faster than concurrent population growth (Hsia, Kellermann, and Shen 2011).

Over the last several decades, EDs have become one of the main pathways through which patients are admitted to the hospital (Morganti et al. 2013). From 1993 to 2006, the share of all inpatient stays in which patients were admitted to the hospital via an ED increased from 33.5 percent to 48.3 percent (Schuur and Venkatesh 2012). Over time, as the use of EDs has gone up, waiting times to be treated in EDs have also increased (Hing and Bhuiya 2012). In response to rising waiting times, EDs increasingly are competing on the length of time patients have to wait before they are treated (Esposito 2015; Rice 2016). Because EDs have become a major source of patients, hospitals now want to keep their EDs open at all hours and run them efficiently (Institute of Medicine 2006; Morganti et al. 2013). As a result, there has been a marked increase in the outsourcing of management of hospital EDs. ED outsourcing companies hire and manage physicians, manage ED operations, and take care of billing. At present, roughly 65 percent of the physician market is outsourced (Deutsche Bank 2013). Among the hospitals that outsource their services, approximately a third contract with a large, national outsourcing chain and the remainder are outsourced to smaller, local firms (Dalavagas 2014).

The national market for physician outsourcing is dominated by two firms, EmCare and TeamHealth, that collectively account for approximately 30 percent of the outsourced physician market (Deutsche Bank 2013). EmCare was publicly traded until 2018 when it was bought by private equity firm KKR & Co. Inc., operates in 45 states, has 23,100 affiliated or employed physicians and health care professionals, and according to their 2016 Form 10-K, delivers more than 18 million emergency episodes per year. More recently, EmCare has partnered with a large, for-profit hospital chain and formed joint ventures where the firm and its hospital partners share in profits from physician bills (Deutsche Bank 2013).

The second firm, TeamHealth, is approximately the same size. According to the firm's 2015 Form 10-K, TeamHealth has more than 18,000 affiliated health professionals and delivers approximately 10 million ED cases per year. After a series of recent acquisitions, TeamHealth is likely to have the largest market share in the physician outsourcing space. The firm was previously publicly traded but was taken private in 2016 when it was purchased by the Blackstone Group.

In the aggregate, ED care is profitable for hospitals. Wilson and Cutler (2014) estimated that average ED profit margins are approximately 7.8 percent per patient. However, the profit margins that hospitals face for ED care vary

significantly depending on how a patient's care is funded and based on whether a patient is admitted to the hospital. Wilson and Cutler (2014) found that hospitals had profit margins of 39.6 percent for privately insured patients treated in EDs, whereas the profit margin for patients covered by Medicare and Medicaid and those uninsured was -15.6 percent, -35.9 percent, and -54.4 percent, respectively. They also found that patients who were admitted to the hospital were significantly more profitable than those who were not. For Medicare patients, the profit margin on ED care for patients who were discharged from the ED was -53.6 percent whereas the profit margin for patients who were admitted to the hospital was 18.4 percent (Wilson and Cutler 2014).

2.2 Out-of-Network Surprise Billing

There has been significant coverage of out-of-network billing in the popular press (Rosenthal 2014a; Rosenthal 2014b; Sanger-Katz and Abelson 2016). However, until recently, there has been no systematic evidence on the frequency that out-of-network billing occurs. Recent survey work suggests that it is fairly common for privately insured patients to be treated by out-of-network physicians. A Consumers Union 2015 survey found that 30 percent of privately insured individuals reported receiving a surprise medical bill within the previous year, and Kyanko, Curry, and Busch (2013) found that most instances in which privately insured individuals involuntarily saw out-of-network providers occurred during medical emergencies. In many instances, when patients receive a surprise bill, they simply pay the balance in full (Consumers Union 2015). Likewise, among those who had trouble paying a medical bill, 32 percent reported that their financial troubles stemmed from a bill from an out-of-network provider for services that were not covered or were only partially covered by their insurer (Hamel et al. 2016). In this Hamel et al. (2016) survey, the authors found that bills from ED physicians made up the largest share of medical debt that patients reported having problems paying.

The results of these surveys have been confirmed by recent empirical evidence. A 2014 report found that among the three largest insurers in Texas, 45 percent, 56 percent, and 21 percent of their in-network hospitals had *zero* in-network ED physicians (Pogue and Randall 2014). Likewise, in the first national study of out-of-network billing, Cooper and Scott Morton (2016) analyzed data from a large commercial insurer and found that 22 percent of in-network ED hospital visits included a primary physician claim from an out-of-network doctor. Using

different data, Garmon and Chartock (2016) found that 20 percent of ED cases in which care was delivered to privately insured patients at in-network hospitals involved care from an out-of-network physician. However, as we will show below, knowing the average propensity of receiving an out-of-network bill does not help diagnose the policy problem, which lies in the tail of the distribution of out-of-network billing rates across hospitals.

There are broadly two types of out-of-network bills. The first form of out-of-network billing results from contracting frictions between insurers and physicians. In the US, there are approximately 54,000 ED physicians, 5,500 hospitals, and over 1000 insurers (Kaiser Family Foundation 2018; American Hospital Association 2018). As a result, it is unlikely that every ED physician could have a contract with every insurer that covers all the patients they treated. As an example, an ED physician in a popular vacation destination could see patients from across the country. Even if she wanted to, this ED physician would struggle to enter into contracts with insurers from across the country. While an out-of-state patient's insurer might have a contract with the hospital in the area the patient is visiting, it is possible they might not have a contract with the patient's ED physician. In these instances, if the physician were not engaging in a deliberate out-of-network strategy, the physician might accept a payment rate that is of the same magnitude as her usual in-network payments.

A second form of out-of-network billing occurs when physicians deliberately do not participate in insurers' networks so that they can reap higher payments. As the New York State Department of Financial Services noted, "a relatively small but significant number of out-of-network specialists appear to take advantage of the fact that emergency care must be delivered and [that] advanced disclosure is not typically demanded or even expected by consumers. The fees charged by these providers can, in some instances, be many times larger than what private or public payers typically allow, and are another source of consumer complaints" (New York State Department of Financial Services 2012). Indeed, a recent study found that physicians who tend not to be chosen by patients (anesthesiologists, radiologists, pathologists, and ED physicians) have the highest charges measured as a percentage of their Medicare payments (Bai and Anderson 2016).

When an insured patient sees an out-of-network physician, there are three potential outcomes. First, the insurer may pay the physician's out-of-network bill in its entirety. This will protect the patient, but ultimately insurers will pass the cost of these higher payment rates on to all beneficiaries in the form of higher premiums. In addition, patients generally face higher co-insurance rates when

they see an out-of-network provider. As a result, even if their insurer pays their physician his charge, the patient may still face substantial cost-sharing. Second, the insurer may pay the out-of-network physician his usual and customary rate, which the insurer calculates based on average charges for the services provided. This payment is generally lower than the total billed amount. When this occurs, the physician may accept the usual and customary rate the insurer is offering and move on. Alternatively, the physician may pursue the patient to pay the difference between the charge and whatever the insurer paid. This is referred to as “balance billing.” Third, the insurer may not cover the costs of out-of-network care at all, leaving the patient to pay the entire physician bill herself. As we show later from our data, these physician bills can be extremely large. While there is no systematic evidence on the frequency that patients are balance billed by physicians, from 2012 to 2015, data from the Texas Department of Insurance showed that balance-billing complaints in the state increased 1000% (Gooch 2016).

3 Incentives for Insurers, Physicians, and Hospitals to Allow or Engage in Out-of-Network Billing

For a patient to receive a surprise bill, there are three parties that have to prefer out-of-network billing to an in-network contract: the ED physician group, the hospital, and the insurer. The physician group and insurer must be unable to come to an agreement on an in-network contract. In addition, the hospital must effectively allow physicians to bill out-of-network from inside their facilities.⁴ We discuss each party’s incentives in turn. We more formally model these incentives in Appendix A.

3.1 Insurers and Out-of-Network-Billing

The physician group and the insurer bargain over the price the insurer will pay the physician for care delivered to policy holders. The insurer faces a tradeoff

⁴The hospital may not have legal authority to prevent a physician (or physician group) from practicing in the ED just because that physician has failed to come to an agreement with any given insurer or insurers. However, we assume there are so many interactions between the hospital and an ED physician group that if the hospital disapproved of the group’s overall strategy, it could make the relationship sufficiently onerous such that the physicians would move in-network.

between including more and better physicians in its network and the higher in-network payments needed to make to retain those physicians in the network. The decision about how broad and how highly reputable a network of providers to create (and how to handle out-of-network bills) is a function of the preferences of the purchasers of health insurance. Buyers of insurance might prefer a broad network of physicians, have a distaste for out-of-network bills, and therefore be willing to accept higher premiums. On the other hand, the buyers might prefer lower premiums and be willing to accept an insurance plan with a narrower network of providers and a higher probability of a policy-holder seeing an out-of-network physician. In the extreme, the buyers of insurance could be willing to accept a plan with out-of-network ED physician billing and believe it to function as a very expensive form of patient cost-sharing for accessing ED services.

When ED physicians are out-of-network, insurers can face higher payments, higher transaction costs, and dissatisfied customers. If an ED group is pursuing a deliberate strategy of remaining out-of-network, raising charges, and refusing to negotiate over payments, the outside option for the insurer depends on laws in state where their policy-holders are treated and the extent to which physicians are sensitive to threats of litigation over their bills. In states without laws to address out-of-network billing, physicians may seek to collect their charges. Physicians' charges are not competitively set by hospital demand and physician labor supply, but are constrained from infinity by the possibility of litigation over their bills.⁵ By contrast, as we discuss, some states, like Maryland, have laws regulating the amounts out-of-network ED physicians can be paid (Lucia, Hoadley, and A. Williams 2017). The laws in states with out-of-network laws in place therefore dictate the outside option physicians face when the bill out-of-network. As a result, the outside option for an insurer of formally disputing an out-of-network charge will be differentially successful depending on state law. This outside option will affect the payment rates an insurer is willing to pay ED physicians who join its network.

3.2 Hospitals and Out-of-Network Billing

EDs serve as the front door to hospitals. The majority of patients in a hospital at any given point in time were admitted via the ED. As a result, hospitals need

⁵See, for example, *UnitedHealthcare Servs., Inc. v Asprinio* (2015 NY Slip Op 25298) and *Children's Hosp. Cent. Cal. v. Blue Cross of Cal.*, 172 Cal. Rptr. 3d 861, 872 (Ct. App. 2014) for examples of litigation over providers' charges. Richman et al. (2017) provides further examples of litigation over providers' charges.

to keep their EDs open at all hours in order to retain patients. To keep their EDs running, hospitals must recruit staff to run their EDs and arrange with physicians to provide care from inside their facilities. Alternatively, they can contract with an ED staffing company to manage the whole of their ED, including recruiting, managing, and paying physicians. Unfortunately, EDs deliver significant amounts of uncompensated care and ED physicians regularly treat patients from whom they receive little or no compensation (Garthwaite, Gross, and Notowigdo 2018). Because of the Emergency Medical Treatment & Active Labor Act (EMTALA), EDs must provide care to patients in an emergency (Centers for Medicare and Medicaid Services 2018). As a result, hospitals must typically pay physicians a fee to work from their facilities.

Hospitals control which physicians or ED staffing firms they allow to work from inside their facilities. We also assume that hospitals are aware of whether or not physician staffing firms engage in a deliberate out-of-network billing strategy. When ED physicians bill out-of-network, the ED physicians themselves (or the staffing firms they work for) benefit from higher out-of-network payments. However, the hospitals where they work do not receive direct benefits from out-of-network ED physician billing. Indeed, when ED physicians remain out-of-network and balance bill patients, it brings reputational harm to hospitals.⁶ Therefore, for hospitals to be willing to permit physicians to bill out-of-network from inside their facility, they must receive a transfer from physicians or staffing firms equal or greater to the cost of the reputational harm they incur.

These transfers could take a myriad of forms. For example, ED staffing firms often demand subsidies from hospitals to staff their EDs. Physician staffing firms could waive these subsidies in exchange for being allowed to bill out-of-network. Alternatively, ED physicians could deliver medical care in a manner that raises revenue for the hospital. This could include increasing imaging and lab testing rates (which raises hospital revenue) or increasing the rate that patients from the ED are admitted to the hospital. Finally, ED staffing firms could raise the quality of hospital EDs, such that they attract more patients and improve the hospital's reputation.

⁶Historically, most media stories of out-of-network billing have cited the hospital where the patient who received an out-of-network bill was treated (See Rosenthal 2014a).

3.3 Physicians and Out-of-Network Billing

A physician or physician group faces a choice of negotiating in-network rates with insurers or going out-of-network, collecting higher out-of-network payments, but incurring costs from engaging in the practice. A physician or physician group must consider the incremental profit she or the group will obtain from going out-of-network. In a standard market with downward-sloping demand, if a physician went out-of-network, she would experience a decline in the number of patients she treats due to her higher out-of-network price that most patients would face. However, because we are examining ED physicians, we make the more realistic assumption (for this setting) that demand for ED physicians is inelastic.⁷ Therefore, in this setting, if the ED physician does not enter into an insurance network and seeks to collect her charges, she still obtains the quantity of patients equal to what she would receive were she in-network. As a result, her increase in revenue (or revenue for the ED staffing firm) is the difference between the in-network prices and out-of-network payments she collects multiplied by the cases she performs per year.

Physicians likely incur costs from engaging in an out-of-network strategy. These could include fixed costs, such as physicians' own intrinsic dislike of the practice, potential peer pressure, unpleasant meetings with stakeholders, and the cost of software necessary for billing and collection. Likewise, these could include are also variable such as costlier communication with patients, hospitals, and insurers, the costs of collecting on each bill, and defending against litigation. Physicians will also have to compensate the hospital for allowing them to engage in out-of-network billing from inside their facilities.

As we described, physicians can compensate the hospital from their own pockets via reducing the subsidies they require for managing a hospital's ED services. A less expensive but more legally risky option for the physician is to deliver medical care in a style that benefits the hospital. However, changes in their clinical activity that benefit the hospital (such as over testing) could open the physician or physician groups to legal risk (e.g. claims of fraudulent billing). As a result, the propensity to engage in these actions depend on the risk-tolerance of these physicians.⁸

⁷We posit that demand is inelastic because ED physicians are not chosen by patients and cannot be avoided. Previous studies have exploited the fact that patients do not choose ED physicians as a source of plausibly exogenous variation in work assessing the impact of seeing physicians with a greater or lower likelihood of prescribing opioids and seeing physicians at the end of their shift (Barnett, Olenski, and Jena 2017; Chan 2015).

⁸See, for example, a 2017 settlement between the US Department of Justice and TeamHealth

In our setting, we think ED management firms may have greater awareness of the intricacies of physician payment and better understand the benefits of setting higher charges than individual physicians operating in small group practices. In this sense the ED management firms engage in informational arbitrage (a la Hayek). Previous work by Clemens, Gottlieb, and Molnár (2017) showed that individual physicians and physicians in small groups tend to set commercial prices that follow the Medicare payment rates. By contrast, physicians in large group practices tend to have payment rates that are less strongly correlated with Medicare payment rates. National professional physician management will likely seek a profit-maximizing price that takes advantage of ED physicians' strong outside option. One might imagine that in equilibrium, this superior fee structure would have arrived at all hospitals. This is not the case in the US for two reasons we can identify. First, outsourcing firms with an out-of-network strategy will not be able to enter hospitals that, because of their utility function, require compensation above what the physicians gain (e.g. some non-profit hospitals may place a high premium on protecting patients from financial harm). Second, if out-of-network billing were pervasive, there would be an extremely high risk of regulatory backlash.⁹

4 Data and Descriptive Statistics on Out-of-Network Billing

4.1 Data

Our claims data come from a large commercial insurer that covers tens of millions of lives annually. The data run from January 1, 2011, through December 31, 2015. The data are structured at the service-line level and include detailed patient characteristics, a provider identifier, and the ability to link to a range of third-party datasets. We define ED episodes as those with a physician service line that includes a Current Procedural Terminology (CPT) code for emergency services and a hospital revenue code associated with an emergency visit.¹⁰

over accusations the firm billed for higher and more expensive levels of medical service than were actually performed (Department of Justice 2017). <https://www.justice.gov/opa/pr/healthcare-service-provider-pay-60-million-settle-medicare-and-medicaid-false-claims-act>.

⁹Indeed this occurred in our setting and remains ongoing.

¹⁰We identify ED claims for physicians as those that include a CPT code of 99281, 99282, 99283, 99284, 99285, or 99291 and a hospital service line as those with a revenue code of 0450, 0451, 0452, 0453, 0454, 0455, 0456, 0457, 0458, or 0459. We require episodes in our analysis to have a physician service line with an ED code and a facility service line with an ED code.

We limit our analysis to episodes that occurred at hospitals registered with the American Hospital Association (AHA). Therefore, we do not include, for example, treatment that was delivered at urgent care clinics.

At baseline, our data include 13,444,445 episodes. We introduce several sample restrictions to our data to produce an analytic dataset. First, we exclude episodes that were missing an AHA hospital ID or did not come from an AHA-identified hospital. Thus, the analysis is focused only on hospital-based ED care. This restriction eliminates 1,908,710 episodes. Second, we exclude episodes for which the same physician billed as in-network and out-of-network on separate service lines on the same claim form. This restriction eliminates 264,636 episodes. Third, we exclude episodes with duplicative insurer payments, episodes with insurer payments that were negative, and episodes for which the insurer paid \$0 because the claims were denied. This restriction removes 217,267 episodes. Fourth, we exclude episodes for which the start date of the episode occurs after the end date of the episode. This restriction excludes 79 episodes. Fifth, we limit our analysis to hospitals that delivered 10 or more episodes per year and appear in all five years of the data. This restriction excludes 330,312 episodes. Sixth, we limit our analysis to individuals who had six months of continuous enrollment before their emergency episode. Having six-months of historical data is necessary to create our Charlson comorbidity scores. This restriction excludes 1,810,245 episodes from our analysis. Finally, we winsorize the top and bottom 1 percent of the prices in our data.¹¹ We do this to limit the influence of idiosyncratically high- and low-priced episodes.

In our data, we observe physician and hospital charges, the amount that the insurer paid, and patients' co-insurance payments, co-payments, and spending under their deductibles. We define the total amount an ED physician was paid as the sum of the insurer payment, the patient co-insurance payment, the patient co-payment, and the patient deductible on physician service lines that have a CPT code for emergency services.¹² We calculate facility payments as the sum of the insurer payment, patient co-insurance, patient co-payment, and patient spending under her deductible summed across all facilities claims. All prices are put in 2015 dollars using the U.S. Bureau of Labor Statistics Consumer Price Index.

Unfortunately, we do not observe whether patients were balance billed by

¹¹Our results are robust to not winsorizing prices, but there are extremely large hospital and physician charges and payments.

¹²These are service lines with a CPT code of 99281, 99282, 99283, 99284, 99285, or 99291.

physicians. Therefore, it is possible that the physician collects more in total than we can measure. To our knowledge, there are no datasets with information on the balance billing of patients. However, we construct a potential balanced bill measure that is the difference between what the physician charged and the sum of what the physician was paid by patients (in the form of cost-sharing) and by the insurer. This difference reflects what the physician could balance bill the patients in our sample. We also create a measure of patients' potential total cost exposure, which we calculate as the sum of the potential balanced bill and their out-of-pocket costs.

In addition, we construct an indicator for whether or not imaging occurred during an episode based on whether or not there are facility claims with revenue codes associated with imaging studies.¹³ Likewise, we identify episodes as involving an admission to the hospital if the facility claim for the episode includes a revenue code for room and board fees.¹⁴

For each episode, we also observe the patient's sex, age (measured in 10-year age bins), and race (white, black, Hispanic, and other). We also use our claims data to measure historical patient spending for six- and 12-month periods preceding an episode. Because we do not want the emergency episodes we are analyzing to feed into the historical spending measures, we measure spending from two weeks before the admission date for an episode back six and 12 months. In addition, we used six and 12 months of claims data to calculate Charlson measures of comorbidity (Charlson et al. 1987).¹⁵

4.2 Identifying Where EmCare and TeamHealth Have Contracts

EmCare and TeamHealth bill using their contracted physicians' National Provider Identifier (NPI) numbers. As a result, our claims data do not indicate that a particular claim is being billed by a physician employed by one of these firms. To identify the hospitals where EmCare and TeamHealth have outsourcing contracts, we use data from the firms' own webpages and documents. We require two independent sources of information to classify a hospital as a facility that outsourced its ED services to EmCare or TeamHealth.

We rely on maps with firm locations to provide the first source of information

¹³We identified episodes that included imaging studies based on whether or not the facility claims had a service line with the revenue codes 350-352, 610-619, 400-404, or 409.

¹⁴We identified room and board fees based on the following revenue codes on facility claims: 100, 101, 103, 110-160, 164, 167, 169-176, 179, 190-194, 199-204, 206-214, 219, 658, or 1000-1005.

¹⁵We pooled individuals with a Charlson score of 6 and higher.

on which hospitals are affiliated with EmCare and TeamHealth. Envision, the parent company of EmCare, posted a map on the company webpage that included (see Appendix Figure A.1a) embedded latitudes and longitudes within the webpage's underlying code, which we use to identify hospitals. Likewise, we use a map from TeamHealth's initial public offering in 2009 that shows the locations where TeamHealth had contracts in 2009 (TeamHealth 2009) (see Appendix Figure A.1b). To identify hospital locations on the TeamHealth map, we scraped the map using mapping software from ArcGIS.¹⁶

The second source of information we use to identify hospitals that contract with EmCare and TeamHealth come from job advertisements posted by the firms. Each firm posts job advertisements for physicians on their respective webpages (see an example in Appendix Figure A.2). The job advertisements include the name of the hospital where physicians are being recruited and the specialty of the physicians the hospital is looking to hire. We scraped the names of the hospitals and the specialty of the physicians being recruited from all job postings that were available from the firms' webpages and webpage histories.

Ultimately, we identify a hospital as having a contract with EmCare or TeamHealth if we are able to identify the hospital on a map of the outsourcing firms' locations and we found a job hiring post for the hospital. This strategy exploits the fact that, in general, these firms wholly take over an ED and participate in exclusive contracts with hospitals (Deutsche Bank 2013).

Using this strategy, we find 194 hospitals affiliated with EmCare and 95 hospitals affiliated with TeamHealth. As a result, of the 3,345 hospitals in our analysis that meet our sample criteria, 5.8 percent outsource their ED to EmCare and 2.8 percent outsource their ED to TeamHealth. Based on investor reports on EmCare and TeamHealth, our sample of hospitals with contracts with EmCare and TeamHealth represents an undercount of the total population of hospitals that have contracts with EmCare and TeamHealth.

We also use the entrance of physician management companies into hospitals to estimate the causal effect the entry of TeamHealth and EmCare had on physician pricing and hospital behavior. To do so, we identify hospitals where these firms entered into an outsourcing contract from 2011 to 2015. To identify the hospitals where EmCare and TeamHealth entered into outsourcing contracts, we searched

¹⁶To obtain the latitudes and longitudes of the hospital locations displayed on the Morgan Stanley Report map, we utilized georeferencing within ArcMap. This technique aligns a map with a known coordinate system to the map of interest (which has no identified coordinate system). After transforming and overlaying the two aligned maps, we then obtain coordinate estimates of each marked hospital within a reasonable range of accuracy.

both companies' webpages for press releases announcing new contracts. Likewise, we used LexusNexus and Google to search the popular press for news stories that announced when either EmCare or TeamHealth entered into a contract with a hospital. Using this strategy, we find evidence that during our time period (2011 through 2015), EmCare entered into contracts with 16 hospitals that were part of nine health systems while TeamHealth entered into contracts with 10 hospitals that were part of six systems (see Appendix Table A.1).

5 Out-of-Network Billing, Physician Prices, and Hospital Outsourcing

5.1 Descriptive statistics on ED Physician Payments and Out-of-Network Billing Rates

Our final dataset is composed of 8,913,196 ED episodes of emergency care that occurred between January 1, 2011 and December 31, 2015 (see Table 1).¹⁷ This represents nearly \$28 billion in emergency spending. The average in-network ED physician payment across our sample period was \$325.91 (266 percent of what the Medicare fee-for-service program paid for the same services) (Table 1). The amount ED physicians were paid increased as a percentage of Medicare over our time period. During this period, patient out-of-pocket costs for emergency care also steadily increased and the average total out-of-pocket cost for an emergency episode (combining the physician and facility component) was \$467.75. Over 99 percent of ED cases in our data occurred at an in-network hospital. Appendix Table 2 includes descriptive statistics for our analytic sample of ED episodes.

At the average in-network hospital in our data, 25.8 percent of patients treated in the ED were treated by an out-of-network ED physician (Table 1). The frequency that patients at in-network hospitals were treated by out-of-network ED physicians has declined over time from 28.6 percent in 2011 to 21.9 percent in 2015. However, this average masks significant heterogeneity in out-of-network billing rates across hospitals and is somewhat misleading. Figure 1 shows the distribution of out-of-network billing rates across hospitals in our data in 2015 and summary statistics for that year. It illustrates that out-of-network billing is highly concentrated in a small group of hospitals. As we illustrate, 50

¹⁷Seventy-seven percent of individuals with an ED episode had insurance from an administrative services only (ASO) insurance product and the balance had coverage from fully insured plans.

percent of hospitals have out-of-network billing rates below two percent. By contrast, the out-of-network billing rate for hospitals in the 75th percentile of the distribution of out-of-network billing rates was 28 percent and 15 percent of hospitals have out-of-network rates of higher than 80 percent. This skewed distribution is evident in 2011, 2013, and 2015 (see Appendix Figure A.3).

5.2 Cross-Sectional Analysis of Hospitals' Out-of-Network Billing Rates

To assess the factors associated with the variation in hospitals' out-of-network billing rates, we follow the approach of Finkelstein, Gentzkow, and H. Williams (2016) and run a least absolute shrinkage and selection operator (Lasso) regression on a range of hospital, local area, physician market, and hospital market characteristics (a complete list and descriptions of the variables that we include in our first-stage Lasso are available in Appendix B). We also include indicator variables for whether or not EmCare and TeamHealth had contracts with hospitals. The Lasso method applies a penalizing parameter to the coefficient of the explanatory variables included in the regression. We use 10-fold cross-validation to choose the penalizing parameter that minimizes the mean squared error. We use this Lasso procedure to select a set of variables that we include in a second stage where we determine their correlation with hospital out-of-network billing rates.

Figure 2 presents our conditional correlations between the variables selected using the Lasso regression and the share of patients per hospital that saw out-of-network physicians between 2011 and 2015 during an emergency. The results are correlates of hospital-level out-of-network billing rates and should not be interpreted causally. As Figure 2 shows, the presence of EmCare at a hospital is positively correlated with the hospital's out-of-network billing rate. By contrast, outsourcing a hospital's ED to TeamHealth is negatively correlated with the hospital's out-of-network billing rate. In addition, we find that non-profit hospitals, teaching hospitals, and government-owned hospitals have lower rates of out-of-network billing; for-profit hospitals have higher out-of-network billing rates. Larger hospitals and hospitals with better technology have lower rates of out-of-network billing. The share of total discharges funded by Medicare is positively correlated with out-of-network billing rates. Finally, we find that areas with a higher fraction of married adults and low inequality have low out-of-network rates.

5.3 Causal Estimates of the Effect of EmCare and TeamHealth on Hospital OON Rates

Our cross-sectional results suggest that out-of-network billing is significantly higher at hospitals that outsource their ED to EmCare. In this section, we estimate the causal effect that the entry of EmCare and TeamHealth had on the likelihood patients were treated by out-of-network physicians working inside in-network hospitals. To do so, we exploit evidence we collected from press releases, news stories on the firms' webpages, and articles in the popular press announcing the timing of the entry of EmCare and TeamHealth into hospitals. We then compare outcomes before and after EmCare and TeamHealth entered hospitals. In total, we analyze the entry of EmCare into 16 hospitals between 2011 and 2015 and the entry of TeamHealth into 10 hospitals during the same period. We begin by showing trends in the raw data of hospitals where EmCare and TeamHealth entered into management contracts. We follow that up with a regression-based analysis. Crucially, we observe no difference in the pre-trends of key outcomes variables before either EmCare or TeamHealth entered a hospital.

Because EmCare and TeamHealth appear to have different strategies, we separately test the impact of their entries on billing practices and hospital and physician behavior. To do so, we estimate a hospital fixed effects model with an indicator variable ($EmCare_{i,t}$ or $TeamHealth_{i,t}$) that takes a value of 1 on and after the date that EmCare (or, in separate regressions, TeamHealth) entered a hospital and returns to zero on the dates that the firm exited hospitals if the firm lost a contract.¹⁸ Our estimation takes the form:

$$Y_{i,j,t} = \beta_0 + \beta_1 EmCare_{i,t} + \delta_j + \theta_t + \varepsilon_{i,j,t}, \quad (1a)$$

and

$$Y_{i,j,t} = \beta_0 + \beta_1 TeamHealth_{i,t} + \delta_j + \theta_t + \varepsilon_{i,j,t}, \quad (1b)$$

where we estimate the outcomes for episode i that occurred at hospital j in month t . We also include a vector of hospital fixed effects δ_j and a unique month dummy, θ_t , for each month in the data. Our standard errors are clustered around hospitals. We interpret a discontinuous change in hospital behavior immediately following the entry of an outsourcing firm into a hospital as the causal impact of entry.

¹⁸We can estimate the impact of EmCare and TeamHealth entry in the same estimator, and we get nearly identical results.

We compare outcomes at hospitals where the two outsourcing firms entered to outcomes at three sets of control hospitals: 1) all hospitals nationally that did not have EDs managed by EmCare or TeamHealth, 2) hospitals drawn from the same states where the hospitals that experienced entry were located but did not outsource their ED services to EmCare or TeamHealth, and 3) hospitals that were not managed by EmCare or TeamHealth that we matched to entry hospitals using propensity scores.¹⁹ One obvious concern with our identification strategy is that treated and untreated hospitals may have differences in their trends in out-of-network billing rates, physician pricing, or hospital behavior prior to the entry of EmCare or TeamHealth. However, as we illustrate, when we plot the raw data from our treated hospitals, there do not appear to be any changes in behavior prior to the entry of those firms.

EmCare enters two types of hospitals (Appendix Figure A.4a). The first group of hospitals has out-of-network rates over 97 percent. The second group has out-of-network rates below 10.1 percent. In Figure 3, we present a smoothed average using a local polynomial regression of the monthly hospital-level out-of-network ED physician billing rates from one year before EmCare (Panel A) and TeamHealth (Panel B) entered a hospital until one year after entry. In Panel A of Figure 3, the raw data show a clear increase in out-of-network billing rates at hospitals immediately after EmCare entered. For interested readers we present the raw, quarterly average out-of-network rates by hospital at each of the 16 hospitals that EmCare entered in Appendix Figure A.5.²⁰ None of these graphs shows marked changes in out-of-network billing rates before EmCare entered a hospital; nearly all show that out-of-network billing rates increase dramatically in the months after EmCare takes over a staffing contract.

We repeat this analysis using regression analysis Equation (1a) and report the results in Table 2. The indicator variable on entry identifies the causal

¹⁹To calculate propensity scores, we ran a logistic regression separately for EmCare and TeamHealth where the dependent variable was an indicator variable that took a value of 1 if one of the national ED staffing companies took over management of the hospital's ED. We regressed that against hospital beds, technology, the square and cubic forms of beds and technology, and non-profit/for-profit status. The predicted values from this regression produce a propensity score for a hospital. We then use a propensity score match to determine hospitals most similar to those with entry, with the condition that matching hospitals must be in the same state.

²⁰For nearly all hospitals that had previously high out-of-network billing rates (Panels I, J, K, L, M, N, O, and P of Appendix Figure A.5), when EmCare entered, out-of-network billing rates remained high. In contrast, after EmCare entered hospitals that previously had low out-of-network billing rates, the likelihood a patient was treated by an out-of-network physician increased to nearly 100% immediately after EmCare entered the hospital (Panels A, B, C, D, E, F, G, H, of Appendix Figure A.5).

impact that the entry of EmCare had on the prevalence of out-of-network billing. In Column (1) of Table 2, we focus on changes in out-of-network billing rates at hospitals that EmCare entered that previously had high out-of-network billing rates. After EmCare entered, there is no statistically significant change in the likelihood a patient was treated by an out-of-network physician. In Column (2), we estimate the impact of the entry of EmCare into hospitals with previously low out-of-network rates (the half of hospitals where the firm entered with OON rates below 10.1 percent). These results mirror what we observe in the raw data. We observe that the entry of EmCare into these hospitals raised out-of-network rates by 81.5 percentage points.²¹ In Appendix Table A.3, we show that these results are robust to using alternative control groups.

TeamHealth appears to pursue a different out-of-network strategy. The raw data from Panel B of Figure 3 shows that out-of-network billing rates increased immediately after the firm took over management of hospital EDs. However, four months after entry and the spike in out-of-network billing, there was a noticeable drop in out-of-network billing rates. These changes are visible in the raw data, presented hospital by hospital in Appendix Figure A.6. In Column (3) of Table 2, we again use an entry regression (Equation (1b)) to identify the effect of TeamHealth entry on hospitals' out-of-network billing. We find that after TeamHealth entered a hospital, there was an increase in out-of-network billing of 32.6 percentage points. This is a qualitatively large increase, although it is still approximately half the size of the out-of-network entry effect that we observed for EmCare. As we illustrate in Appendix Table A.3, this estimate is robust to using alternative control groups.

5.4 The Impact of Out-of-Network Strategies on Payment Rates

These results suggest that EmCare does not negotiate with insurers and instead utilizes its outside option and seeks to collect its charges. In Panel A of Figure 4, we show that immediately after entry, EmCare raised its charges significantly. In Column (1) of Table 3, we quantify these changes and show that after EmCare entered, it increased its physician charges, on average, by \$556.84 (96 percent). This increase in charges was driven, in part, by a 14.8 percentage point (43 percent) increase in the rate that physicians working for the firm billed patients for ED services using the highest-intensity CPT code (Column (7) in Table 3).

²¹This result is robust to estimating Equation (1a) using logistic regression

This increase in the use of high severity coding occurred immediately after the firm entered (Panel G of Figure 4). It is unlikely that hospitals would have experienced a sharp and immediate change in their mix of patients immediately after EmCare entered that would have precipitated such a large change in coding practice.²² Indeed, as we discuss and illustrate in Panels A and B of Appendix Figure A.7, there were no immediate and observable changes in the case mix of patients at hospitals after EmCare entered. We have further discussion of the impact of the entry of physician management companies on hospitals' case mix in Section 5.7.

This increase in out-of-network billing and physician charges generated large increases in revenue for EmCare physicians. Likewise, it also exposed patients to increased cost sharing and financial risk. Our data contributor paid most of physicians' out-of-network bills. As a result, after EmCare entered, we observe that the insurer payments to ED physicians increased by \$402.67 (122 percent). Because patients typically have out-of-pocket costs that are set via co-insurance that pays a fixed percentage of the total cost of care, patient payments (e.g. cost-sharing payments) to ED physicians increased by \$45.23 (83 percent). Collectively, we observe that the total payments to ED physicians increased by \$447.90 after EmCare entered a hospital. This is a 117 percent increase in ED physician payments. Notably, these changes occurred in the month immediately after EmCare entered a hospital and then persisted (Figure 4).

While our data contributor covered most of physicians' out-of-network charges, we still observe a difference between EmCare physicians' charges and the total payments the firm received from the insurer and patients. We classify the difference between physician charges and their total payments as the potential balanced bill patients could face. In our data, we observe that patients' potential balanced bills were, on average, \$195.30. We estimate that after EmCare entered a hospital, the potential balanced bill patients faced increased by \$108.94 (56 percent). Note that these are lower-bound estimates of the impact of EmCare entry on patients' out-of-pocket costs. In many instances, patients who are treated by out-of-network physicians are liable for the entirety of their physicians' charges, since insurers will not cover out-of-network care. As we described, average physician charges were \$578.95 across our sample and they nearly doubled, increasing by \$556.84 after EmCare entered a hospital. As a result, a patient whose insurer did not cover out-of-network physician care would face

²²As we illustrate in Appendix Table A.4 and A.5, these results are robust when we use alternative control groups.

a bill from EmCare physicians of, on average, \$1,135.79(= \$556.84 + \$578.95). Bills of this magnitude would be financially devastating to a large share of the population (Board of the Governors of the Federal Reserve System 2016).

That TeamHealth exits networks and then rejoins them suggests that the firm exercises the threat of exit to credibly negotiate higher in-network payment rates. Consistent with theory, in Panels B and C of Figure 5, we observe an increase in the in-network and out-of-network payments to TeamHealth from insurers after the firm enters a hospital. In Table 4, we observe that insurer payments for in-network physician care increased by \$236.56 (90 percent) after the firm entered. We also observe a \$21.85 (39 percent) increase in patient cost-sharing paid to physicians after TeamHealth entered. While this is a large increase in physician payments, the increase is approximately 60 percent of the size of the gain in physician payments experienced by physicians after EmCare entered a hospital.²³

We argued that having the ability to go out-of-network without seeing a reduction in the number of patients they treat gave ED physicians a stronger outside option in negotiations with insurers. We argued that this stronger outside option would allow them to negotiate higher in-network payments. In Table 5, we show the average in-network payments in our data made to internists for performing standard office visits and orthopedists for performing hip replacement. We observe that, on average, internists are paid 158 percent of Medicare rates (Column (1)) and orthopedists are paid 178 percent of Medicare rates (Column (2)). By contrast, the average in-network ED physician in our data is paid 266 percent of Medicare rates (Column (3)). We posited that firms that could credibly threaten to go out-of-network could negotiate higher payments. Indeed, we observe that in the cross-section, TeamHealth, who appears to go out-of-network and then rejoin the insurer's network, earn on average, 364 percent of Medicare rates (Column (4)). Likewise, we observe that the average payment in our data to EmCare ED physicians (who, for the most part, do not participate in networks) is 536 percent of Medicare rates (Column (5)).²⁴

²³As we illustrate in Appendix Tables A.6 and A.7, these results are robust to using other control groups.

²⁴Appendix Table A.8 provides detailed summary statistics of ED physicians' prices and charges.

5.5 Transfers to Hospitals To Permit Out-of-Network Billing

When physicians bill out-of-network, it creates costs for the hospital where they work. We hypothesized that physician management firms that used out-of-network billing as a strategy would have to offer transfers to hospitals to offset these costs. These costs could take the form of direct payments or reductions in subsidies (which we cannot observe) or changes in physician behavior that benefits hospitals (which we can observe). Our results presented in Table 6 are consistent with our predictions. We estimate Equation (1a) and find that after EmCare entered a hospital and began billing out-of-network for ED services, facility charges at the hospitals where they worked increased by \$1,683.63 (27 percent) and facilities' total payments increased by \$294.58 (11 percent). As we illustrate in Table 6, this increase in facility payments was driven, in part, by a 1.4 percentage point (5 percent) increase in the probability that a patient received an imaging procedure (Column (5)) and a 2.1 percentage point (23 percent) increase in the likelihood that a patient was admitted to the hospital.²⁵ As we illustrate in Panel F of Figure 6, this increase in admissions is visible in the raw data and occurred immediately after EmCare entered a hospital. It is notable that physicians both order patients to be admitted from the ED and order imaging studies, so these are outcomes that EmCare physicians can alter.

Because TeamHealth does not remain out-of-network, the hospitals they serve do not bear reputation costs. Therefore, we would not expect TeamHealth to make transfers to the hospitals where they work. Consistent with these predictions, as we illustrate in Table 7, unlike what we observed following the entry of EmCare, after TeamHealth enters hospitals, we do not observe an increase in facility charges (Column (1)) or total payments (Column (4)). Likewise, we observe that patients treated by TeamHealth physicians after the firm entered a hospital were slightly less likely to have an imaging study and be admitted to the hospital (Columns (5) and (6)). Although facility payments do not increase, as we illustrate in Column (7), we observe a 515.4 person (30 percent) increase in the number of patients treated in the ED after the firm entered a hospital.²⁶ Notably, these changes in admissions rates and activity are evident immediately after TeamHealth enters a hospital (Panels F and G of Figure 7).

²⁵As we illustrate in Appendix Tables A.9 and A.10, these results are robust against other control groups.

²⁶As we illustrate in Appendix Tables A.11 and A.12, these results are robust against other control groups.

5.6 Contracting with EmCare and TeamHealth

Hospitals that knowingly allow an ED staffing company like EmCare to bill out-of-network from their facility in exchange for a transfer (e.g. higher admission rates or a reduction in subsidies to physician groups) are explicitly weighing profits over patient and community benefits. As a result, we would expect that for-profit hospitals to be more likely to contract with EmCare. In Table 8, we present the characteristics of hospitals in our sample that did and did not contract with EmCare and TeamHealth. We find that across all hospitals that meet our sample restrictions, 66 percent are non-profit, 19 percent are for-profit, and 15 percent are government owned. Consistent with our predictions, 56 percent of hospitals where EmCare has a contract are for-profit facilities. Hospitals in areas with lower numbers of physicians per capita are also more likely to contract with EmCare. By contrast, whereas TeamHealth has a higher share of for-profit hospitals than we observe across the universe of hospitals in our data, the majority of TeamHealth contracts occur at non-profit facilities.²⁷

5.7 Robustness Checks

It is possible that the entry of EmCare and TeamHealth led to subsequent changes in the case mix of patients that the hospitals treat. Indeed, both EmCare and TeamHealth advertise that a benefit of their service is to shorten ED waiting times (Cantlupe 2013). With shorter waiting times, hospitals could potentially attract healthier patients who would have otherwise received treatment at urgent care centers. Likewise, on EmCare's webpage, EmCare has highlighted its excellence in improving the treatment of complex cases, such as stroke care (EmCare 2014). To the extent that this improves a hospital's reputation, advertising and improvements in quality could allow that hospital to attract more complex patients. Any changes in the case mix of hospitals EmCare entered could explain why, after the firm entered hospitals, the rates of hospital admissions, the rates of imaging tests, and the rates at which physicians coded for the most intensive services increased.

In Appendix Table A.15, we analyze the impact that the entry of EmCare and TeamHealth had on the case mix of patients that hospitals treat. We find

²⁷In Appendix Table A.13, we present conditional correlates of whether a hospital is managed by either EmCare or TeamHealth using logistic regression. These results are qualitatively similar to the above. As we show in Appendix Table A.14, hospitals that contract with EmCare or TeamHealth before 2011 have similar characteristics to hospitals where we observe the entry of EmCare or TeamHealth between 2011 and 2014.

evidence that after EmCare entered a hospital, the hospital attracted a sicker mix of patients. In Columns 1 and 2, we show that after EmCare entered a hospital, the six-month historical spending of the hospital's patients increased by \$916.02 (15 percent) and the 12-month historical spending increased by \$1,306.16 (11 percent). We also find that after the entry of EmCare into a hospital, the patients who attend the ED were 3.3 percentage points more likely to have a non-zero Charlson comorbidity score measured using six months of patient history and 3.6 percent more likely to have a non-zero Charlson comorbidity score measured using 12 months of patient history. In contrast, following the entry of TeamHealth, hospitals attracted seemingly healthier patients who spent \$336.35 (5.4 percent) less in the six months preceding an episode and \$783.08 (6.8 percent) less in the 12 months preceding an episode. In Appendix Figure A.7, we show the average Charlson co-morbidity score and six-month historical spending levels of patients, by month, at hospitals where EmCare and TeamHealth entered. There is no evidence of immediate changes in these outcomes after a change in management.

Crucially, however, we find the same changes in physician behavior and hospital activity at EmCare facilities appearing across all health severity groups of patients, including patients in the least severe group. Thus, *even holding patient severity constant*, we still see an increase in quantity of care delivered after EmCare enters a hospital. In Appendix Table A.16, we estimate Equation (1a) using several different sample restrictions and sets of controls for the health of the patients. We focus on the impact that the entry of EmCare had on the frequency that physicians code using the CPT code for the most intensive emergency. We find that even among patients with low historical spending and no comorbidities, there was a substantial increase in the rate they had episodes that included physician claims coded using the highest intensity CPT code. In Column 1, we estimate Equation (1a) with no patient controls; in Column 2, we re-estimate Equation (1a) controlling for patients' age, sex, and race; and in Column 3, we control for patients' age, sex, race, and their Charlson comorbidity score. Across all three estimates, the point estimate on the impact of entry on the rate of using the highest-intensity CPT code for emergency physician visits is consistent and ranges from 0.148 to 0.151. In Column 4, we estimate Equation (1a) and limit our analysis to patients throughout our sample who have a Charlson comorbidity score of 0 (e.g., patients who have no comorbidities). In Column 5, we estimate Equation (1a) and limit our analysis to patients throughout our data who have a non-zero Charlson score. The point estimates in

Columns 4 and 5 illustrate that whether or not they had comorbidities, patients were almost equally more likely to have physician visits coded using the CPT code for the most intensive emergency after EmCare entered a hospital. Likewise, in Columns 6, 7, and 8, we estimate Equation (1a) on the samples of patients in the lower third (\$0 to \$279.67), the middle-third (\$279.68 to \$2,033.59), and the top-third (\$2,033.60 to \$115,499.30) of the distribution of historical six-month patient health spending. Across all three sub-samples, the entry of EmCare led to an increase in the rate patients had physician claims coded using the CPT code for the most severe emergency.

In Appendix Table A.17, we repeat this analysis and examine the impact of the entry of EmCare on facility spending across different samples of the data. We see that there was increased facility spending across patients with and without comorbidities and with high and low historical spending. Likewise, controlling for patients' comorbidities does little to alter the impact of the entry of EmCare on facility spending. In Appendix Table A.18, we see similarly robust findings for imaging studies. After the entry of EmCare into a hospital, patients with no comorbidities are 4.9 percent more likely to receive an imaging study.

Finally, in Appendix Table A.19, we analyze whether we observe higher hospital admission rates for patients with low historical spending and no comorbidities following the entry of EmCare. In Column 4, we find that after EmCare entered a hospital, patients with no comorbidities were 20 percent more likely to be admitted to the hospital. In Column 6, we find patients with low historical spending (e.g., less than \$279.67 in the previous six months) were 17 percent more likely to be admitted to the hospital after EmCare took over the management of the hospital ED.

6 Policies to Address Out-of-Network Billing

6.1 Policy Goals and Scaling the Effect of Policies to Address Out-of-Network Billing

A successful out-of-network policy should achieve two aims. First, a policy should protect consumers from large, unexpected bills from out-of-network ED physicians whom the consumers could not reasonably avoid. Second, a successful policy should establish an environment in which the price that out-of-network ED physicians are paid for their services is either competitively determined or is as close to the competitively determined price as possible. Addressing

this currently “missing” price will both settle disputes between physicians and insurers over their bills and influence in-network payments by determining ED physicians’ outside option in negotiations with private insurers.

The effect of curtailing ED physicians’ outside option could have a significant effect on total health spending. To produce a back of the envelope estimate of the potential savings from addressing out-of-network ED billing, consider the nation-wide average in-network payment rates orthopedic surgeons negotiate with the insurer that supplied our data. Orthopedic surgeons form an interesting comparison group because, according to a recent survey, they have the highest salaries among physicians in the US (Grisham 2017). However, whereas the average in-network ED physician payment in our data was 266 percent of the Medicare payment rates (and the average out-of-network payment was 637 percent of the Medicare payment rates), the average in-network payments to orthopedic surgeons for performing hip replacements during our sample period was 178 percent of the Medicare payment rates. If we assumed our policy proposal would generate competition that lowered ED physicians’ in-network payment levels to approximate the in-network payment rate of orthopedic surgeons in our data (178 percent of the Medicare payment rates), this would lower total ED physician spending by 46 percent. If we assume that private spending is one-third of total health spending in the US and that ED physicians account for approximately 1 percent of total private spending, a reasonable back of the envelope calculation would suggest that addressing this issue would produce savings in the range of \$5 billion annually.²⁸

6.2 Existing State and Federal Policies to Address Out-of-Network Billing

At present, the majority of states have no laws to protect consumers from out-of-network billing, 21 states have some legal protections, and 6 of those 21 have comprehensive policies that both protect consumers and include a process determine payments from insurers to out-of-network providers (Lucia, Hoadley, and A. Williams 2017). Unfortunately, state policies only apply to the 40 percent of commercially insured individuals in the US that are enrolled in fully-insured, employer-sponsored health plans (Kaiser Family Foundation 2017). Sixty percent of the individuals in the US with commercial insurance are enrolled in plans offered by firms that self-insure. Because of the Employee Retirement Income

²⁸These numbers are from Morganti et al. (2013) and Hartman et al. (2017).

Security Act of 1974, state-based protections for out-of-network policies do not apply to these enrollees. Notably, however, two recent bi-partisan policy proposals from the Senate, if passed, would offer federal protections that applied to individuals enrolled in fully- and self-insured insurance plans.

Most states' surprise billing laws include a hold harmless provision to protect patients from financial risks (Lucia, Hoadley, and A. Williams 2017). These laws stipulate that patients cannot be charged more than their usual in-network cost sharing during emergencies if they see an out-of-network provider that is working at an in-network facility. However, only 9 of the 21 states with hold-harmless provisions restrict providers from balance-billing patients. So, while patients that saw an out-of-network provider would not be subject to higher cost-sharing rates, they could still be exposed to significant financial risk if physicians acted to collect the balance of their bill from them directly.

The harder policy problem for the states is choosing the "missing" price when there is no contract between physicians and insurers. By 2017, only 6 states (California, Connecticut, Florida, Illinois, Maryland, and New York) introduced state-specific methods for determining how insurers should pay out-of-network ED physicians who treat patients at in-network hospitals. In California, Connecticut, and Maryland, the "missing" price is determined via regulation. In California, insurers are required to pay providers the greater of 125 percent of Medicare's rate or the average in-network rate paid by the insurer in the region; Connecticut sets insurer payments to out-of-network providers at the 80th percentile of providers' charges; and in Maryland, insurers must pay providers 140 percent of in-network payments. A recent Senate proposal has proposed similar regulated payments where the insurer is required to pay providers the average in-network prices in the region (Cassidy 2018). However, it is extremely unlikely that a regulated price of this sort will match the market price for any given transaction. As soon as the regulated price set by states differs from the market price, either the insurer or the physician will take advantage of a regulated price that favors them. If the regulated payment for providers' out-of-network bills is greater than the expected in-network price, ED physicians will be reluctant to join networks. Likewise, if the regulated payment is below expected in-network rates, insurers will not want to form networks.

In Florida, Illinois, and New York, laws prohibit consumers from being balanced bills. In addition, policy-makers in these states introduced an arbitration process to determine insurer payments in the event that insurers and providers cannot reach a resolution on payments in cases when an ED physician is out-of-

network. Likewise, a recent bill sponsored by Senator Maggie Hassan of New Hampshire also introduces an arbitration process (Hassan 2018). New York State's law, passed on April 1, 2014, is the most ambitious in the nation to date. The law has two components. The first is a hold harmless provision that prohibits balance billing and requires patients who are treated by an out-of-network physician to pay no more than what they would have paid in cost sharing should the physician have been in-network. The second component is an arbitration process to determine what providers are paid when they treat a patient and do not participate in the patient's insurer's network. The also law stipulates that insurers must develop reasonable payment rates for out-of-network care, illustrate how their out-of-network payments were calculated, and show how they compare to usual and customary rates (Hoadley, Ahn, and Lucia 2015).²⁹

In practice, under this law in New York, when a patient is seen out-of-network, the insurer makes its payment to the provider. If the out-of-network provider does not accept the payer's offer, the provider can initiate an independent dispute resolution process. The independent dispute resolution process is judged by practicing physicians who use baseball rules arbitration: the arbitrator can stipulate that the provider will be paid the insurer's original payment or alternatively the provider's original charge. Ultimately, this policy disadvantages providers that bill for unreasonably high charges and punishes insurers that offer unreasonably low initial payments. The law also encourages physicians and payers to negotiate independently and avoid arbitration. Technically, the law applies only to fully insured insurance products, as states cannot regulate ASO plans (which account for the majority of privately insured products in the US) (Kaiser Family Foundation 2017). However, because most providers are unaware of a patient's plan funding, their billed amount is likely chosen to reflect the possibility of arbitration.

This type of arbitration process shifts the outside option for physicians when they negotiate their in-network payments. Under the New York law, physicians cannot balance bill patients or collect their inflated charges from insurers. As a result, the 2014 New York law should both reduce the incidence of out-of-network billing (since it is no longer as profitable a strategy) and impact in-network payments (via lowering ED physicians disagreement payoff). We take these propositions to the data by testing the impact of New York State's 2014 surprise

²⁹Usual and customary rates are defined in the New York State law as the 80th percentile of charges based on the Fair Health database, which captures physician charges in the states for most medical procedures.

billing on out-of-network billing rates and the level of physicians' in-network payments.

6.3 Analyzing the Impact of New York State's Law

As Appendix Table A.20 shows, our data include 323,936 ED episodes delivered at New York hospitals between 2011 and 2015, which captures approximately \$1 billion in emergency health care spending. In addition, 90.2 percent of the patients in our data in New York are in ASO products. To test the impact of the New York State laws, we run a difference-in-difference regression and compare New York hospitals' out-of-network rates, physician in-network payment rates, and facility payment rates before and after the passage of the out-of-network legislation to outcomes in hospitals in New Jersey, Pennsylvania, Connecticut, Vermont, and Massachusetts. To do so, we estimate:

$$Y_{i,h,t} = \beta_0 + \beta_1 NY_h + \beta_2 Post_t + \beta_3 NY_h * Post_t + \gamma_h + \mu_t + \varepsilon_{i,h,t}, \quad (2)$$

where the dependent variable is our outcome of interest for patient i , treated at hospital h , in quarter t . We include an indicator for whether a hospital is located in New York. This is our treatment variable and it takes a value of 1 for all time periods if a hospital is located in New York (e.g. is in our treated group). $Post_t$ takes value of 1 for all periods from April 1, 2014, onward, after New York State passed its out-of-network billing laws. Our β_3 coefficient is the coefficient of interest and captures the interaction between our treatment variable (that a hospital is located in New York) and our post variable, which is turned on after the out-of-network billing law was passed. All standard errors are clustered around hospitals.³⁰ In addition, we introduce a non-parametric specification of Equation (2) where our treatment variable is interacted with dummy variables for each quarter. This allows us to illustrate graphically the parallel trends between New York and other the control states before the passage of the New York State law.

6.4 The Impact of New York State's Out-of-Network Billing Laws

Table 9 presents least-squares estimates of Equation (2) and shows the impact of the New York State law on hospitals' out-of-network rates, physician charges

³⁰Our results are also robust to clustering around HRRs.

and payments, and hospital charges and payments. As Column 1 illustrates, the New York State law reduced the frequency of out-of-network billing by 6.8 percentage points relative to changes observed in other New England states. Figure 8 presents non-parametric estimates of Equation (2) graphically. The out-of-network rates in New York and the other New England states followed similar trends before the introduction of the New York State out-of-network protection law in 2014. However, almost immediately after the law was passed (and before the required implementation date), there was a marked reduction in out-of-network billing in the state. Figure 9 shows the distribution of out-of-network rates across hospitals in 2013 and 2015. The out-of-network rate in New York in 2013 was 20.1 percent. Two years later, the rate was 6.4 percent, and the reduction in out-of-network rates was driven by reductions in out-of-network rates across nearly all hospitals, including those that previously had high rates of out-of-network billing. Columns 6 and 7 in Table 9 show that although the law applied only to fully insured insurance products, the reduction in out-of-network rates occurred for patients with fully insured insurance plans and those covered by ASO policies. If physicians cannot infer whether a patient has an ASO or fully insured insurance product before sending a bill, they will want to charge a moderate amount in order to win in any arbitration.

Perhaps more notably, as we illustrate in Column (3), the New York state law lowered in-network payments to physicians by \$43 (8.8 percent). This reduction in payments is consistent with predictions that the law would lower ED physicians' disagreement payoff in negotiations with insurers over in-network payments, which should lower the prices reached in the negotiations. It is also notable that this effect was observable in New York where, in addition to engaging in arbitration, insurers have to identify how their proposed out-of-network payments are scaled relative to usual and customary payments (average physician charges).

6.5 An Alternative Policy To Protect Consumers from Out-of-Network Bills and Restore a Competitive Price for ED Physician Services

Evidence from New York state suggests that introducing a hold-harmless provision and arbitration over insurers' payments to out-of-network physicians can lower the frequency of out-of-network billing and the level of physicians' in-network payments. This result shows how changing physicians' outside option

in negotiations alters their ultimate negotiated payment. Nevertheless, the New York State law is administratively complex and potentially costly. If patients receive a surprise out-of-network bill and are charged out-of-network rates, they must be aware that the protections exist and fill out the form included in Appendix C. Likewise, the state has to fund and administer the arbitration process in perpetuity. Moreover, because states cannot regulate ASO products, the New York protections only offer formal protection to individuals covered by fully insured insurance products.

In our view, the best option for addressing out-of-network billing is not for the state to try to regulate the missing price, but instead to regulate the *form* of the contract between hospitals, physicians, and insurers, so that the resulting physician payment is generated by market forces. When patients choose an ED, they are choosing a package of emergency services that includes the services of the hospital and physicians. Under our preferred policy, states or the federal government could require hospitals to sell and insurers to contract for an ED service package that includes physician and facility services. Hospitals would purchase the inputs for ED services the way they purchase other labor inputs, such as nursing care and non-labor inputs, such as bandages and needles. All care provided in the ED would be included when the hospital contracted to be “in-network” with an insurer. This type of policy would require the hospital to buy ED physician services in a local labor market, which would expose hospitals and physicians to competitive forces and produce a market price for ED physician services. Hospitals would then submit a single bill to insurers.

With this type of policy in place, patients consuming emergency services would be protected from surprise bills as long as the patients chose in-network facilities. This policy is also likely to lower the equilibrium prices for in-network ED physicians. This policy also solves the inability of states to regulate ASO products. Rather than regulating insurance, this would be a form of hospital regulation. As a result, it would apply to all patients in a state regardless of the type of insurance they have.

7 Conclusion

Out-of-network physician ED billing from in-network EDs in the US is a function of an idiosyncrasy in the US health system: physicians working in a hospital may not participate in the same insurance networks as the hospital itself. For inseparable services, like emergency care, where the patient must consume a

package care that includes hospital and physician services, this means that ED physicians face inelastic demand. When a physician is out-of-network, depending on a patient's insurance plan, the patient can be hit with a large and unexpected bill. These out-of-network bills can expose patients to significant financial risk. Moreover, when physicians and physician groups can bill out-of-network without seeing a reduction in the number of patients they treat, it undercuts the functioning of health care markets by insulating physician from competition and changing the outside option physicians face when negotiating with insurers over their prices.

Consistent with their strong outside option, we observe that ED physicians were paid more, as a percentage of Medicare payments, than other physician specialties. Moreover, we observe that two leading ED physician outsourcing firms - EmCare and TeamHealth - use out-of-network billing to significantly raise the amounts they are paid, although each utilize a distinct strategy. These two examples are instructive in their differences and provide a nice illustration of the economics of bargaining that underlies the rate-setting carried out by all physicians.

We find that after EmCare takes over the management of ED services at a hospital, it raises out-of-network billing rates by over 80 percentage points. This allows the firm to collect higher payments from insurers and from patients. We calculate that the payments they received from insurers increased by 122 percent and patient cost sharing increased by 83 percent. Crucially, this increase in patient costs represents a lower bound of the cost exposure patients could face when they are treated by an out-of-network ED physician. The insurer supplying our data, in most instances, pays out-of-network physicians their charges. However, in practice, many insurers either do not pay out-of-network physicians anything (leaving the patient to pay their physicians themselves) or they only pay standard in-network rates (leaving patients to pay the difference between the physician's charges and the insurer's payments). Hospitals with ED services that are outsourced to EmCare form a significant percentage of the 15 percent of hospitals in the US with extremely high out-of-network billing levels.

TeamHealth pursues a different strategy. When TeamHealth enters a hospital, they also increase out-of-network rates significantly. However, after several months, TeamHealth returns in-network. Notably, when TeamHealth goes back in-network, the in-network payments their physicians receive are 68 percent higher than they were before the firm entered the hospital. We posit that TeamHealth uses its stronger outside option to negotiate higher in-network

payments. Interestingly, the number of patients seen in the TeamHealth ED increases, which may be a sign of efficiencies.

When ED physicians bill out-of-network, it likely creates reputational harm for the in-network hospitals where they work. We find evidence that EmCare offsets the costs of harm for hospitals by providing transfers. The transfers we observe include EmCare-affiliated physicians ordering treatments that lead to increased hospital billing, such as ordering more imaging studies and increasing rates that patients are admitted to the hospital. Both changes generate additional revenue for the hospitals. We do not find similar transfers at hospitals that outsourced their ED care to TeamHealth.

What is the appropriate policy response to surprise out-of-network billing? A variety of states have implemented policies to protect consumers. One of the most innovative policies was introduced in New York. In 2014, the state passed a law that banned balanced billing and required insurers and physicians to enter into binding arbitration to settle disputed bills. This strategy aims to restore a competitively set price for out-of-network ED services and dramatically changes ED physicians outside option in negotiations with insurers. We assessed the impact of this law and found that it reduced out-of-network billing by 34%. Of note, after it was introduced, the policy also reduced the level of in-network ED physician payments in the state by 9%. An alternative policy approach would be for states to require that hospitals to sell an “ED package” to insurers that includes both physician and hospital services. Here, regulating the structure of the contract rather than the level of the payment would also generate out-of-network payments that were competitively set and therefore generate higher social welfare.

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Table 1: ED Episodes Per Year

	Emergency Episodes	Total Facility Spending (millions)	Total Facility Spending (millions)	Mean			Pat. Cost-Sharing on Physicians	Pat. Cost-Sharing Hospitals	Hospital Out-of-Network Frequency
				Physician In-Network Payment (%)	Medicare				
2011	1,699,451	\$4,291	\$572	\$278.70 (228%)		\$43.58	\$347.41		28.6%
2012	1,899,513	\$4,856	\$696	\$293.62 (245%)		\$49.85	\$368.17		28.0%
2013	1,820,059	\$5,010	\$741	\$324.91 (269%)		\$59.17	\$416.61		26.1%
2014	1,745,100	\$5,037	\$751	\$348.98 (284%)		\$67.60	\$451.80		24.2%
2015	1,749,073	\$5,262	\$779	\$383.33 (303%)		\$70.40	\$464.16		21.9%
Total	8,913,196	\$24,458	\$3,538	\$325.91 (266%)		\$58.12	\$409.63		25.8%

Notes: The table shows episodes per year, facility spending per year, physician spending per year, the mean payment to an in-network ED physician (and the mean expressed as a percentage of Medicare payments), patient payments for physician fees, patient payments for hospital fees, and yearly out-of-network rates. The physician payment is the sum of the insurer and patient contribution. All dollar amounts are in 2015 dollars. We observe that over 99% of ED care occurred at in-network hospitals.

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Table 2: The Impact of EmCare and TeamHealth Entry on Hospitals' Out-of-Network Rates

	(1)	(2)	(3)
	Hospitals with OON Rates above 97% Prior to Entry	Hospitals with OON Rates Below 97% Prior to Entry	All Hospitals
	EmCare Entry		TeamHealth Entry
	OON Indicator		OON Indicator
Management Company Entry	-0.030 (0.044)	0.815*** (0.061)	0.326*** (0.030)
Hospital FE	Yes	Yes	Yes
Month FE	Yes	Yes	Yes
Mean	0.209	0.204	0.226
SD	0.407	0.403	0.419
Observations	8,401,884	8,351,799	8,661,796
Control	All Non-Entry Hospitals	All Non-Entry Hospitals	All Non-Entry Hospitals

Notes: $*p < 0.10$, $**p < 0.05$, $***p < 0.01$. This table presents least-squares estimates of Equations (1a) and (1b). In Column (1), we focus on hospitals that EmCare entered that had out-of-network rates prior to entry that were above 97%. In Column (2), we focus on hospitals that had out-of-network rates prior to entry below 97% (in practice, all hospitals with out-of-network rates below 97% had out-of-network rates below 11%). In Column (3), we focus on the sample of all hospitals where TeamHealth entered. The dependent variable in all regressions is a binary indicator for whether a patient at an in-network hospital was treated by an out-of-network physician. Our analysis is run at the patient-level. The control groups are all hospitals in the US that did not outsource their ED management to EmCare or TeamHealth. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Mean and standard deviation are drawn from the analytic sample population underlying the regression. In Appendix Table A.3, we show these estimates using alternative control groups.

Table 3: The Impact of the Entry of EmCare on Physician Charges, Payments, and Coding

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Physician Charge	Insurer Payment	Patient Cost Sharing	Total Payment	Potential Balanced Bill	Total Patient Cost Exposure	CPT Severity
EmCare Entry	556.84*** (62.12)	402.67*** (54.52)	45.23*** (4.38)	447.90*** (55.16)	108.94*** (38.71)	154.17*** (35.12)	0.148*** (0.030)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	578.95	329.17	54.47	383.64	195.32	249.79	0.347
SD	364.61	290.13	108.72	297.99	225.12	243.57	0.476
Observations	8,418,226	8,418,226	8,418,226	8,418,226	8,418,226	8,418,226	8,418,226
Control	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals

Notes: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. This table presents least-squares estimates of Equation (1a). Each observation is a patient episode. The control group in all regressions is all hospitals in the US exclusive of those that outsourced their ED services to EmCare. We winsorized the top and bottom percentile of hospital and physician payments. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars. In Appendix Table A.4 and Appendix Table A.5, we show these estimates using alternative control groups.

Table 4: The Impact of the Entry of TeamHealth on Physician Charges, Payments, and Coding

	(1)	(2)	(3)	(4)	(5)	(6)
	Physician Charge	Insurer Payment (In-network)	Insurer Payment (Out-of- -network)	Patient Cost Sharing	Total Payment	CPT Severity
TeamHealth Entry	52.49 (35.90)	236.56*** (12.87)	203.09*** (73.66)	21.85*** (3.43)	269.01*** (19.06)	0.016 (0.015)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes
Mean	589.58	263.95	597.44	55.92	395.38	0.346
SD	374.63	226.87	371.14	110.54	310.46	0.476
Observations	8,661,796	6,700,621	1,961,175	8,661,796	8,661,796	8,661,796
Control	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals

Notes: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. This table presents least-squares estimates of Equation (1b). Each observation is a patient episode. The control group in all regressions is all hospitals in the US exclusive of those that outsourced their ED services to TeamHealth. We winsorized the top and bottom percentile of hospital and physician payments. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars. In Appendix Table A.6 and Appendix Table A.7, we show these estimates using alternative control groups.

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Table 5: Comparison of Physician Payments as a Percent of Medicare

(1)	(2)	(3)	(4)	(5)
Orthopedist Hip Replacement Payment Rate	Internist Office Visit Payment Rate	ED Physician Standard Visit Rate (In-network)	TeamHealth ED Physician Standard Visit Rate	EmCare ED Physician Standard Visit Rate
(% of Medicare)				
178%	158%	266%	364%	536%

Notes: This table shows physician payments as a percentage of Medicare based on speciality. Columns (3,4,5) are derived from our analytic sample of ED episodes. Columns (4,5) include all physician payments to physicians working in Emcare and TeamHealth hospitals identified in our data. Columns (1) and (2) are based on claims from the same period as the ED claims and were paid by the same payer.

Table 6: The Impact of the Entry of EmCare on Hospital Charges, Payments, and Activity

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Facility Charge	Insurer Payment	Patient Cost Sharing	Total Payment	Imaging	Admission to Hospital	Episode Count
EmCare Entry	1683.63*** (401.04)	240.70** (98.68)	53.88*** (17.91)	294.58*** (113.64)	0.014*** (0.005)	0.021*** (0.006)	-104.0 (218.1)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	6,304.63	2,350.46	393.81	2,744.27	0.278	0.090	1,695.5
SD	12,415.53	4,885.15	561.89	5,034.47	0.448	0.286	1,566.5
Observations	8,418,226	8,418,226	8,418,226	8,418,226	8,418,226	8,418,226	8,418,226
Control	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals

Notes: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. This table presents least-squares estimates of Equation (1a). Each observation is a patient episode. The control group in all regressions is all hospitals in the US exclusive of those that outsourced their ED services to EmCare. We winsorized the top and bottom percentile of hospital and physician payments. Imaging is an indicator variable capturing whether a patient had an imaging study performed during an ED visit. Admissions to hospital is an indicator variable that captures whether a patient was admitted to the hospital after an ED visit. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars. In Appendix Table A.9 and Appendix Table A.10, we show these estimates using alternative control groups.

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Table 7: The Impact of the Entry of TeamHealth on Hospital Charges, Payments, and Activity

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Facility Charge	Insurer Payment	Patient Cost Sharing	Total Payment	Imaging	Admission to Hospital	Episode Count
TeamHealth Entry	170.17 (174.03)	-76.61 (76.82)	24.42** (12.41)	-52.19 (82.70)	-0.008** (0.003)	-0.006** (0.002)	515.4*** (182.8)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	6,400.68	2,355.70	394.19	2,749.89	0.279	0.091	1,692.1
SD	12,555.33	4,891.99	561.51	5,041.25	0.448	0.287	1,557.4
Observations	8,661,796	8,661,796	8,661,796	8,661,796	8,661,796	8,661,796	8,661,796
Control	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals

Notes: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. This table presents least-squares estimates of Equation (1b). Each observation is a patient episode. The control group in all regressions is all hospitals in the US exclusive of those that outsourced their ED services to TeamHealth. We winsorized the top and bottom percentile of hospital and physician payments. Imaging is an indicator variable capturing whether a patient had an imaging study performed during an ED visit. Admissions to hospital is an indicator variable that captures whether a patient was admitted to the hospital after an ED visit. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars. In Appendix Table A.11 and Appendix Table A.12, we show these estimates using alternative control groups.

Table 8: Comparison EmCare and TeamHealth Hospital Characteristics

Hospital Characteristics	All Hospitals (3,056)	EmCare Hospitals (194)	P-value from two-sided t-test	All Hospitals (3,056)	TeamHealth Hospitals (95)	P-value from two-sided t-test
For-profit	0.19	0.56	0.00	0.21	0.29	0.09
Non-profit	0.66	0.26	0.00	0.63	0.57	0.28
Government	0.15	0.17	0.50	0.15	0.13	0.63
Teaching	0.09	0.05	0.06	0.09	0.04	0.09
Hospital Beds	227.32	185.43	0.01	225.74	197.63	0.21
Technologies	55.26	44.38	0.00	54.84	47.79	0.04
Hospital HHI	0.55	0.57	0.57	0.55	0.59	0.35
Proportion Medicare	47.45	48.04	0.56	47.36	51.42	0.00
Proportion Medicaid	19.88	19.14	0.39	19.83	20.15	0.78
ED Physicians per Capita (per 10,000)	0.77	0.66	0.00	0.77	0.70	0.04
Physicians per Capita (per 10,000)	22.11	21.21	0.01	22.04	22.66	0.23
Physician HHI	0.43	0.41	0.37	0.43	0.41	0.39
Insurer HHI	0.38	0.36	0.32	0.38	0.36	0.23
Household Income (\$)	36,862.23	37,277.03	0.41	36,904.38	36,287.42	0.38
Gini Coefficient	0.32	0.33	0.00	0.32	0.33	0.04

Notes: The table compares characteristics of identified EmCare and TeamHealth hospitals to the entire sample of hospitals. The number of hospitals in each column is shown in parenthesis. Hospitals where EmCare and TeamHealth have contracts are excluded from all hospitals. The p-value is reported from a two-sided t-test comparing the difference in means between all hospitals and identified EmCare and TeamHealth hospitals.

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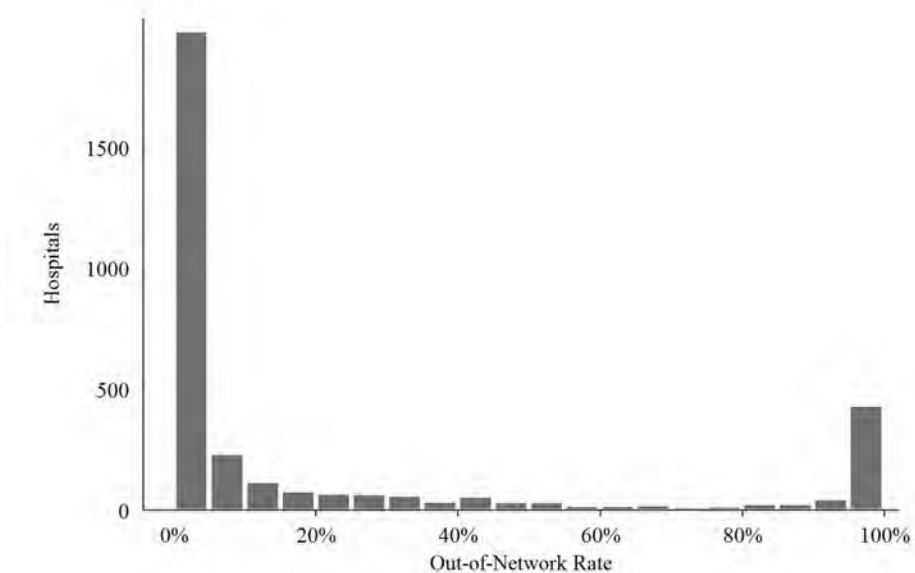
Table 9: Estimating the Impact of the New York State Surprise Billing Law

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Out-of- Network Rate	Physician Charge	In-Network Physician Payment	Facility Charge	Facility Payment	Out-of- Network Rate (ASO)	Out-of- Network Rate (Full Insurance)
NY * Post dummy	-0.068** (0.030)	21.46 (20.74)	-43.74*** (11.51)	-98.73 (148.39)	-1.21 (81.85)	-0.069** (0.031)	-0.062** (0.031)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Quarterly FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	0.202	499.17	335.86	6,100.52	2,571.28	0.198	0.227
SD	0.401	313.11	251.95	12,693.62	5,122.37	0.399	0.419
Observations	905,441	905,441	905,441	905,441	905,441	787,005	116,642
R-Square	0.636	0.435	0.488	0.113	0.114	0.629	0.687

Notes: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. This table presents least-squares estimates of Equation (2). All regressions are run at the patient level. Each regression includes an indicator variable for whether the episode occurred in New York. The post dummy turns on in 2014 Q1 (when the NY vote was passed). Hospital and physician payments are winsorized at the top and bottom one percentile. The control states included are NJ, PA, CT, VT, and PA. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars.

003105

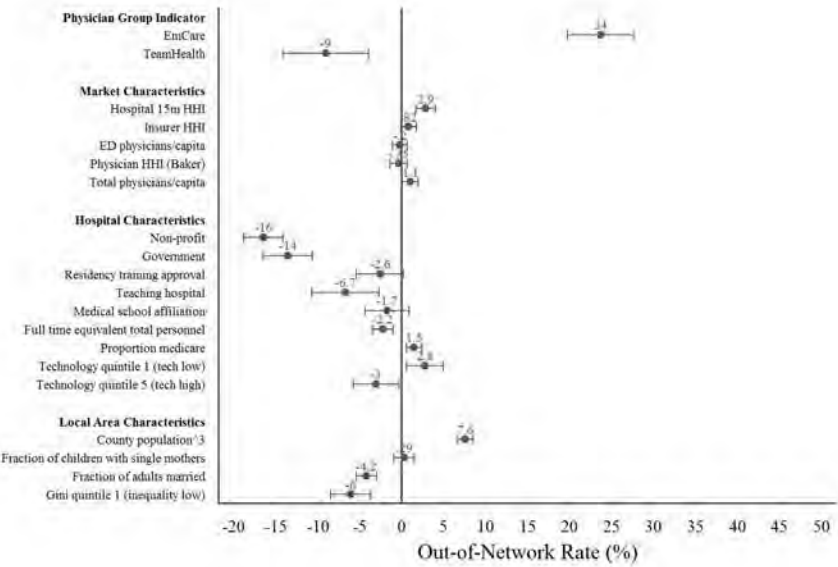
Figure 1: The Distribution of Hospital Out-of-Network Billing Rates in 2015



	10 th	25 th	50 th	75 th	90 th
Out-of-Network Rate	0	0	0.011	0.278	0.990

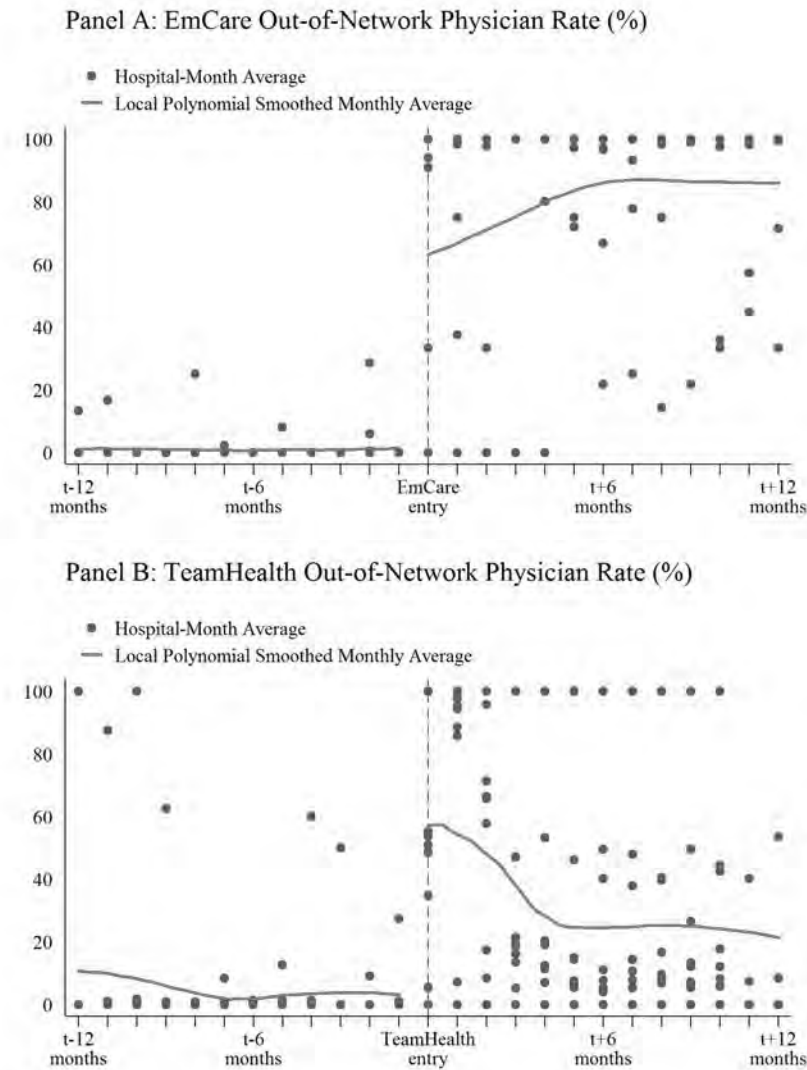
Notes: The figure shows the distribution of ED physicians out-of-network rates across hospitals in 2015.

Figure 2: Conditional Correlates of Hospital Out-of-Network Billing



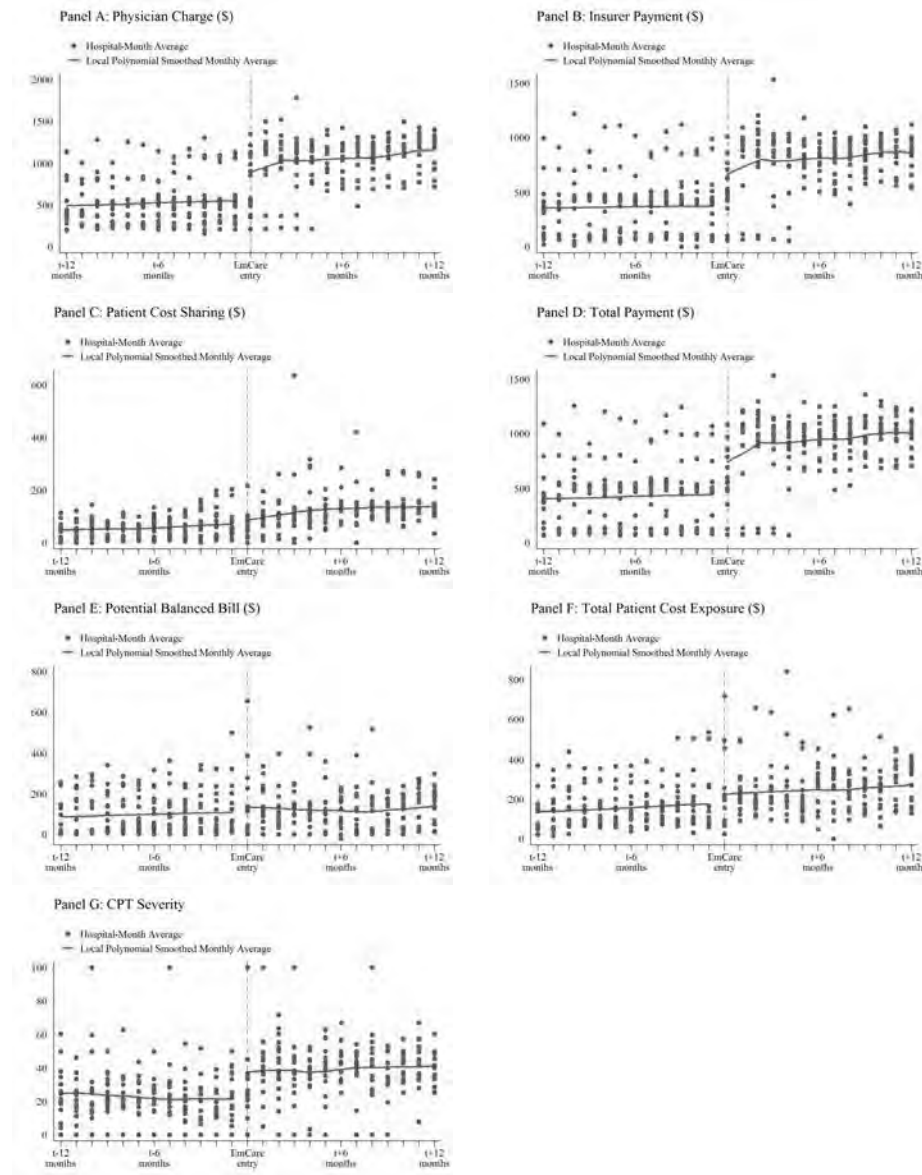
Notes: The figure shows the point estimates from a least-squared regression of hospital out-of-network rates on variables chosen from our Lasso. We used data from 2011 through 2015. Each observation is a hospital-year rate of out-of-network billing. The regression includes year fixed-effects. For continuous variables, the point estimates can be interpreted as the percentage point change in out-of-network rate for a one standard deviation increase in the explanatory variable. For binary variables, the point estimate illustrates the impact of having the variable take a value of one. To obtain these results, we first run a Lasso with all possible variables (90 in total). We then square and cube continuous variables chosen from the Lasso and run a second Lasso that includes all variables in addition to those that are now squared and cubed. We then run an OLS regression of hospital out-of-network rates on variables chosen from the Lasso. We also included measures of physician, hospital and insurer market concentration and physician group indicators.

Figure 3: Discontinuity Analysis of Out-of-Network Rates at Hospitals Where EmCare and TeamHealth Took Over Management of ED Services



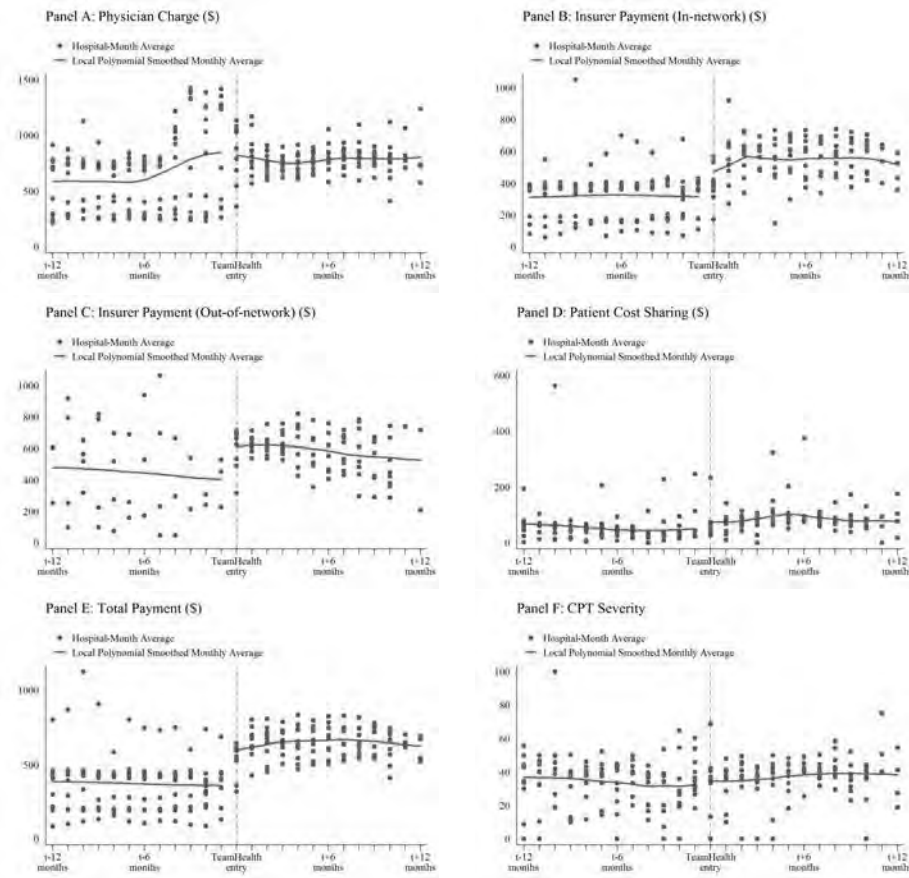
Notes: The panels plot the monthly average by hospital from 12 months before to 12 months after EmCare or TeamHealth entered the hospital. For Panel A, we limit our analysis to hospitals with out-of-network rates below 97% in 2011.

Figure 4: Discontinuity Analysis of Physician Billing at Hospitals Where EmCare Took Over Management of ED Services



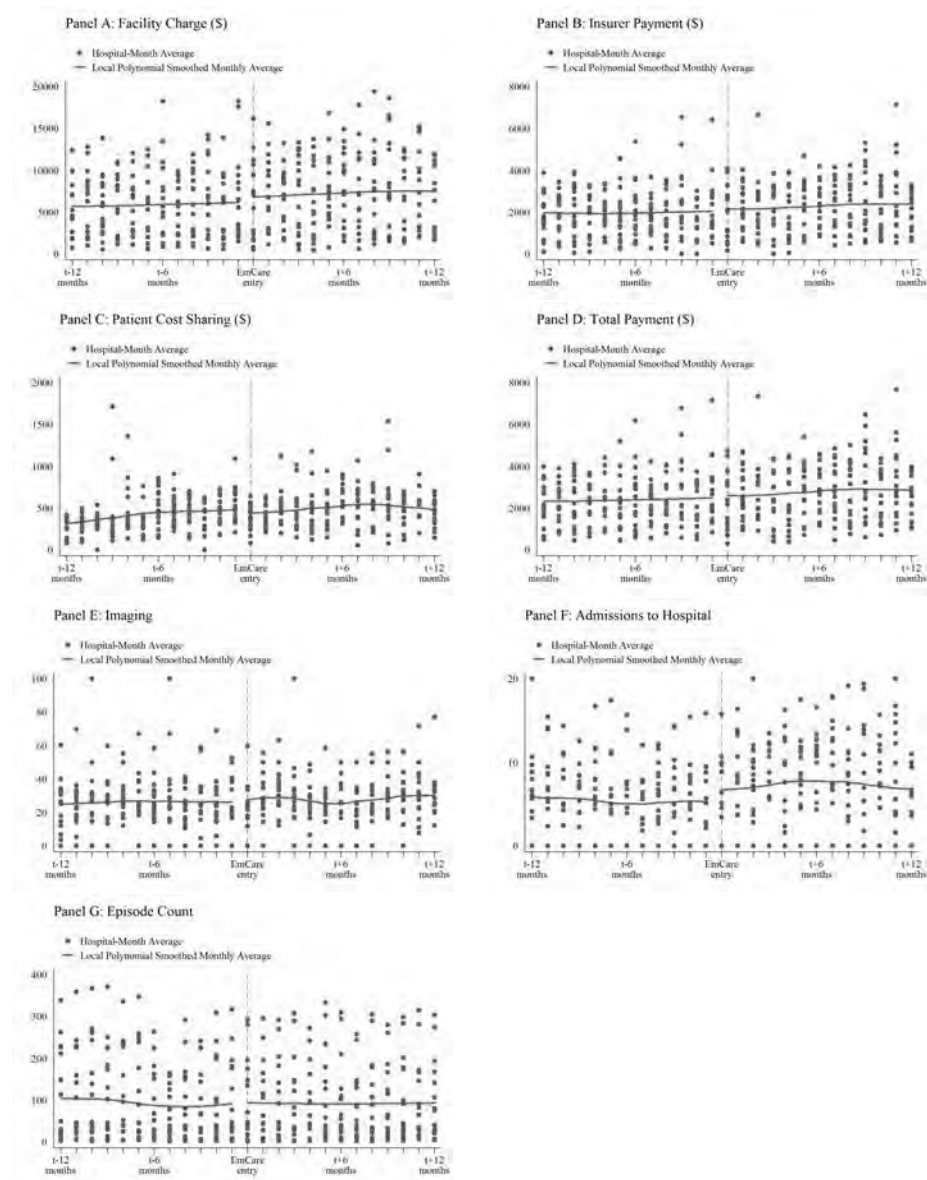
Notes: The panels plot the monthly average by hospital from 12 months before to 12 months after EmCare entered the hospital.

Figure 5: Discontinuity Analysis of Physician Billing at Hospitals Where TeamHealth Took Over Management of ED Services



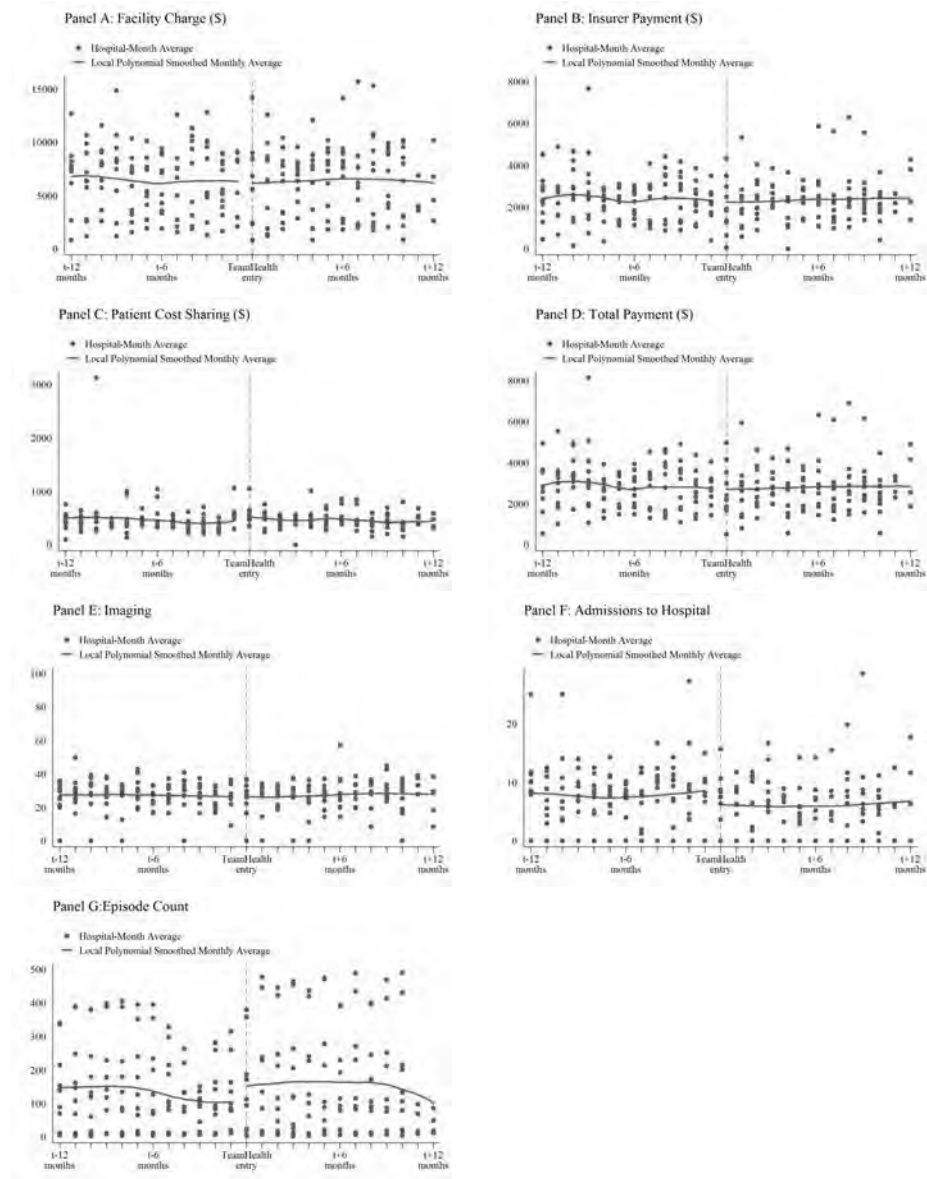
Notes: The panels plot the monthly average by hospital from 12 months before to 12 months after TeamHealth entered the hospital.

Figure 6: Discontinuity Analysis of Hospital Activity at Hospitals Where EmCare Took Over Management of ED Services



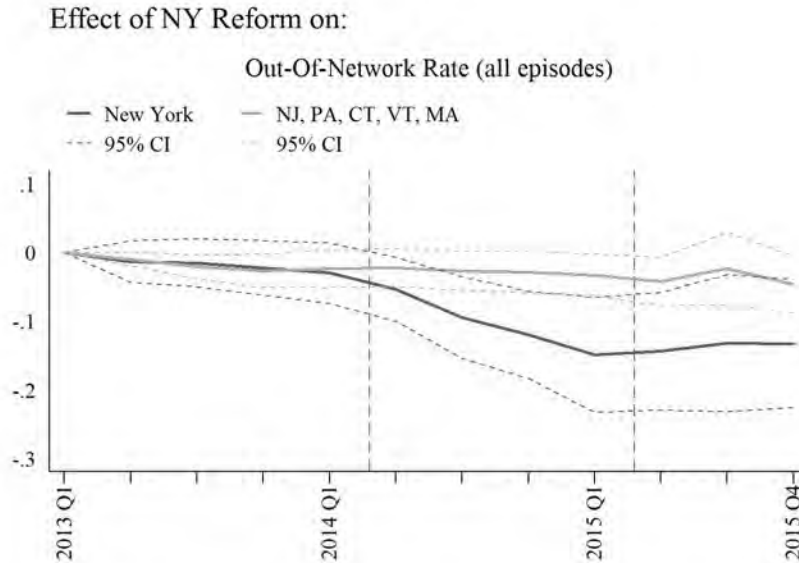
Notes: The panels plot the monthly average by hospital from 12 months before to 12 months after EmCare entered the hospital.

Figure 7: Discontinuity Analysis of Hospital Activity at Hospitals Where TeamHealth Took Over Management of ED Services



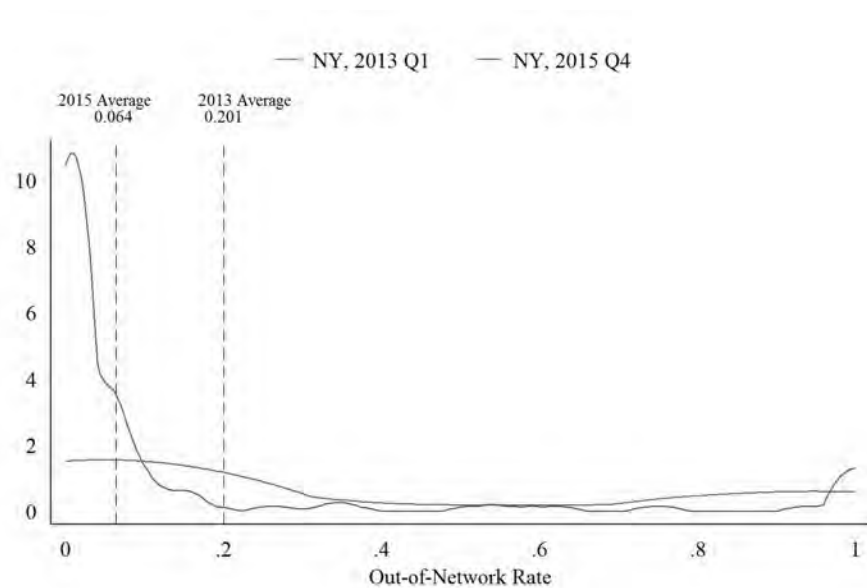
Notes: The panels plot the monthly average by hospital from 12 months before to 12 months after TeamHealth entered the hospital.

Figure 8: Out-of-Network Billing Rates in New York Versus Surrounding States



Notes: The figure presents least-squares estimates of an episode-level regression where the dependent variable is whether or not a patient at an in-network ED received a bill from an out-of-network physician. We regress that against an indicator for whether the episode occurred in the state of New York, a vector of quarterly fixed effects, and the interaction of the New York indicator and the quarterly fixed effects. Patient age, gender, race, and Charlson scores are included as controls. The omitted category is Q1 2013. We include a vector of hospital fixed effects. The control group is composed of ED episodes that occurred in New Jersey, Pennsylvania, Connecticut, Vermont, and Massachusetts. Standard errors are clustered around hospitals. The red dotted line denotes when the NY vote passed, and the green dotted line denotes when the NY law was enacted.

Figure 9: The Distribution of Out-of-Network Billing in New York in 2013 and 2015



Notes: The figure shows the kernel density distribution of hospital out-of-network rates in New York in 2013 and 2015

Appendix – For Online Publication

Appendix A Modelling Surprise Out-of-Network Billing

For it to occur, there are three parties that have to prefer out-of-network billing to an in-network contract: the physician group, the hospital, and the insurer. The physician group and insurer must be unable to come to an agreement on an in-network contract. In addition, the hospital must effectively allow physicians to bill out-of-network from inside their facilities.³¹ We discuss each party's incentives in turn.

Out-of-Network Prices

The physician group and the insurer bargain over the price the insurer will pay the physicians. The revenue component of the disagreement payoff of the physician group should it end up out-of-network is a price limited only by the laws of a state, s . Since state laws differ, this net price will vary by state, and we could think of the price as being a function of that state's institutional environment, e.g. $p = f(law_s)$.³² However, the model below will focus on agents all in one state and describe the average out-of-network price the group can collect, p^L , as coming from the legal environment, not the market environment in that state. A crucial feature of emergency medicine (that our model exploits) is that the quantity of patients seen by the emergency physician group is invariant to its network status.³³

³¹The hospital may not have legal authority to prevent a physician (or physician group) from practicing in the ED just because that physician has failed to come to an agreement with any given insurer or insurers. However, we assume there are so many interactions between the hospital and an ED physician group that if the hospital disapproved of the group's overall strategy, it could make the relationship sufficiently onerous such that the physicians would move in-network.

³² In Maryland and California, for example, out-of-network physicians cannot bill more than the greatest of either their in-network payments, a fixed percentage of Medicare payments, or physicians' usual and customary charges.

³³When patients attend a hospital ED, they have no choice over the physician that treats them. As a result, once a patient decides to attend a hospital ED, the patient cannot avoid out-of-network physicians working in that ED. Previous researchers have used this feature of emergency medicine as a source of random variation in physician assignment (see Barnett, Olenski, and Jena 2017).

Insurers

We denote the equilibrium negotiated price as p^* . We abstract from all other revenue and costs of the insurer and simply define r to be the insurer's net revenue per patient without any ED physician cost. Thus, the net benefit of a representative enrollee to the plan is r less the cost of the ED physician. If the physician group and the insurer agree to a contract at p^* , the insurer gets:

$$U_{i,IN} = r - p^*. \quad (3)$$

If the two parties do not agree, then the physician group begins billing its charges, which are higher than negotiated network rates. The insurer may take advantage of any state law to reduce those physician charges, but the laws result in an effective price received by the physicians of p^L . We assume that the insurer ends up paying some fraction γ , less than one of the new out-of-network price p^L . We will treat γ as exogenous in our model.³⁴ The net insurer payoff under disagreement is thus:

$$U_{i,OUT} = r - \gamma p^L. \quad (4)$$

A second difference under disagreement is that now the physicians also collect the balance of the payment from the patient, who earns a disutility payoff $W((1 - \gamma)p^L) < 0$. The patient blames the hospital for the balance bill so the hospital suffers harm to its reputation of k_h . Throughout the model, when we use the term “out-of-network billing” we are referring to physicians using the deliberate strategy of raising charges by a significant amount in order to earn higher payments. It is perfectly possible for an ED physician group to not have a contract with a patient's insurer (perhaps due to transaction costs) and to charge that patient a typical in-network price. We assume, as is the case in our data, that in this situation the patient and the insurer will share costs in the usual way and there are no disputes. We further assume that in that case there is no reputational cost to the hospital. While this setting is technically also “out-of-network billing,” we exclude it from the definition in our discussion below in order to focus on the deliberate strategy of raising prices.

³⁴It could be that γ is determined by state laws and norms as well as by competition in the insurer market. We assume that frictions in the physician ED market are too small to create any feedback to insurance competition.

Hospitals

We assume that hospitals understand when their outsourcing firm will be taking advantage of patients and insurers with an out-of-network billing strategy. Hospitals appreciate that the management company cannot carry out its strategy without access to the ED, and therefore the hospital will be able to bargain to keep a share of the increased profits generated by the outsourcing firm. These profits could take the form of physicians allowing the hospitals to share in the physicians' profits (e.g., with a joint venture), through a reduction in any management fees that a hospital would have to pay a firm to staff their ED. The payment could alternatively be generated by increases in facility fees that result from increased testing rates, imaging rates, or admissions to the hospital. Recall that, ultimately, physicians control patient utilization and what gets billed by the hospitals. As a result, ED physicians have significant influence over hospitals' revenue.

Because the hospital can block an out-of-network billing strategy, it must be compensated for the reputational loss it incurs from having this practice occur inside its facility. We assume that an outsourcing firm can pay a fixed amount $c > k_h$ to satisfy the hospital.³⁵ Physicians also have the ability to generate payment c to the hospital without it coming from the physician's own pocket. This could occur via potentially unnecessary activities A such as ordering additional lab testing, imaging studies, or raising the rates that patients are admitted to the hospital. Increasing these activities does not generate revenue for the physician, but it does generate revenues to the hospital. Engaging in activity A carries with it some legal risk indicated by $R(A)$, (with $R'(A) > 0$, $R(0) = 0$), since it potentially involves giving care to patients who don't need it which could be found to violate laws or regulations. A more complex model could make c endogenous and allow outsourcing firms to compete by increasing it, but we do not take on that topic in this paper.

We also assume the hospital does not face any cost of higher-priced in-network billing. We think this is a reasonable assumption because it is hard for patients to observe counterfactual prices and patients perceive they are 'covered' in these circumstances. That is, the level of p^* paid to ED physicians when they

³⁵We recognize a possible role for asymmetric information. A hospital may not realize the strategy of the outsourcing firm *ex ante*. An uninformed hospital may sign a contract that is later terminated when the hospital realizes its patients are receiving balance bills and the reputational cost is high. For example, the Los Alamos Medical Center began contracting with EmCare in 2012 (DeRoma 2012). Several years later, the hospital ended their contract with the hospital over concerns about out-of-network billing and coding practices.

participate in an insurer's network does not affect the hospital's payoff. Hospitals value consumer welfare and also profits with weight α_h . If a hospital hires an out-of-network group to staff its ED, hospital utility changes by:

$$\Delta U_h = (c - k_h) + \alpha_h W((1 - \gamma)p^L), \quad (5)$$

which represents its incremental financial earnings less the dollar value of the disutility of patients. The hospital will only agree to out-of-network billing if its weight α_h on patients is sufficiently low. Recall that $W < 0$ and $c > k_h$, so α_h will be positive but smaller, all else equal, for hospital willing to engage in out-of-network billing:

$$\alpha_h < (c - k_h)/(-W((1 - \gamma)p^L)). \quad (6)$$

If a hospital experiences a very high reputational or other cost to hosting a physician group engaged in an out-of-network billing strategy, physician groups will find it expensive to locate their strategy in that hospital and will tend to locate elsewhere. In the empirical section of the paper we will identify the characteristics of hospitals that have high out-of-network rates and contract with firms that engage in an out-of-network billing strategy.

Physicians

A physician group faces a tradeoff between exercising its threat of going out-of-network and collecting p^L while compensating the hospital c (or engaging in A) and having a disutility from financially harming patients, or joining the network for p^* . Consumer welfare, W , is constant at zero across in-network prices because we assume the impact of out-of-network billing on premiums takes place slowly over time and is not perceived by consumers within our game. Out-of-network billing from a patient's doctor results in disutility to that patient of $W((1 - \gamma)p^L)$ which the physicians also take into account with a weight α_p .

Physicians value profits, consumer welfare, and legal risk with weights as noted below. Profit is the negotiated price times a fixed quantity of patients less any financial costs due to the physician group's choice. If out-of-network status is chosen, the group must either pay the hospital the financial cost c or bear risk $R(A)$, which is a decrement to the physicians' utility weighted by β_p . Physician

per patient utility (the number of patients is fixed) when bargaining fails is:

$$U_{p,OUT}(\pi, W, A) = p^L + \alpha_p W((1 - \gamma)p^L) - \min\{c, \beta_p R(A)\}. \quad (7)$$

We assume that everywhere physicians' gain from an additional dollar increase in p^L is larger than their utility loss from the harm to consumers. Physicians' increased utility from income can be offset by harm to consumers, but not reversed. This is particularly plausible when γ is large, which is the case in our setting.³⁶ We therefore assume $|\alpha_p W'| < 1$.

When bargaining succeeds and the physician group is in-network at the hospital, its utility is:

$$U_{p,IN}(\pi, W, A) = p^*. \quad (8)$$

We assume equal bargaining power for the two parties. The Nash bargaining expression is therefore the product of the gains from agreement for both parties:

$$[U_{p,OUT} - U_{p,IN}] * [U_{i,IN} - U_{i,OUT}]. \quad (9)$$

Which can equivalently be written:

$$[p^* - p^L + \alpha_p W((1 - \gamma)p^L) - \min\{c, \beta_p R(A)\}] * [\gamma p^L - p^*]. \quad (10)$$

We assume bargaining strengths are equal and therefore p^* will split any difference between the two outside options. If the following holds:

$$U_{p,OUT}(\pi, W, A) = p^L + \alpha_p W((1 - \gamma)p^L) - \min\{c, \beta_p R(A)\} \geq \gamma p^L, \quad (11)$$

then there are no gains from a contract and the physician group will stay out-of-network. On the other hand, if:

$$U_{p,OUT}(\pi, W, A) = p^L + \alpha_p W((1 - \gamma)p^L) - \min\{c, \beta_p R(A)\} < \gamma p^L, \quad (12)$$

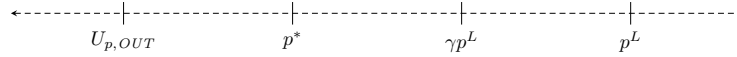
then we expect an equilibrium p^* :

$$p^* = [p^L + \alpha_p W((1 - \gamma)p^L) - \min\{c, \beta_p R(A)\} - \gamma p^L]/2 \quad (13)$$

The intuition for the case where an in-network price is possible is graphed

³⁶Few consumers have savings to pay a large medical bill and therefore the fraction of it that can be actually collected by physicians is relatively small.

below. The key is that the physician's net utility for being out-of-network is low, either because of concern for patient welfare or because the hospital's reputational cost, and therefore transfer, is high. Alternatively, if $U_{p,OUT}$ (measured in dollars) lies above γp^L on the line below, either because physicians are not concerned about putting patients in a bad situation or hospital reputation costs are low, then there is no scope for agreement.



The insurer's outside option (γp^L) is not specific to an insurer but is constant across all insurers due to state law. Equilibrium p^* will fall in between the two outside options when $U_{p,OUT}$ is low enough. In the case when there is possibility of an agreement, if the law or other forces raise the insurer's out-of-network payment, the equilibrium negotiated price will increase. We can check if an increase in p^L will raise the equilibrium negotiated rate by taking the derivative of the expression for p^* with respect to p^L and asking if it is positive.

$$1 - \gamma + (1 - \gamma)\alpha_p W' > 0 \quad (14)$$

We know W' is negative (a higher payment paid by consumers makes their utility more negative) and we also know $|\alpha_p W'| < 1$ by our assumption above. Since $(1 - \gamma)$ is positive, the derivative is therefore positive.

Take the case where physicians put no weight on legal risk or patient disutility. In that case the physician payoff is p^L (they choose activity A and do not pay c) and there is nothing the insurer can offer as an in-network price that will be attractive. The physicians will stay out of the network, insurers will pay γp^L and patients will pay the balance. As physicians' disutility for risk, c , and weight on patients all rise, the outside option for the physician group becomes worse and eventually will fall below γp^L whereupon there is scope for an in-network rate that benefits both sides.

Out-of-network physician groups will choose between paying c or engaging in activity A according to whichever is cheaper, which will depend on their risk tolerance β_p . Physician groups with low α_p and high β_p want to choose the out-of-network strategy but do not want the risk of activity A and therefore must pay the hospital directly. Physician groups with low α_p and low will β_p choose the out-of-network billing strategy for the additional profit, and pay the hospital through activity A which they find relatively cheap compared to giving up profit.

Appendix B Variables Used in Lasso

	Description	Source
aha_mapp2	Cancer program approved by ACS	AHA
aha_mapp20	Sole Community Provider	AHA
aha_mapp21	DNV	AHA
aha_mapp3	Residency training approval	AHA
aha_mapp5	Medical school affiliation	AHA
aha_mapp6	Hospital-controlled professional nursing school	AHA
aha_mapp7	Accreditation by CARF	AHA
aha_mapp8	Teaching hospital	AHA
aha_mapp9	Blue Cross contracting or participating	AHA
aha_mcdc	Total facility Medicaid discharges	AHA
aha_mcdipd	Total facility Medicaid days	AHA
aha_mcrdc	Total facility Medicare discharges	AHA
aha_npayben	Total facility employee benefits	AHA
aha_paytot	Facility payroll expenses	AHA
aha_prop_caid	Proportion medicaid	AHA
aha_prop_care	Proportion medicare	AHA
aha_ptlab	Part-time laboratory technicians	AHA
aha_ptlpntf	Part-time licensed practical or vocational nurses	AHA

Continued on next page

Description		Source
aha_ptndtf	Part-time physicians and dentists	AHA
aha_ptplr	Part-time pharmacists, licensed	AHA
aha_ptplt	Part-time pharmacy technicians	AHA
aha_ptrad	Part-time radiology technicians	AHA
aha_ptres	Part-time medical and dental residents and interns	AHA
aha_ptresp	Part-time respiratory therapists	AHA
aha_pttoth	Total part-time hospital unit personnel	AHA
aha_pttotlt	Total part-time nursing home personnel	AHA
aha_pttran84	Part-time other trainees	AHA
aha_sunits	Separate nursing home	AHA
aha_suropip	Inpatient surgical operations	AHA
aha_suroptot	Total surgical operations	AHA
aha_syshhi_15m	Hospital 15m HHI	AHA
aha_techtotal	Technology (put into quintiles)	AHA
aha_vem	Emergency room visits	AHA
aha_vtot	Total outpatient visits	AHA
eop_cs00_seg_inc	Income segregation	Equality of Opportunity Project
eop_cs_divorced	fraction of divorced adults	Equality of Opportunity Project
eop_cs_elf_ind_man	manufacturing employment share	Equality of Opportunity Project
eop_cs_fam_wkdsinglemom	Fraction of children with single mothers	Equality of Opportunity Project

Continued on next page

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	Description	Source
eop_cs_labforce	Labor participation rate	Equality of Opportunity Project
eop_cs_married	Fraction of adults married	Equality of Opportunity Project
eop_cs_race_bla	Fraction black	Equality of Opportunity Project
eop_cs_race_theil_2000	Theil Index of racial segregation	Equality of Opportunity Project
eop_frac_traveltime_lt15	Fraction with commute less than 15 minutes	Equality of Opportunity Project
eop_gini	Gini (includes top 1%)	Equality of Opportunity Project
eop_hhinc00	Household Income (put into quintiles)	Equality of Opportunity Project
eop_inc_share_1perc	Top 1% income share	Equality of Opportunity Project
eop_incgrowth0010	income growth, 2000-2006/10	Equality of Opportunity Project
eop_intersects_msa	Urban indicator	Equality of Opportunity Project
eop_mig_inflow	Migration inflow rate	Equality of Opportunity Project
eop_mig_outflow	migration outflow rate	Equality of Opportunity Project
eop_rel_tot	Fraction religious	Equality of Opportunity Project
eop_subcty_expend	Local government expenditures/capita	Equality of Opportunity Project
eop_taxrate	local tax rate	Equality of Opportunity Project
baker_hhi	Physician HHI	Baker et. al
hli_hhi_all	Insurer HHI	Health Leader Interstudy
hli_share	Insurer share of market	Health Leader Interstudy
cen_countypop	County population	US Census Bureau
ska_ed_phys_per_capita	ED Physicians/capita	SKA

Continued on next page

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	Description	Source
ska_phys_per_capita	Physicians/capita	SKA
EmCare	Indicator for EmCare hospitals	Internal
TeamHealth	Indicator for TeamHealth hospitals	Internal

Notes: AHA: American Hospital Association Annual Survey. Equality of Opportunity Project: Selected variables from (<http://www.equality-of-opportunity.org/data/>). Baker et. al: Physician HHI constructed by Laurence Baker, Kate Bundorf, and Anne Royalty. Health Leader Interstudy: Data from US Managed Market Solutions, formerly Health Leader Interstudy. SK&A: Healthcare database with list of physicians for marketing purposes. Internal: See Appendix Figure A.1a and A.1b. These are all variables that may be selected from the Lasso. Hospitals missing any of these variables or not appearing in all 5 years of the data are not included. A total of 1,602 unique hospitals are included.

Appendix C Surprise Billing Forms from New York State

New York State Out-of-Network Surprise Medical Bill

You may not be responsible for a surprise bill for out-of-network services

A "Surprise Bill" is when you have insurance coverage issued in the State of NY:

Hospital or surgical centers: You are a patient at a participating hospital or ambulatory surgical center and you receive services for which:

- A network doctor was not available
- An out-of-network doctor provided without your knowledge
- Unforeseen medical circumstances arose at the time the health care services were provided.

It will not be a surprise bill if you chose to receive services from an out-of-network doctor instead of from an available network doctor.

Referrals: Your network doctor did not ask your consent to refer you to an out-of-network doctor, lab or other health care provider, and did not tell you it would result in costs not covered by your health plan.

An independent dispute resolution entity (IDRE) can determine if you need to pay the bill. You, the plan or your doctor may request an independent dispute resolution (IDR) for surprise bills and referrals. Use the form on the next page to submit your request. You do not have to pay the bill in order to be eligible to submit the dispute for review to an IDRE.

Dispute resolution prices

1. **Submit your request for independent review:** Complete the form on the next page. You can call Customer Service if you need help completing the form. The phone number is on your ID card. You may mail the form to us at:

Consolidated Health Plans
2077 Roosevelt Ave.
Springfield, MA 01104

Or send the form electronically to:
customerservice@consolidatedhealthplan.com

2. **An independent dispute resolution entity (IDRE) approved by the State of New York will screen your request for eligibility.**

If the IDRE needs more information, it will contact the health plan or health care provider. If the requested information is not submitted with three business days, or if the application is not eligible, the IDRE will reject the application.

3. **The IDRE will send a letter to the person who initiated the request (you, the doctor, CHP)**

The letter will include

- A request for the information needed to complete the review
- A request for any additional information that may be available to support the request
- Where to send the information

4. **You must submit any requested information within five business days of receiving the letter**

If IDRE receives a partial response or no response, the dispute will be decided based on the available information. You cannot ask for reconsideration by submitting additional information after the decision is made.

5. **The IDRE will make a determination within 30 days of receiving the request**

If IDRE feels either the provider's bill or the health plan's coverage policy is extreme, it may direct them to attempt a good faith negotiation for settlement. They will have up to ten business days for this negotiation.

A neutral and impartial reviewer with training and experience in health care billing, reimbursement, and usual and customary charges will review the dispute. The IDRE will forward copies of its decision to the health plan, the physician, superintendent, and as applicable, the nonparticipating referred health care provider and the patient, within two business days of making the decision.

**New York State Out-of-Network Surprise Medical Bill Assignment of Benefits
Form**

Use this form if you receive a surprise bill for health care services and want the services to be treated as in network. To use this form, you must: (1) fill it out and sign it; (2) send a copy to your health care provider (include a copy of the bill or bills); and (3) send a copy to your insurer (include a copy of the bill or bills). If you don't know if it is a surprise bill, contact the Department of Financial Services at 1-800-342-3736.

A surprise bill is when:

1. You received services from a nonparticipating physician at a participating hospital or ambulatory surgical center, where a participating physician was not available; or a nonparticipating physician provided services without your knowledge; or unforeseen medical circumstances arose at the time the services were provided. You did not choose to receive services from a nonparticipating physician instead of from an available participating physician; OR
2. You were referred by a participating physician to a nonparticipating provider, but you did not sign a written consent that you knew the services would be out-of-network and would result in costs not covered by your insurer. A referral occurs: (1) during a visit with your participating physician, a nonparticipating provider treats you; or (2) your participating physician takes a specimen from you in the office and sends it to a nonparticipating laboratory pathologist; or (3) for any other health care services when referrals are required under your plan.

I assign my rights to payment to my provider and I certify to the best of my knowledge that:

I (or my dependent/s) received a surprise bill from a health care provider. I want the provider to seek payment for this bill from my insurance company (this is an "assignment"). I want my health insurer to pay the provider for any health care services I or my dependent/s received that are covered under my health insurance. With my assignment, the provider cannot seek payment from me, except for any copayment, coinsurance or deductible that would be owed if I or my dependent/s used a participating provider. If my insurer paid me for the services, I agree to send the payment to the provider.

Your name: _____

Your Address: _____

Insurer Name: _____

Your Insurance ID No: _____

Provider Name: _____ Provider Phone Number: _____

Provider Address: _____

Date of Service: _____

Any person who knowingly and with intent to defraud any insurance company or other person files and application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

(Signature of patient)

(Date of signature)

Table A.1: Hospital Entry from EmCare and TeamHealth

	EmCare	TeamHealth
2012	3 Hospitals	1 Hospital
2013	1 System (8 hospitals); 1 Hospital	2 Hospitals
2014	4 Hospitals	1 Hospital
2015	0	1 System (5 hospitals); 1 Hospital
<i>Total</i>	<i>9 Entries (16 hospitals)</i>	<i>5 Entries (10 hospitals)</i>

Notes: We identified hospitals that entered into an outsourcing contract with EmCare and TeamHealth between 2011 and 2015 based on press releases and news stories.

Table A.2: ED Episode Descriptives

	Mean	SD	Min	P10	P25	P50	P75	P90	Max
Physician Payment	412.09	320.02	49.15	106.43	182.40	314.33	543.82	872.11	1,642.45
Physician Charge	614.92	385.70	107.10	224.64	332.80	519.18	787.52	1,136.10	2,146.42
Physician Insurer Payment	354.02	310.78	0.00	45.01	135.23	271.20	483.00	789.36	1,642.45
Physician Patient Payment	58.07	114.61	0.00	0.00	0.00	0.00	65.31	185.17	679.45
Potential Balance Bill	202.90	237.04	0.00	0.00	41.68	135.66	274.96	484.55	2,067.52
Patient Cost Exposure	260.94	256.20	0.00	0.00	87.40	190.90	352.26	592.98	2,146.42
Facility Payment	2,850.62	5,218.31	119.22	400.40	689.52	1,139.04	2,418.20	6,379.46	36,286.11
Facility Charge	6,642.39	13,011.33	172.38	552.70	1,065.90	2,325.69	5,802.44	15,300.48	90,184.31
Facility Insurer Payment	2,441.31	5,063.87	0.00	0.00	367.69	862.51	2,001.42	5,629.37	36,286.11
Facility Patient Payment	409.31	581.84	0.00	0.00	104.00	200.96	444.60	1,081.61	3,352.42
Admissions	0.09	0.29	0	0	0	0	0	0	1
Imaging	0.28	0.45	0	0	0	0	1	1	1
Length of Stay	0.58	1.97	0	0	0	0	0	1	30
CPT 99281	0.05	0.21	0	0	0	0	0	0	1
CPT 99282	0.13	0.34	0	0	0	0	0	1	1
CPT 99283	0.48	0.50	0	0	0	0	1	1	1
CPT 99284	0.50	0.50	0	0	0	0	1	1	1
CPT 99285	0.35	0.48	0	0	0	0	1	1	1

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Table A.2. ED Episode Descriptives (continued)

	Mean	SD	Min	P10	P25	P50	P75	P90	Max
Hispanic	0.08	0.28	0	0	0	0	0	0	1
Black	0.10	0.30	0	0	0	0	0	1	1
White	0.48	0.50	0	0	0	0	1	1	1
Ages 57-65	0.17	0.38	0	0	0	0	0	1	1
Ages 47-56	0.18	0.38	0	0	0	0	0	1	1
Ages 37-46	0.17	0.37	0	0	0	0	0	1	1
Ages 27-36	0.16	0.36	0	0	0	0	0	1	1
Ages 20-26	0.13	0.33	0	0	0	0	0	1	1
Ages 0-19	0.20	0.40	0	0	0	0	0	1	1
Charlson Scores	0.34	0.99	0	0	0	0	0	1	17
6-month Spending	6,248	17,195	0	0	149	757	3,548	14,254	115,499
Episodes per hospital	2,665	3,821	60	190	442	1,177	3,279	6,964	47,599

Notes: These are the descriptive statistics for all ED episodes in our data. These are limited to episodes that occurred at in-network hospitals. Payment and charges are winsorized at the top and bottom one percentiles. Payments and charges are also inflation adjusted into 2015 dollars using the BLS All Consumer Price Index.

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Table A.3: The Impact of the Entry of EmCare and TeamHealth on Hospital Out-of-Network Rates

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	Hospitals with Out-of-Network Rates Above 97% Prior to Entry		Hospitals with Out-of-Network Rates Below 97% Prior to Entry		Hospitals with Out-of-Network Rates Below 97% Prior to Entry		All Hospitals Where TeamHealth Entered		
	OON Indicator		OON Indicator		OON Indicator		OON Indicator		
Management Company Entry	-0.030 (0.044)	0.035 (0.048)	-0.032 (0.060)	0.815*** (0.061)	0.846*** 0.073	0.896*** (0.156)	0.326*** (0.03)	0.376*** (0.034)	0.261*** 0.082
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	0.209	0.392	0.896	0.204	0.372	0.549	0.226	0.305	0.232
SD	0.407	0.488	0.306	0.403	0.483	0.498	0.419	0.460	0.422
Observations	8,401,884	1,704,541	85,741	8,351,799	1,654,456	34,876	8,661,796	2,118,144	132,549
Control	All Non-Entry Hospitals	Hospitals in Same State	Propensity Score Match	All Non-Entry Hospitals	Hospitals in Same State	Propensity Score Match	All Non-Entry Hospitals	Hospitals in Same State	Propensity Score Match

Notes: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. This table presents least-squares estimates of Equation (1a) separately on hospitals with out-of-network (OON) rates below 11% (Columns 1-3) and above 97% (Columns 4-6). We also estimate Equation (1b) for hospitals with TeamHealth entry in Columns (7-9). The dependent variable in all regressions is a binary indicator for whether a patient at an in-network hospital was treated by an out-of-network physician. Our analysis is run at the patient-level. The control groups for Columns (1,4,7) are all hospitals in the US that did not outsource their ED management to EmCare or TeamHealth. The control groups for Columns (2,5,8) are all hospitals in same states as the treated hospitals, excluding hospitals that outsourced their ED services to EmCare or TeamHealth. The control groups in Columns (3,6,9) are hospitals matched to treated hospitals using propensity scores calculated using entry as predicted by a treated hospital's beds, technology, and non-profit/for-profit status. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Mean and standard deviation are drawn from the analytic sample population underlying the regression.

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Table A.4: The Impact of the Entry of EmCare on Physician Charges, Payments, and Coding Same-State Hospitals Control Group

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Physician Charge	Insurer Payment	Patient Cost Sharing	Total Payment	Potential Balanced Bill	Total Patient Cost Exposure	CPT Severity
EmCare Entry	548.40*** (62.97)	396.98*** (55.28)	46.23*** (4.53)	443.22*** (56.13)	105.18*** (38.86)	151.42*** (35.28)	0.148*** (0.030)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	615.73	409.62	61.68	471.30	144.42	206.11	0.357
SD	386.33	327.27	111.05	340.41	215.56	236.11	0.479
Observations	1,720,883	1,720,883	1,720,883	1,720,883	1,720,883	1,720,883	1,720,883
Control	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State

Notes: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. This table presents least-squares estimates of Equation (1a). Each observation is a patient episode. The control group includes hospitals in the same states as the treated hospitals. We winsorized the top and bottom percentile of hospital and physician payments. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollars amounts are adjusted into 2015 dollars.

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Table A.5: The Impact of the Entry of EmCare on Physician Charges, Payments, and Coding Propensity Score Control Group

(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Physician Charge	Insurer Payment	Patient Cost Sharing	Total Payment	Potential Balanced Bill	Total Patient Cost Exposure
EmCare Entry	478.19*** (77.87)	390.28*** (62.71)	42.21*** (5.51)	432.50*** (64.73)	45.69 (38.02)	87.90** (38.39)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes
Mean	817.20	578.37	83.43	661.80	155.40	238.83
SD	485.98	427.60	130.57	452.12	313.02	325.70
Observations	130,263	130,263	130,263	130,263	130,263	130,263
Control	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match

Notes: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. This table presents least-squares estimates of Equation (1a). Each observation is a patient episode. The control groups are composed of hospitals matched to treated hospitals using propensity scores calculated using entry as predicted by a treated hospital's beds, technology, and non-profit/for-profit status. We winsorized the top and bottom percentile of hospital and physician payments. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollars amounts are adjusted into 2015 dollars.

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Table A.6: The Impact of the Entry of TeamHealth on Physician Charges, Payments, and Coding Same-State Hospitals Control Group

	(1)	(2)	(3)	(4)	(5)	(6)
	Physician Charge	Insurer Payment (In-network)	Insurer Payment (Out-of-network)	Patient Cost Sharing	Total Payment	CPT Severity
TeamHealth Entry	13.63 (37.39)	220.79*** (14.84)	163.09** (73.60)	18.45*** (3.71)	249.08*** (20.91)	0.0225 (0.015)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes
Mean	635.76	279.73	639.79	62.21	451.66	0.362
SD	397.92	234.97	369.83	112.14	342.54	0.481
Observations	2,118,144	1,472,630	645,514	2,118,144	2,118,144	2,118,144
Control	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State

Notes: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. This table presents least-squares estimates of Equation (1b). Each observation is a patient episode. The control group includes hospitals in the same states as the treated hospitals. We winsorized the top and bottom percentile of hospital and physician payments. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars.

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Table A.7: The Impact of the Entry of TeamHealth on Physician Charges, Payments, and Coding Same-State Hospitals Control Group

	(1)	(2)	(3)	(4)	(5)	(6)
	Physician Charge	Insurer Payment (In-network)	Insurer Payment (Out-of-network)	Patient Cost Sharing	Total Payment	CPT Severity
TeamHealth Entry	-28.41 (44.01)	183.56*** (57.74)	174.12** (80.06)	18.82*** (6.53)	234.04*** (27.91)	0.0267 (0.024)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes
Mean	705.85	375.18	664.77	61.54	503.96	0.387
SD	372.52	240.15	351.89	108.89	304.59	0.487
Observations	132,549	101,776	30,773	132,549	132,549	132,549
Control	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match

Notes: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. This table presents least-squares estimates of Equation (1b). Each observation is a patient episode. The control groups are composed of hospitals matched to treated hospitals using propensity scores calculated using entry as predicted by a treated hospital's beds, technology, and non-profit/for-profit status. We winsorized the top and bottom percentile of hospital and physician payments. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars.

Table A.8: Physician Payment Rates for ED Visits

	Mean	S.D.	P25	P50	P75	Max
In-Network ED Physician Payment (Percent Medicare)	\$326.70 (266%)	\$238.99	\$156.55	\$267.14	\$422.12	\$1,642.45
Out-of-Network ED Physician Charge (Percent Medicare)	\$785.91 (637%)	\$443.86	\$440.64	\$680.34	\$1,013.29	\$2,146.42

Notes: We limit our data to hospitals with more than 10 episodes per year from 2011 to 2015. Physician charges and payments are winsorized at the top and bottom percentile. Prices are inflation adjusted using the BLS All Consumer Price Index.

Table A.9: The Impact of the Entry of EmCare on Hospital Charges, Payments, and Activity Same-State Control Group

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Facility Charge	Insurer Payment	Patient Cost Sharing	Total Payment	Imaging	Admission to Hospital	Episode Count
EmCare Entry	1522.14*** (395.07)	191.94* (98.48)	45.47** (17.79)	237.41** (112.91)	0.012*** (0.005)	0.0176*** 0.0062	-188.98 (219.4)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	6,304.63	2,350.46	393.81	2,744.271	0.278	0.090	1,695.5
SD	12,415.53	4,885.15	561.89	5,034.470	0.448	0.286	1,566.5
Observations	8,418,226	8,418,226	8,418,226	8,418,226	8,418,226	8,418,226	8,418,226
Control	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State

Notes: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. This table presents least-squares estimates of Equation (1a). Each observation is a patient episode. The control group includes hospitals in the same states as the treated hospitals. We winsorized the top and bottom percentile of hospital and physician payments. Imaging is an indicator variable capturing whether a patient had an imaging study performed during an ED visit. Admissions to hospital is an indicator variable that captures whether a patient was admitted to the hospital after an ED visit. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars.

Table A.10: The Impact of the Entry of EmCare on Hospital Charges, Payments, and Activity Propensity Score Match Control Group

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Facility Charge	Insurer Payment	Patient Cost Sharing	Total Payment	Imaging	Admission to Hospital	Episode Count
EmCare Entry	1238.37*** (412.95)	88.38 (114.20)	32.52 (19.32)	120.90 (129.20)	0.018 (0.010)	0.011 0.0103	-58.62 (211.7)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	8,396.29	2,614.88	483.73	3,098.618	0.304	0.095	1797.0
SD	14,579.69	4,781.73	609.50	4,938.139	0.460	0.294	1,021.8
Observations	130,263	130,263	130,263	130,263	130,263	130,263	130,263
Control	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match

Notes: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. This table presents least-squares estimates of Equation (1a). Each observation is a patient episode. The control groups are composed of hospitals matched to treated hospitals using propensity scores calculated using entry as predicted by a treated hospital's beds, technology, and non-profit/for-profit status. We winsorized the top and bottom percentile of hospital and physician payments. Imaging is an indicator variable capturing whether a patient had an imaging study performed during an ED visit. Admissions to hospital is an indicator variable that captures whether a patient was admitted to the hospital after an ED visit. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars.

Table A.11: The Impact of the Entry of TeamHealth on Hospital Charges, Payments, and Activity

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Facility Charge	Insurer Payment	Patient Cost Sharing	Total Payment	Imaging	Admission to Hospital	Episode Count
TeamHealth Entry	112.10 (179.33)	-109.47 (78.38)	13.23 (12.81)	-96.24 (84.41)	-0.008** (0.004)	-0.008*** 0.0026	507.3*** (188.0)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	6248.05	2435.69	426.91	2862.60	0.280	0.082	1984.0
SD	12156.69	4832.48	573.76	4983.91	0.449	0.274	1563.2
Observations	2,118,144	2,118,144	2,118,144	2,118,144	2,118,144	2,118,144	2,118,144
Control	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State

Notes: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. This table presents least-squares estimates of Equation (1b). Each observation is a patient episode. The control group includes hospitals in the same states as the treated hospitals. We winsorized the top and bottom percentile of hospital and physician payments. Imaging is an indicator variable capturing whether a patient had an imaging study performed during an ED visit. Admissions to hospital is an indicator variable that captures whether a patient was admitted to the hospital after an ED visit. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars.

Table A.12: The Impact of the Entry of TeamHealth on Hospital Charges, Payments, and Activity Propensity Score Match Control Group

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Facility Charge	Insurer Payment	Patient Cost Sharing	Total Payment	Imaging	Admission to Hospital	Episode Count
TeamHealth Entry	-153.30 (270.94)	-276.64** (109.79)	-8.50 (32.65)	-285.14** (132.72)	-0.008 (0.010)	-0.010 0.0068	340.8* (181.8)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	7,396.29	2,546.26	425.88	2,972.141	0.304	0.083	2,587.3
SD	12,920.69	4,871.93	558.87	5,045.284	0.460	0.275	1458.9
Observations	132,549	132,549	132,549	132,549	132,549	132,549	132,549
Control	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match

Notes: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. This table presents least-squares estimates of Equation (1b). Each observation is a patient episode. The control groups are composed of hospitals matched to treated hospitals using propensity scores calculated using entry as predicted by a treated hospital's beds, technology, and non-profit/for-profit status. We winsorized the top and bottom percentile of hospital and physician payments. Imaging is an indicator variable capturing whether a patient had an imaging study performed during an ED visit. Admissions to hospital is an indicator variable that captures whether a patient was admitted to the hospital after an ED visit. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars.

Table A.13: Hospital Characteristics Associated with EmCare and TeamHealth

	(1)	(2)	(3)	(4)
	EmCare	EmCare	TeamHealth	TeamHealth
For-profit	0.1063*** (0.013)	0.1206*** (0.012)	0.011 (0.010)	0.011 (0.009)
Government	0.0464*** (0.015)	0.0440*** (0.014)	0.005 (0.011)	0.002 (0.010)
Teaching Hospital	-0.007 (0.019)	-0.008 (0.019)	-0.017 (0.014)	-0.016 (0.014)
Hospital Beds	0.003 (0.009)	0.000 (0.008)	0.004 (0.007)	0.0108* (0.006)
Technologies	0.006 (0.019)	-0.001 (0.018)	-0.008 (0.013)	-0.011 (0.013)
Hospital HHI	0.0187* (0.011)	0.0184** (0.008)	0.001 (0.008)	0.0138** (0.006)
Proportion Medicare	0.014 (0.017)	0.001 (0.016)	0.014 (0.012)	0.0245** (0.012)
Proportion Medicaid	0.004 (0.008)	-0.003 (0.008)	0.005 (0.006)	0.007 (0.006)
ED Physicians per Capita	11.510 (9.167)	-0.0433*** (0.011)	-22.9726*** (6.637)	-0.0197** (0.008)
Physicians per Capita	-14.979 (13.582)	-0.004 (0.023)	29.3776*** (9.833)	0.0506*** (0.017)
Physician HHI	0.016 (0.020)	0.011 (0.016)	-0.008 (0.014)	-0.003 (0.012)
Insurer HHI	0.021 (0.019)	-0.008 (0.011)	0.002 (0.014)	-0.0148* (0.008)
Household Income	0.0893** (0.042)	0.0951*** (0.030)	0.0517* (0.030)	-0.025 (0.021)
Gini Coefficient	-0.1182** (0.052)	0.0697*** (0.026)	0.026 (0.038)	0.028 (0.019)
HRR FE	Yes	No	Yes	No
Mean	0.0581	0.0581	0.0285	0.0285
SD	0.2340	0.2340	0.1663	0.1663
Observations	3,345	3,345	3,345	3,345

Notes: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. Each observation is a hospital. The table presents a logit regression of an indicator for EmCare or TeamHealth hospitals on the hospital characteristics in the table. Means and standard deviation are drawn from the analytic sample population underlying the regression.

Table A.14: Comparison of Entry Hospital Characteristics

Hospital Characteristics	EmCare Hospitals	EmCare Entry Hospitals	P-value from two-sided t-test	TeamHealth Hospitals	TeamHealth Entry Hospitals	P-value from two-sided t-test
For-profit	0.55	0.57	0.87	0.29	0.30	0.96
Non-profit	0.27	0.21	0.65	0.57	0.70	0.45
Government	0.18	0.21	0.76	0.13	0.00	0.22
Teaching	0.04	0.00	0.44	0.04	0.00	0.54
Hospital Beds	173.97	266.50	0.03	197.63	227.40	0.50
Technologies	43.10	57.79	0.06	47.79	54.80	0.45
Hospital HHI	0.57	0.58	0.98	0.59	0.66	0.48
Proportion Medicare	48.31	43.58	0.12	51.42	44.43	0.03
Proportion Medicaid	18.97	24.18	0.15	20.15	18.14	0.48
ED Physicians per Capita (per 10,000)	0.65	0.61	0.58	0.70	1.06	0.00
Physicians per Capita (per 10,000)	21.64	19.01	0.06	22.82	25.52	0.09
Physician HHI	0.41	0.59	0.02	0.41	0.65	0.13
Insurer HHI	0.36	0.35	0.75	0.35	0.40	0.31
Household Income	38,146.20	35,404.44	0.22	36,849.58	38,080.67	0.59
Gini Coefficient	0.34	0.34	0.61	0.33	0.31	0.19

Notes: The table compares characteristics of identified EmCare and TeamHealth hospitals to characteristics of hospitals where we have entry. Hospitals with entry are excluded from identified TeamHealth and EmCare hospitals. The *p*-value is reported from a two-sided t-test comparing the difference in means between hospitals and hospitals with entry.

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Table A.15: The Impact of Entry on Historical Patient Spending and Charlson Scores

	EmCare			TeamHealth				
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
6 month historical spending	12 month historical spending	6 month Charlson	12 month Charlson		6 month historical spending	12 month historical spending	6 month Charlson	12 month Charlson
Firm Entry	916.02*** (253.83)	1306.16*** (425.64)	0.033*** (0.010)	0.036*** (0.012)	-336.35** (166.74)	-783.08** (305.09)	0.004 (0.005)	0.006 (0.005)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	6,247.15	11,476.89	0.326	0.449	6,266.03	11,512.46	0.326	0.450
SD	1,7201.02	27,910.51	0.919	1.056	17,236.61	27,971.30	0.919	1.056
Observations	8,418,226	7,056,427	8,418,226	7,056,427	8,661,796	7,256,251	8,661,796	7,256,251
Control	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals

Notes: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. This table presents least-squares estimates of Equations (1a) and (1b). Each observation is a patient episode. The control group in all regressions is all hospitals in the US exclusive of those that outsourced their ED services to EmCare or TeamHealth. We winsorized the top percentile of 6 and 12 month historical spending. Standard errors are clustered around hospitals.

003143

Table A.16: The Impact of the Entry of EmCare on Coding Severity from Physician Visits, Robustness Checks

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	CPT Severity	CPT Severity	CPT Severity	CPT Severity	CPT Severity	CPT Severity	CPT Severity	CPT Severity
EmCare Entry	0.151*** (0.031)	0.149*** (0.030)	0.148*** (0.030)	0.148*** (0.030)	0.156*** (0.033)	0.142*** (0.030)	0.152*** (0.030)	0.153*** (0.031)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	0.347	0.347	0.347	0.326	0.445	0.297	0.319	0.424
SD	0.476	0.476	0.476	0.469	0.497	0.457	0.466	0.494
Observations	8,418,226	8,418,226	8,418,226	6,960,514	1,457,712	2,806,097	2,806,055	2,806,074
Controls	No	Patient Character- istics	Patient and Charlson	Charlson Score of 0	Non-zero Charlson Score	Lowest third of the historical spending distribution	Middle third of the historical spending distribution	Upper third of the historical spending distribution

Notes: $*p < 0.10$, $**p < 0.05$, $***p < 0.01$. This table presents least-squares estimates of Equation (1a). Each observation is a patient episode. The control group in all regressions is all hospitals in the US exclusive of those that outsourced their ED services to EmCare. We winsorized the top and bottom percentile of facility payments. Standard errors are clustered around hospitals. In columns 6, 7, and 8 historical spending is split into thirds where each column contains the sample of patients from the bottom, middle, and upper third of spending.

003144

Table A.17: The Impact of the Entry of EmCare on Facility Payments, Robustness Checks

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	Facility Payment	Facility Payment	Facility Payment	Facility Payment	Facility Payment	Facility Payment	Facility Payment	Facility Payment
EmCare Entry	316.63** (124.89)	309.57*** (115.77)	294.58*** (113.64)	204.95** (82.50)	742.32** (356.38)	215.426** (106.80)	228.37** (109.11)	428.78*** (160.14)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	2,744.27	2,744.27	2,744.27	2,417.80	4,303.16	2,353.30	2,355.26	3,524.26
SD	5,034.47	5,034.47	5,034.47	4,418.88	7,084.79	4,492.45	4,350.98	6,001.00
Observations	8,418,226	8,418,226	8,418,226	6,960,514	1,457,712	2,806,097	2,806,055	2,806,074
Controls	No	Patient Character- istics	Patient and Charlson	Charlson Score of 0	Non-zero Charlson Score	Lowest third of the historical spending distribution	Middle third of the historical spending distribution	Upper third of the historical spending distribution

Notes: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. This table presents least-squares estimates of Equation (1a). Each observation is a patient episode. The control group in all regressions is all hospitals in the US exclusive of those that outsourced their ED services to EmCare. We winsorized the top and bottom percentile of facility payments. Standard errors are clustered around hospitals. In columns 6, 7, and 8 historical spending is split into thirds where each column contains the sample of patients from the bottom, middle, and upper third of spending.

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Table A.18: The Impact of the Entry of EmCare on the Frequency of Imaging, Robustness Checks

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	Imaging	Imaging	Imaging	Imaging	Imaging	Imaging	Imaging	Imaging
EmCare Entry	0.016*** (0.005)	0.014*** (0.005)	0.014*** (0.005)	0.013** (0.006)	0.028*** (0.009)	0.014** (0.007)	0.017** (0.008)	0.012** (0.005)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	0.278	0.278	0.278	0.268	0.324	0.254	0.261	0.319
SD	0.448	0.448	0.448	0.443	0.468	0.435	0.439	0.466
Observations	8,418,226	8,418,226	8,418,226	6,960,514	1,457,712	2,806,097	2,806,055	2,806,074
Controls	No Controls	Patient Characteristics	Patient and Charlson	Charlson Score of 0	Non-zero Charlson Score	Lowest third of the historical spending distribution	Middle third of the historical spending distribution	Upper third of the historical spending distribution

Notes: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. This table presents least-squares estimates of Equation (1a). Each observation is a patient episode. The control group in all regressions is all hospitals in the US exclusive of those that outsourced their ED services to EmCare. We winsorized the top and bottom percentile of facility payments. Standard errors are clustered around hospitals. In columns 6, 7, and 8 historical spending is split into thirds where each column contains the sample of patients from the bottom, middle, and upper third of spending.

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Table A.19: The Impact of the Entry of EmCare on the Frequency of Admissions, Robustness Checks

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	Admissions	Admissions	Admissions	Admissions	Admissions	Admissions	Admissions	Admissions
EmCare Entry	0.022*** (0.007)	0.022*** (0.006)	0.021*** (0.006)	0.014*** (0.005)	0.053*** (0.019)	0.011* (0.006)	0.016*** (0.005)	0.035*** (0.010)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	0.090	0.090	0.090	0.071	0.181	0.066	0.070	0.134
SD	0.286	0.286	0.286	0.257	0.385	0.248	0.256	0.341
Observations	8,418,226	8,418,226	8,418,226	6,960,514	1,457,712	2,806,097	2,806,055	2,806,074
Controls	No	Patient Characteristics	Patient and Charlson	Charlson Score of 0	Non-zero Charlson Score	Lowest third of the historical spending distribution	Middle third of the historical spending distribution	Upper third of the historical spending distribution

Notes: * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. This table presents least-squares estimates of Equation (1a). Each observation is a patient episode. The control group in all regressions is all hospitals in the US exclusive of those that outsourced their ED services to EmCare. We winsorized the top and bottom percentile of facility payments. Standard errors are clustered around hospitals. In columns 6, 7, and 8 historical spending is split into thirds where each column contains the sample of patients from the bottom, middle, and upper third of spending.

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Table A.20: ED Episodes and Annual Spending

	Emergency Episodes	Total Facility Spending	Total Physician Spending	Percent ASO	Share of Episodes at in-network hospitals
2011	61,331	\$148,222,782	\$19,125,875	87.6%	97.9%
2012	69,404	\$170,582,628	\$22,812,526	89.2%	99.0%
2013	67,317	\$182,161,431	\$22,551,581	91.5%	99.6%
2014	65,388	\$187,074,086	\$21,531,723	92.1%	99.8%
2015	60,496	\$184,594,280	\$21,197,031	90.4%	99.8%
Total	323,936	\$872,635,207	\$107,218,736	90.2%	99.2%

Notes: The table shows summary statistics for our data in New York State. Only episodes that occur in an in-network hospital are included. There are a small percentage of episodes (> 0.5%) that are missing a label for ASO or fully-insured.

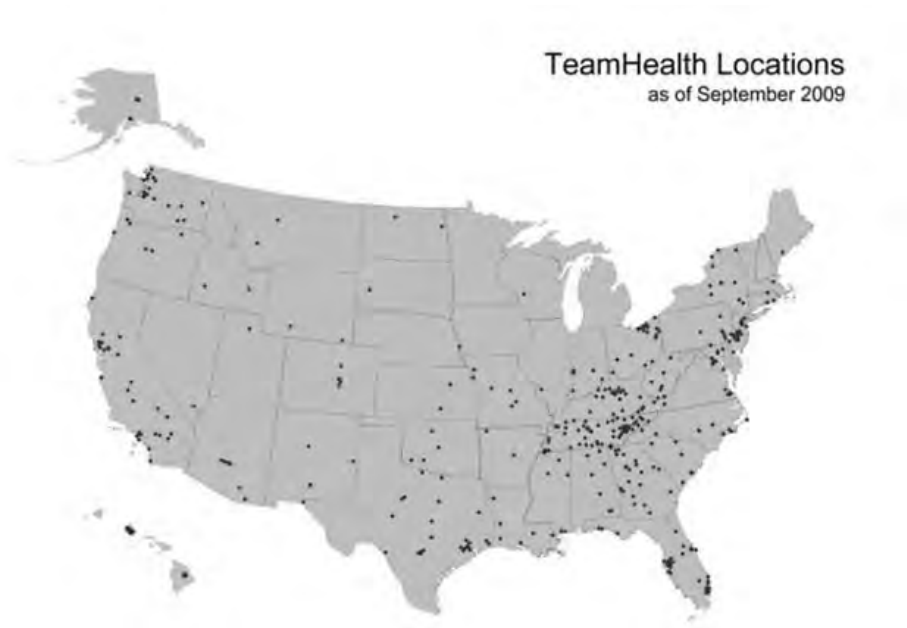
Figure A.1

(a) Map of EmCare Locations



Notes: This map was taken from the webpage of EmCare's parent company Envision Healthcare (<https://www.evhc.net/vision/emcare>). The underlying HTML source code from the web page contains the latitude and longitude coordinates of each white point displayed. We calculate each coordinate pair's distance to AHA-registered hospital coordinates, and keep hospitals that are within only a 30-mile radius from an AHA-registered hospital. If there are multiple hospitals within a 30-mile radius, we keep only the nearest facility and define it as the identified hospital. We further cross-validate our findings with hospitals from EmCare's job listings found on their website. Our final list includes hospitals that are identified using mapping locations that are cross-validated with job hiring posts.

(b) Map of TeamHealth Locations



Notes: This is a map from a 2009 Morgan Stanley report on TeamHealth. To determine the hospital locations shown on this map, we used georeferencing in ArcGIS. Georeferencing takes an image or scanned photo without spatial reference information and aligns it to a map with a known coordinate system. In our case, we used a map of the United States (obtained here: https://www.census.gov/geo/maps-data/data/cbf/cbf_state.html), and linked control points from the US map to the map of TeamHealth's locations. To link control points, the location of two identical points on each map are identified (for example, the southern tip of Florida). With several control points defined, the TeamHealth map is then warped and transformed to overlay directly onto the known US map. With the map in place, we mark the center of each blue dot as a hospital location. Because the map now has a defined coordinate system, we are able to obtain the latitude and longitude from these markers. We subsequently calculate each coordinate pair's distance to AHA-identified hospital coordinates, and keep hospitals that are within only a 30-mile radius from an AHA-identified hospital. If there are multiple hospitals within a 30-mile radius, we keep only the nearest facility and define it as the identified hospital. We cross-validate our mapping with hospitals from TeamHealth's job listings page on their website. Our final list of hospitals only includes hospitals that are both identified from the map and appear in job listings.

Figure A.2: Example of EmCare Job Listing

CAREERS >
Clinical Job Search

Share   

SEARCH CAREERS **SUBMIT CV** **CONTACT A RECRUITER**

Keyword or Job ID Search

Clinical Specialty
Emergency Medicine

Job Title
Any Job Title

State
Any State

Job Status
Any Job Status

SEARCH >

COST OF LIVING CALCULATOR >

Backlist Hospital Review
150 Great Places to Work
EmCare
Three Year Recognition 2014 - 2015 - 2016

RESULTS Page: 1 of 62

EM Physician (Full Time, PRN)
Emergency Medicine
Coliseum Medical Center - EM
Macon, GA
EmCare is searching for a Full-Time Emergency Medicine Physician to join our prestigious practice at Coliseum Medical Center located in Macon, GA...[read more](#)

EM Physician (Full Time)
Emergency Medicine
Fairview Park Hospital - EM
Dublin, GA
EmCare is searching for a Full-Time Emergency Medicine Physician to join our prestigious practice at Fairview Park Hospital located in Dublin, GA...[read more](#)

EM Physician (Full Time, Part Time)
Emergency Medicine
Muhlenberg Community Hospital - EM
Greenville, KY
EmCare is currently seeking an Emergency Medicine or Primary Care physician with Emergency Medicine experience for our site in Greenville, KY

EM Physician (Full Time, Part Time, PRN, Moonlighting)
Emergency Medicine
Owensboro Health Regional Hospital - EM
Owensboro, KY
EmCare is seeking Full-time Emergency Medicine, Residency trained Physicians to join our dynamic

FILTERS

Sort By:
Date

Descending

Clinical Specialty
☐ Any Clinical Specialty
☒ Emergency Medicine

Job Title
☐ Any Job Title

State
☐ Any State

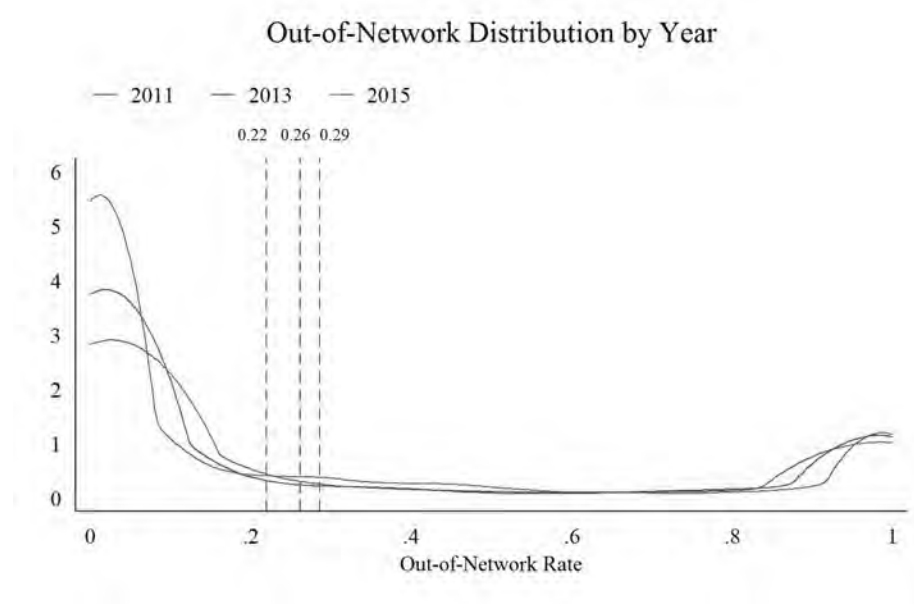
Job Status
☐ Any Job Status

Working at EmCare



Notes: This screen grab is taken from EmCare's job hiring page.
(<https://www.emcare.com/careers/clinical-job-search>)

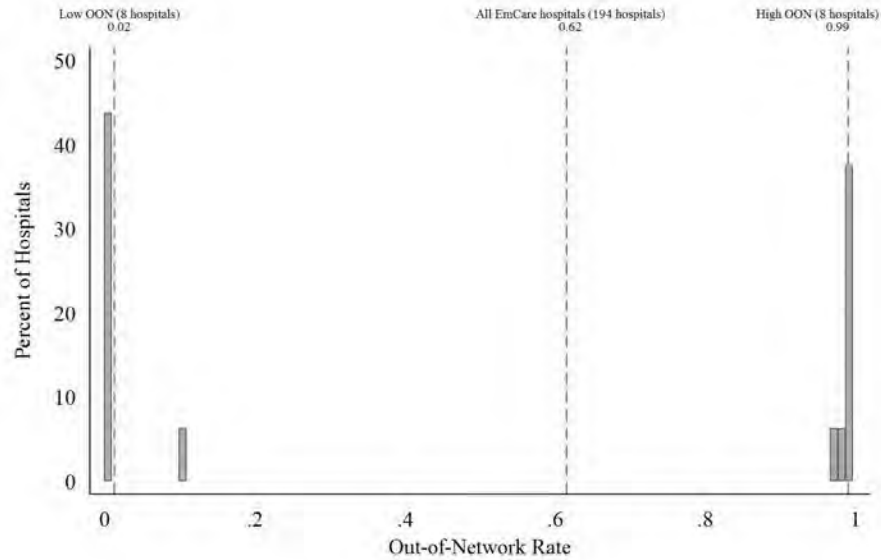
Figure A.3: The Distribution of Hospital Out-of-Network Rates, 2011, 2013, and 2015



Notes: The figure shows the distribution of hospital out-of-network rates in years 2011, 2013, and 2015. There are 3,345 hospitals that appear in each year of the data.

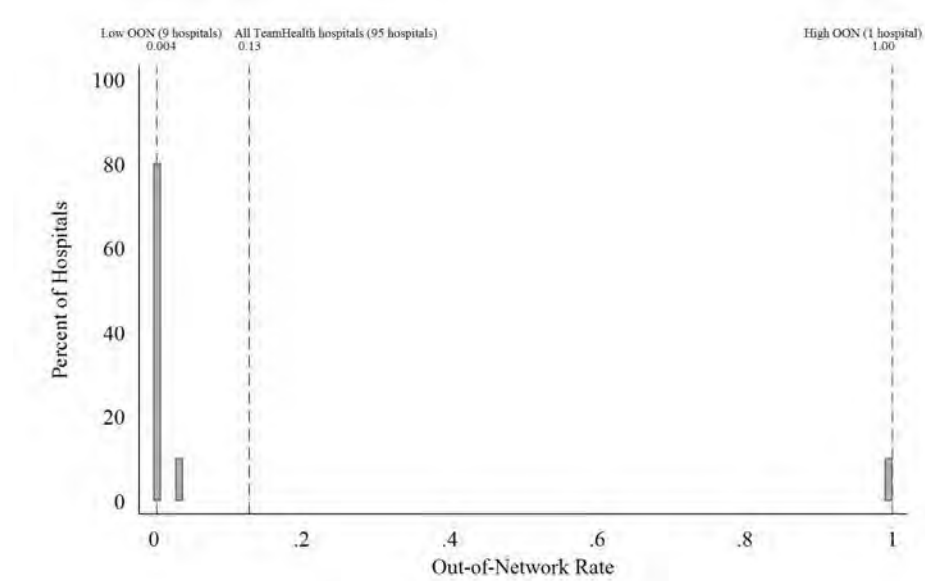
Figure A.4

(a) The Distribution of Out-of-Network Rates at Hospitals where EmCare Enters, 2011



Notes: The figure shows a histogram of out-of-network rates for hospitals prior to EmCare entry in 2011. There are a total of 16 EmCare entry hospitals. Each bar shows the percent of hospitals falling into a given out-of-network rate. The red vertical line is the average of all EmCare hospitals from 2011-2015.

(b) The Distribution of Out-of-Network Rates at Hospitals Where TeamHealth Enters, 2011



Notes: The figure shows a histogram of out-of-network rates for hospitals prior to TeamHealth entry in 2011. There are a total of 10 TeamHealth entry hospitals. Each bar shows the percent of hospitals falling into a given out-of-network rate. The red vertical line is the average of all TeamHealth hospitals from 2011-2015.

Figure A.5: Out-of-Network Rates at Hospitals Where EmCare Entered

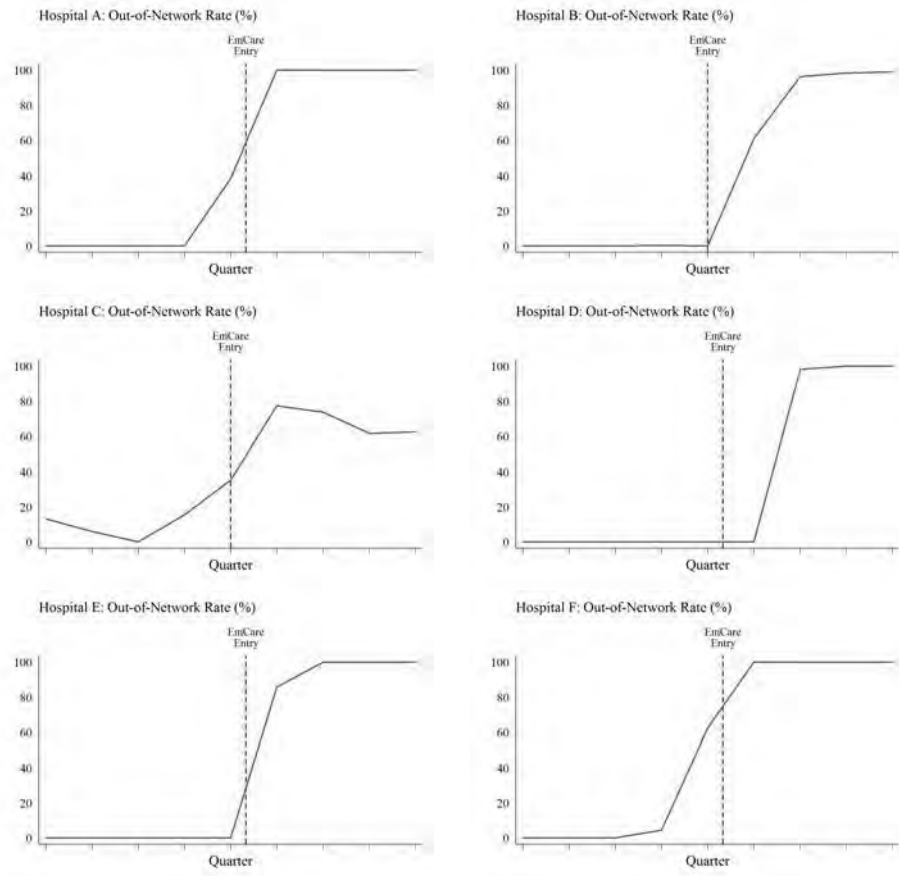


Figure A.5: Out-of-Network Rates at Hospitals Where EmCare Entered (continued)

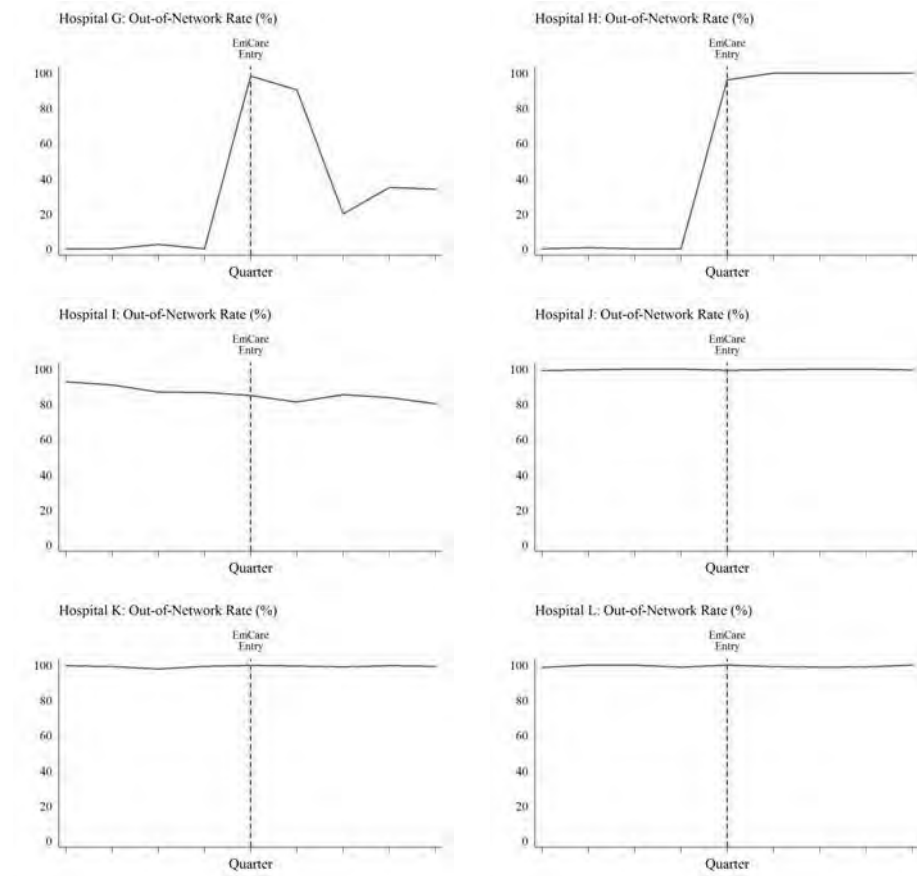
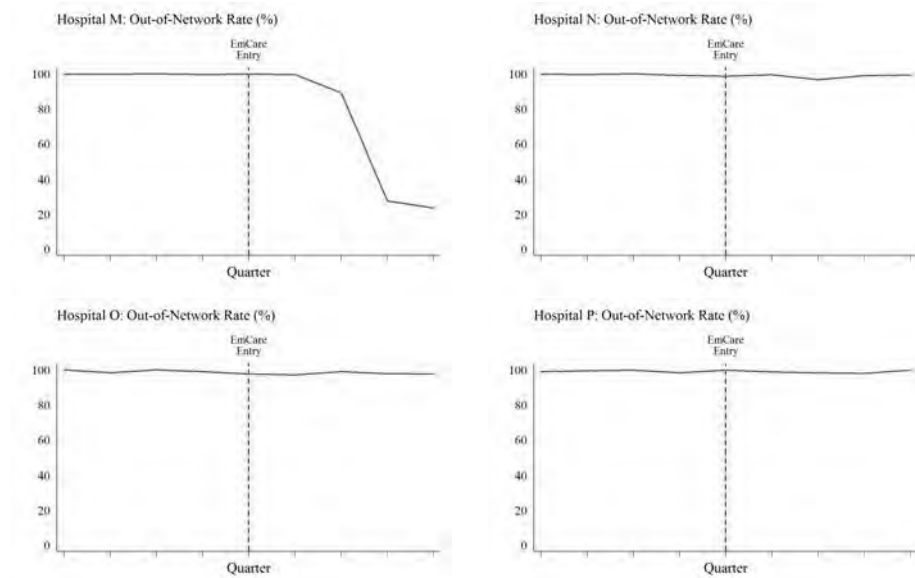


Figure A.5: Out-of-Network Rates at Hospitals Where EmCare Entered (continued)



Notes: This figure plots the average quarterly out-of-network rates at hospitals where EmCare entered. We present data from the four quarters before and the four quarters after EmCare took over the management of each hospital's ED.

Figure A.6: Out-of-Network Rates at Hospitals Where TeamHealth Entered

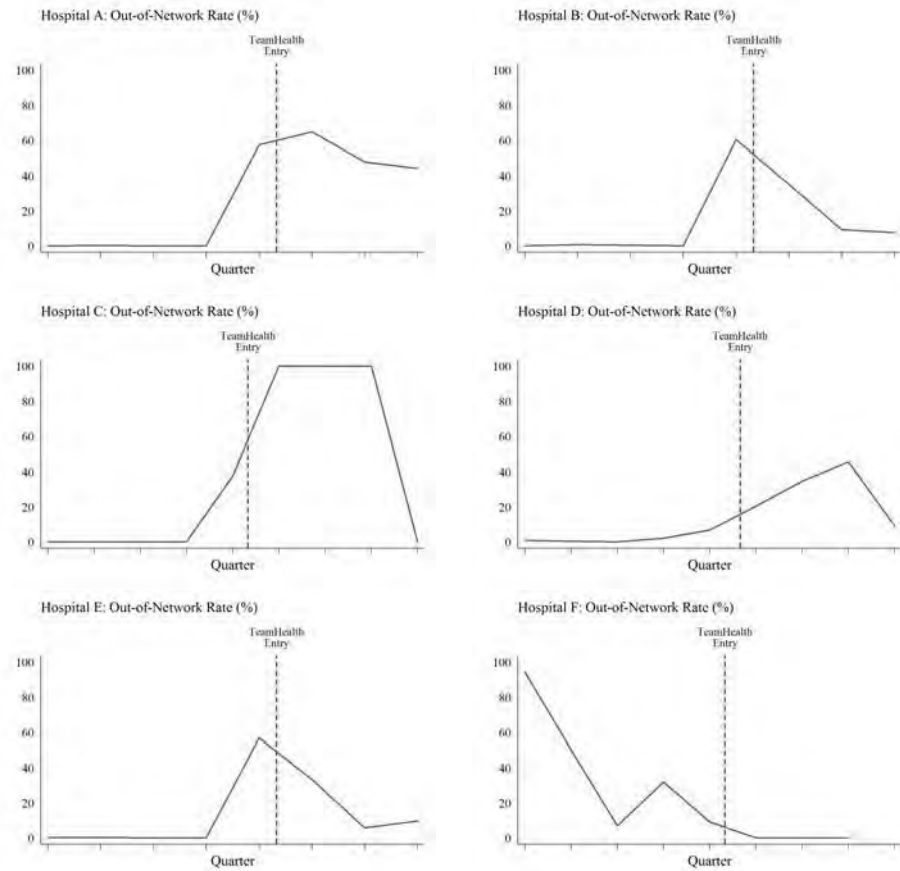
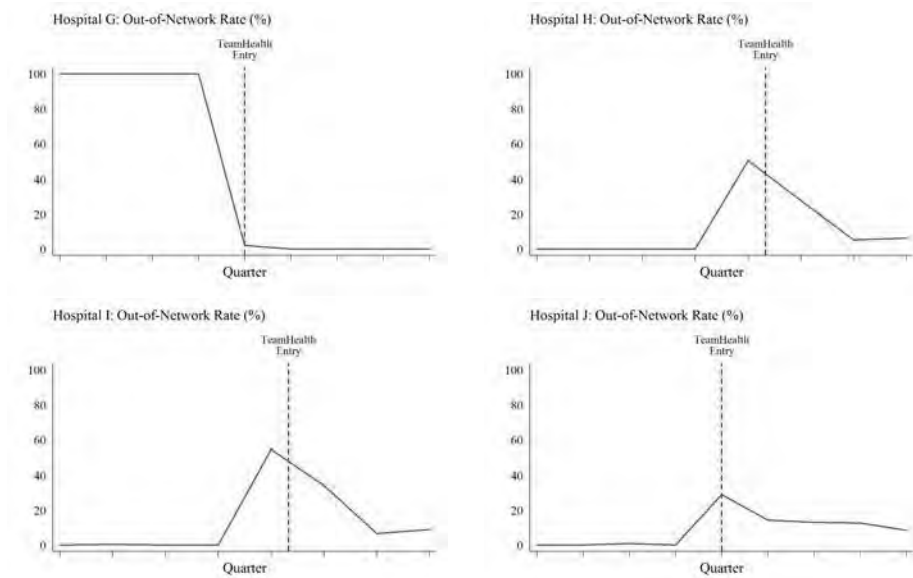


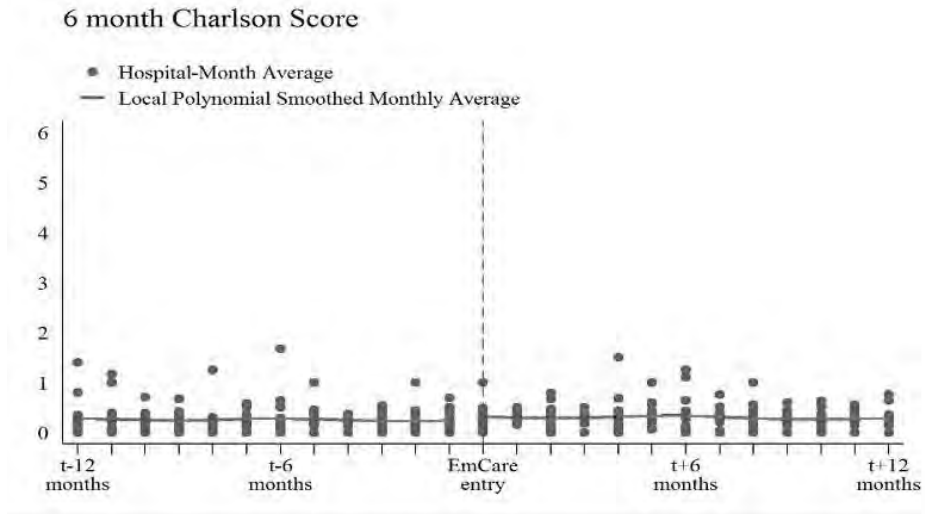
Figure A.6: Out-of-Network Rates at Hospitals Where TeamHealth Entered
(continued)



Notes: This figure plots the average quarterly out-of-network rates at hospitals where TeamHealth entered. We present data from the four quarters before and the four quarters after TeamHealth took over the management of each hospital's ED.

Figure A.7: EmCare and TeamHealth Entry on Patient Characteristics

Panel A: EmCare Entry on Hospitals' Average Charlson Score of Patients



Panel B: EmCare Entry on Hospitals' Average Patient 6-Month Spending History

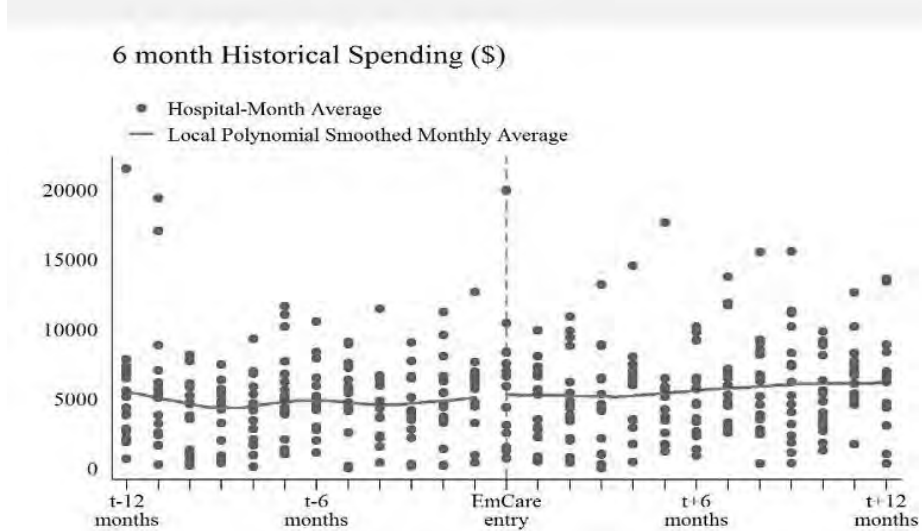
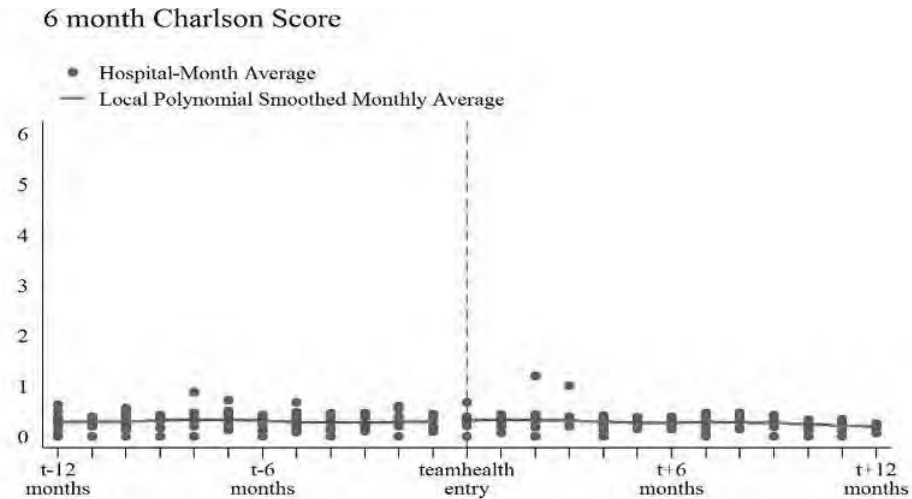
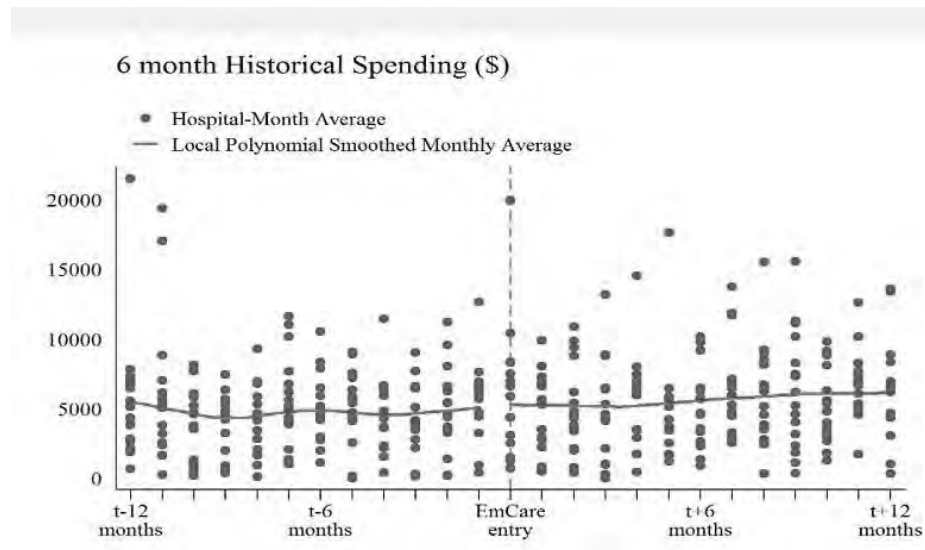


Figure A.7: EmCare and TeamHealth Entry on Patient Characteristics (continued)

Panel C: TeamHealth Entry on Hospitals' Average Charlson Score of Patients



Panel D: TeamHealth on Hospitals' Average Patient 6-Month Spending History



Notes: The panels plot the monthly average by hospital from 12 months before to 12 months after EmCare or TeamHealth entered the hospital.

VIEWPOINT

Surprise Medical Bills, the High Cost of Emergency Department Care, and the Effects on Patients

Sarah Kliff, BA
The New York Times,
Washington, DC.



Editorial page 1465



Related article
page 1543

In May, 2018, a reader of Vox, the news and opinion website where I worked as a health care reporter, sent me a remarkable medical bill for his young daughter's emergency department visit. He and his wife were trimming the 1-year-old's nails and accidentally cut her finger, causing it to bleed profusely. The nervous, first-time parents wanted a doctor to examine the wound. They went to the emergency department, the only place that would see a pediatric patient over the weekend.

The little girl turned out to be just fine. A doctor put a Band-Aid on her finger, and the family went home. But a few weeks later, the family got the bill: \$629 for the short encounter.¹

This reader sent me this bill with a question: why was this simple visit to an emergency department so expensive? Although I did not know the answer, I was determined to find out.

To better understand how the high costs of emergency care affect patients, my Vox colleagues and I collected patient bills from all 50 states and the District of Columbia. We wrote stories that helped explain why emergency department prices are high in the United States and are increasing quickly.

Collecting Hundreds of Emergency Department Medical Bills

Each year, there are an estimated 145 million emergency department visits in the United States.² It is typically difficult to impossible for patients to know what they will pay for that care until they receive a bill because the prices are not disclosed. Even patients with health insurance may in some instances face "surprise" emergency department medical bills of hundreds or thousands of dollars.

We felt it would be in the public interest to give patients greater access to those prices. But we realized the only way to get the data would be from patients themselves. So we built an online portal that would allow readers to submit their billing documents and a narrative description of what happened during their visit, and the financial consequence, if any, the visit had on their lives.

We launched the project in October 2017. We publicized the new portal widely on social media, the Vox website, and podcasts that I hosted. We received hundreds of submissions, and I got to work reading through them; sorting the bills by location, size, and type of insurance plan to look for trends; and writing articles. As we wrote more stories, our collection of bills grew. Before concluding the project in May 2019, we had collected more than 2000 bills.

What We Learned About Surprise Medical Bills

One of the most common problems we documented was surprise medical bills: instances where a patient went to an in-network hospital but received care from an out-of-network clinician. Between 2010 and 2016, the percentage of in-network emergency department visits with an out-of-network bill increased to about 43%, and the average potential financial responsibility increased to \$628, in 2018 US dollars, according to a study in this issue of *JAMA Internal Medicine*.³ In my reporting, I was able to see how these bills came about and what effects they had on patients' lives.

One story in particular jumped out at me, from a patient who went to an emergency department after being attacked and left unconscious in downtown Austin, Texas.⁴ A bystander called 911, and an ambulance transported him to a hospital.

When the patient woke up the next morning, he immediately took out his phone to check the hospital's network status. He was relieved to find out that the hospital was in-network with his health plan.

There was an important exception, however. This patient needed emergency jaw surgery. And the surgeon who performed the procedure was not in-network with any private insurance, which ended up leaving the patient with a \$7924 bill that he did not know how to pay. After I called to inquire, the doctor ultimately reversed the bill.

While the online portal was open for billing submissions, we also received multiple surprise bills from patients with private health insurance who received care at an out-of-network emergency department. This included a woman with \$20 243 in medical debt after a bike crash,⁵ and a college student with a \$27 660 bill after being hit by a public bus.⁶

Both those patients^{5,6} were seen at Zuckerberg San Francisco General, a public hospital with a Level 1 Trauma Center that had made the unusual decision to not be in-network with any private health insurance. Both of these patients had been brought to the hospital by ambulance and had little choice over where they received care.

After I reported on that billing practice, Zuckerberg San Francisco General in 2019 changed its policies and put new limits on what it would charge patients.⁷ The hospital will no longer engage in a practice called "balance billing," where the hospital sends the patient a bill for the balance that an insurer will not pay. The hospital has also limited how much it will charge patients for emergency care, with a maximum bill of \$4800.

Patients Forgoing Care

I was not surprised to learn that patients were struggling with expensive medical bills. The United States has

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the highest health care prices in the developed world. What surprised me, though, was the way that patient knowledge of those prices reshaped decision-making around when to seek care.

A mother from Texas told me about what happened when her 2-year-old daughter accidentally consumed an unknown number of antinausea dramamine pills.⁸ The mother called the poison control hotline, which recommended taking the young girl to the emergency department to be monitored for a possible overdose. The mother, however, knew how expensive emergency care could be. She and her daughter did not have health insurance, and the mom already had an outstanding debt of \$1200 for her own, recent emergency department visit for an ankle injury.

The mother decided to drive the toddler to the emergency department, but to not go inside. Instead, they sat in the car while the little girl watched a Disney movie, and she monitored her for any signs of overdose, such as a seizure. When we spoke later, the mom told me that she planned to run her daughter inside if she developed any symptoms. If no symptoms were observed, she did not feel she could afford the visit.

Responses and Pending Legislation

Between 2017 and 2019, I wrote approximately 20 articles for Vox on the high cost of emergency department care and its effects on patients. This series has led to the cancelation of more than \$60 000 in medical debt. It has also inspired legislative proposals to better protect patients from surprise medical bills for emergency department and other health care services.

In California, the state legislature is currently debating Assembly Bill 1611, which would require hospitals to keep their emergency departments in-network with private health insurance.⁹ The sponsor of that bill has said it was inspired by Vox's reporting on Zuckerberg San Francisco General. Other proposals are being considered by Congress, such as setting limits on what clinicians and health care facilities can charge patients in certain situations or establishing an arbitration process to settle surprise medical bills, a policy currently in place in New York State.¹⁰ If Congress and state legislatures act, surprise medical bills for emergency department and other medical care can become a thing of the past.

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Research

JAMA Internal Medicine | Original Investigation

Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-Network Hospitals

Eric C. Sun, MD, PhD; Michelle M. Mello, JD, PhD; Jasmin Moshfegh, MA, MSc; Laurence C. Baker, PhD

IMPORTANCE Although surprise medical bills are receiving considerable attention from lawmakers and the news media, to date there has been little systematic study of the incidence and financial consequences of out-of-network billing.

OBJECTIVE To examine out-of-network billing among privately insured patients with an inpatient admission or emergency department (ED) visit at in-network hospitals.

DESIGN, SETTING, AND PARTICIPANTS A retrospective analysis using data from the Clinformatics Data Mart database (Optum), which includes health insurance claims for individuals from all 50 US states receiving private health insurance from a large commercial insurer was conducted of all inpatient admissions ($n = 5\,457\,981$) and ED visits ($n = 13\,579\,006$) at in-network hospitals between January 1, 2010, and December 31, 2016. Data were collected and analyzed in March 2019.

EXPOSURES Receipt of a bill for care from at least 1 out-of-network physician or medical transport service associated with patient admission or ED visit.

MAIN OUTCOMES AND MEASURES The incidence of out-of-network billing and the potential amount of patients' financial liability associated with out-of-network bills from the admission or visit.

RESULTS Of 5 457 981 inpatient admissions and 13 579 006 ED admissions between 2010 and 2016, the percentage of ED visits with an out-of-network bill increased from 32.3% to 42.8% ($P < .001$) during the study period, and the mean (SD) potential financial responsibility for these bills increased from \$220 (\$420) to \$628 (\$865) ($P < .001$; all dollar values in 2018 US\$). Similarly, the percentage of inpatient admissions with an out-of-network bill increased from 26.3% to 42.0% ($P < .001$), and the mean (SD) potential financial responsibility increased from \$804 (\$2456) to \$2040 (\$4967) ($P < .001$).

CONCLUSIONS AND RELEVANCE Out-of-network billing appears to have become common for privately insured patients even when they seek treatment at in-network hospitals. The mean amounts billed appear to be sufficiently large that they may create financial strain for a substantial proportion of patients.

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In the United States, physicians who are part of an insurer's network typically agree to accept a set amount from the insurer as payment in full for their services. However, out-of-network physicians can seek additional payment from the patient, a practice known as out-of-network or balance billing. Many clinicians have a standard charge for their services that is larger than the rate paid by the insurer. Under out-of-network billing, physicians may bill the patient for the difference between the 2 amounts. This amount increases the patient's financial responsibility beyond any coinsurance or copayments under the terms of the patient's insurance plan. Although federal legislation bans balance billing for Medicare beneficiaries,¹ no federal protections against out-of-network billing for privately insured patients exist. In particular, while the Affordable Care Act prevents insurers from levying additional copayments for out-of-network emergency department care, these protections do not prevent out-of-network billing by physicians.² As of June 2019, 25 states had enacted legislation providing patients some protection against out-of-network billing, ranging from dispute resolution processes to provisions holding the insurer responsible for the balance-billed amount; these protections, however, are rarely comprehensive.^{3,4} In other states and the Congress, pending legislation would limit the scope and effects of out-of-network billing.^{3,5,6}

In theory, out-of-network billing could benefit patients by providing flexibility for them to see out-of-network physicians. Such flexibility would require the patient to be aware in advance that the physician is out-of-network and may send a balance bill. More commonly, however, the patient is unaware of these possibilities. For example, at many hospitals, some physicians (eg, anesthesiologists) are not hospital employees and make decisions separate from the hospitals about participating in insurance. Thus, even if the hospital and the admitting physician are in-network, the patient could still be cared for by out-of-network physicians and be sent balance bills.

Although out-of-network billing has received news media attention,⁷⁻¹⁰ to date there has been little systematic study of its incidence and financial consequences. Studies have examined the incidence of out-of-network billing by emergency department (ED) physicians,¹¹⁻¹³ but to our knowledge billing by other physicians and ambulance transport services has not been fully explored. One report analyzed out-of-network billing for air ambulances,¹⁴ and studies have examined the incidence but not the financial liabilities of out-of-network billing for inpatient admissions.^{15,16}

Using a national data set of people with private health insurance, we characterized the incidence and potential financial consequences of out-of-network billing among patients undergoing an ED visit or inpatient admission at in-network hospitals between 2010 and 2016.

Methods

We obtained data from the Clinformatics Data Mart database (Optum), which includes health insurance claims for individuals from all 50 US states receiving private health insurance from a large commercial insurer,¹⁷⁻¹⁹ with

Key Points

Question What are the incidence and financial consequences of out-of-network billing for inpatient admissions and emergency department visits?

Findings In this analysis of 5 457 981 inpatient admissions and 13 579 006 emergency department admissions between 2010 and 2016 in a large national sample of privately insured patients, the incidence of out-of-network billing increased from 32.3% to 42.8% of emergency department visits, and the mean potential liability to patients increased from \$220 to \$628. For inpatient admissions, the incidence of out-of-network billing increased from 26.3% to 42.0%, and the mean potential liability to patients increased from \$804 to \$2040.

Meaning It appears that out-of-network billing is becoming more common and potentially more costly in both the emergency department and inpatient settings.

approximately 13 million covered lives annually.^{20,21} The individuals in the database represent about 19% of those with commercial health insurance,¹⁵ and their geographic distribution broadly matches the geographic distribution of the US population.²² We used claims submitted between January 1, 2010, and December 31, 2016. Data were collected and analyzed in March 2019. For each claim, the database reports information such as service dates (ie, physician specialty or medical transport service) and whether the claim was paid as in-network or out-of-network. In addition, each claim reports financial variables including the amount charged by the clinician and a standardized cost, which broadly represents the national mean amount insurance companies would pay an in-network clinician or medical transport service (ie, ambulance) for the service. The database has been used in a variety of health services and health policy studies.^{17,23,24} As the study used deidentified data, the Stanford University Institutional Review Board (IRB) determined it did not meet the definition of human subjects research and therefore required no further review from the IRB or written and informed patient consent.

The initial sample consisted of all inpatient admissions (n = 6 454 236) and ED visits (n = 17 073 129) to in-network hospitals between January 1, 2010, and December 31, 2016. We confined the analysis to care received at in-network hospitals because unexpected out-of-network billing from physicians would be more likely in this setting. Inpatient admissions were directly identified in the data by a unique coded identifier which is assigned to all claims (ie, hospital claims, claims for services performed by physicians) associated with a given inpatient admission. In constructing the sample of inpatient admissions, we included admissions from the emergency department as well as admissions from other sources (ie, elective admissions), and excluded admissions to observation status. We identified ED visits by searching for claims with a procedure code consistent with an evaluation and management visit in the ED setting (*Current Procedural Terminology* codes 99281-99285). Any claims submitted on the same day as a claim with the relevant ED codes (ie, claims submitted for consults from other

specialties) were considered to be associated with that ED visit.

After construction of the initial sample, we excluded visits and admissions with claims for charges that were either \$0 or negative ($n = 92\,901$ ED visits; 76 688 inpatient admissions) and those for which the network status of the clinician or medical transport service was unknown or missing ($n = 3\,264\,060$ ED visits; 864 435 inpatient admissions). Last, visits with charges in the top 1% of all visits and admissions ($n = 137\,162$ ED visits; 55 132 inpatient admissions) were removed to avoid the inclusion of outliers, resulting in a final sample of 13 579 006 ED visits and 5 457 981 inpatient admissions. A flow diagram outlining sample construction is available in the eFigure in the Supplement.

We analyzed 2 primary outcomes. The first outcome was whether the patient received any out-of-network bill during the inpatient admission or ED visit, which was directly reported on the claim. In measuring this outcome, we restricted the analysis to claims submitted by physicians (of any specialty) or medical transport services. The latter was included because patients typically have little choice about their transport and thus may be more likely to be subject to unexpected out-of-network billing.¹⁴

The second outcome was the amount of money the patient could potentially be liable for as a result of having received care from the out-of-network clinician or medical transport service. Consistent with previous work,^{11,25} this amount was defined as the difference between the amount charged by the out-of-network physician or transport service, which is directly reported, and the amount the insurer would pay in-network for the same service. For the in-network payments, we used the standardized costs included in the database. Although the actual amount the insurer may have paid an in-network clinician or transport service for a specific claim may be higher or lower, this approach can provide reliable estimates for national-level analyses, and has been used in previous studies.²⁵ All dollar values are reported in 2018 US\$.

For 1 080 616 ED visits (20.4%) and 547 467 inpatient admissions (27.1%), the patient's estimated potential financial responsibility was negative (ie, the amount charged by out-of-network physicians and/or medical transport services was less than the standardized mean cost). For these visits and admissions, we set the patient's potential additional financial liability to \$0, and also performed sensitivity analyses, as described below. We adjusted all dollar amounts to 2018 dollars with the Consumer Price Index.²⁶

Statistical Analysis

We calculated the incidence of out-of-network billing (defined as ED visits or inpatient admissions with at least 1 out-of-network physician or medical transport service) and the patient's potential financial liability on an annual basis. We calculated the incidence of out-of-network billing by physician specialty and medical transport service for the entire sample period. We characterized the distribution of out-of-network billing across hospitals by calculating the percentage of ED visits and inpatient admissions to a given hospital

that resulted in at least 1 out-of-network bill. In calculating these hospital-level measures of the incidence of balance billing, hospitals with fewer than 100 inpatient admissions ($n = 5771$ of 9067 hospitals) or 100 ED visits ($n = 5151$ of 9179 hospitals) during the sample period were excluded.

We assessed the statistical significance of differences across groups with a t test for continuous variables and a χ^2 test for discrete variables, using Stata, version 14.0 (StataCorp Inc). All tests were 2-sided with $P < .05$ indicating statistical significance.

Sensitivity Analyses and Subgroup Analyses

With a subgroup analysis, we examined the incidence and magnitude of out-of-network billing for medical and surgical inpatient admissions separately. Surgical admissions were defined as admissions in which the patient received care (ie, ≥ 1 claim submitted) by a physician from a surgical specialty, such as general surgery, orthopedics, and obstetrics and gynecology (eTable 1 in the Supplement).

The main analysis assigned a potential financial responsibility of \$0 to the patient in situations where the out-of-network physician or medical transport service charged less than the insurer's in-network payment. With 2 sensitivity analyses, we explored the consequences of this decision. The first reanalyzed the data after excluding these cases, and the second included them and assigned them the mean potential financial responsibility for that year.

In another sensitivity analysis, we included the 13.3% of inpatient admissions and 19.1% of emergency department visits excluded from the main analysis because the network status of at least 1 involved physician (or the medical transport service) was unknown. This analysis conservatively treated any physician or medical transport service whose network status was unknown as in-network.

Although patients generally would have little choice of physician or medical transport service for ED visits and emergency inpatient admissions, they could have more choice for elective inpatient admissions (ie, choosing an out-of-network surgeon to perform an elective surgery), so out-of-network billing, if it occurred, would not necessarily be unexpected. To exclude the bills least likely to be unexpected, we performed an additional analysis for elective inpatient admissions ($n = 2\,149\,893$; defined as admissions with no claims from an emergency department physician or a medical transport service) which only included out-of-network billing by hospital-based physicians (diagnostic radiology, anesthesiology, pathology, and critical care medicine), over whom the patient would likely have limited choice.

Results

ED Visits

Among all 13 579 006 ED visits to in-network hospitals, 5 303 390 (39.1%) resulted in an out-of-network bill (Table 1). The incidence of out-of-network billing among ED visits increased from 32.3% in 2010 to 42.8% in 2016 ($P < .001$). The

Table 1. Annual Incidence and Magnitude of Out-of-Network Billing for Emergency Department Visits

Year	No. of Visits ^a	Visits With Out-of-Network Bill, No. (%) ^b	Potential Out-of-Network Responsibility, \$ ^c					
			Mean (SD)	10th	25th	50th	75th	90th
2010	1 458 291	470 978 (32.3)	220 (420)	0	5	107	300	575
2011	1 656 869	584 628 (35.3)	268 (483)	0	24	149	361	683
2012	1 833 907	691 592 (37.7)	326 (572)	0	42	191	448	795
2013	1 923 205	774 042 (40.2)	418 (651)	0	84	270	581	1001
2014	1 909 557	792 623 (41.5)	478 (733)	6	118	323	658	1108
2015	2 146 751	855 960 (39.9)	558 (809)	18	155	409	774	1272
2016	2 650 426	1 133 567 (42.8)	628 (865)	23	181	482	891	1364
Overall	13 579 006	5 303 390 (39.1)	419 (671)	0	73	266	588	1003

^a Total annual emergency department visits to an in-network hospital.^b Number of visits to an in-network emergency department with at least 1 claim submitted by an out-of-network physician or medical transport service.^c Patient's responsibility for out-of-network services reported by percentiles and

defined as the difference between the physician or medical transport charge and the amount typically paid by the insurer for an in-network service. These amounts are in addition to any other out-of-pocket payments (eg, payments for deductible and coinsurance). All dollar values are adjusted to 2018 US\$.

Table 2. Incidence and Magnitude of Out-of-Network Billing for Medical Transport Services and the 10 Most Common Physician Specialties for Emergency Department Visits

Specialty	No. of Visits ^a	Visits With Out-of-Network Bill, No. (%) ^b	Potential Out-of-Network Responsibility, \$ ^c					
			Mean (SD)	10th	25th	50th	75th	90th
Emergency medicine	11 811 471	3 853 305 (32.6)	396 (382)	19	117	292	576	910
Radiology	7 286 182	1 319 676 (18.1)	115 (203)	11	20	49	150	294
Medical transport	1 661 978	1 422 134 (85.6)	244 (801)	0	0	25	296	704
Cardiology	1 537 176	321 230 (20.9)	64 (344)	7	15	25	58	96
Internal medicine	1 387 236	329 787 (23.8)	186 (308)	0	23	103	237	452
Family practice	1 026 329	206 147 (20.1)	255 (359)	0	32	132	347	682
Unknown	774 159	149 746 (19.3)	284 (425)	9	81	181	372	682
Pediatrics	221 995	18 656 (8.4)	323 (394)	0	23	178	565	761
General surgery	200 980	26 650 (13.3)	676 (2236)	0	40	157	439	1341
Anesthesiology	167 185	38 196 (22.8)	568 (855)	0	44	268	763	1504

^a Total emergency department visits with at least 1 claim submitted by the given specialty.^b Total emergency department visits with at least 1 out-of-network claim submitted by the given specialty.^c Patient's responsibility for out-of-network services reported by percentiles and

defined as the difference between the physician or medical transport charge and the amount typically paid by the insurer for an in-network service. These amounts are in addition to any other out-of-pocket payments (eg, payments for deductible and coinsurance). All dollar values are adjusted to 2018 US\$.

potential financial responsibility associated with out-of-network billing also substantially increased, from a mean (SD) of \$220 (\$420) in 2010 (median, \$107; interquartile range [IQR], \$5-\$300) to a mean (SD) of \$628 (\$865) in 2016 (median \$482; IQR, 181-891). The potential financial responsibility among the top decile of patients who received an out-of-network bill increased from \$575 in 2010 to \$1364 in 2016.

Out-of-network billing for ED visits was particularly common for ambulance transport: 85.6% of encounters with ambulance services resulted in an out-of-network bill to the patient, with a mean (SD) potential financial responsibility of \$244 (\$801); Table 2 presents the 10 most commonly encountered specialties and eTable 1 in the Supplement presents all specialties. Of patients receiving care from an emergency physician, 32.6% received an out-of-network bill (mean [SD] potential responsibility, \$396 [\$382]), as did nearly a quarter of patients receiving care from an internist (23.8%; mean [SD], \$186 [\$308]) or anesthesiologist (22.8%; mean [SD], \$568 [\$855]).

Inpatient Admissions

During the entire study period, 37.0% of inpatient admissions to in-network hospitals (2 019 922 of 5 457 981) resulted in at least 1 out-of-network bill, with the incidence of out-of-network billing increasing from 26.3% in 2010 (159 609 of 607 160) to 42.0% in 2016 (397 447 of 947 111; $P < .001$) (Table 3). As for ED visits, the mean (SD) potential financial responsibility substantially increased during the study period, from \$804 (\$2456) in 2010 (median, \$285; IQR, \$30-\$794) to \$2040 (\$4967) in 2016 (median, \$984; IQR, \$325-\$2084). In 2016, the top decile of patients with out-of-network bills faced a potential liability of \$4112 or more.

Among the physician specialties with the most frequent billing for inpatient care, the incidence of out-of-network billing ranged from 0.8% for obstetrics and gynecology (mean [SD] potential responsibility, \$1228 [\$3457], median, \$293; IQR, 91-1075; see Table 4 for 10 most commonly encountered specialties and eTable 2 in the Supplement for all specialties) to 81.6%

Table 3. Annual Incidence and Magnitude of Out-of-Network Billing for Inpatient Admissions

Year	No. of Admissions ^a	Admissions With Out-of-Network Bill, No. (%) ^b	Potential Out-of-Network Responsibility, \$ ^c					
			Mean (SD)	10th	25th	50th	75th	90th
2010	607 160	159 609 (26.3)	804 (2456)	0	30	285	794	1684
2011	573 457	175 610 (30.6)	990 (2876)	0	73	389	971	2060
2012	830 824	301 568 (36.3)	1277 (3899)	0	125	508	1194	2568
2013	867 523	338 715 (39.0)	1483 (4188)	16	192	653	1428	2950
2014	803 425	327 676 (40.8)	1731 (4698)	25	244	760	1682	3474
2015	828 481	319 297 (38.5)	1920 (5157)	35	291	853	1842	3791
2016	947 111	397 447 (42.0)	2040 (4967)	44	325	984	2084	4112
Overall	5 457 981	2 019 922 (37.0)	1574 (4382)	8	183	667	1538	3215

^a Total annual inpatient admissions to an in-network hospital.^b Number of inpatient admissions with at least 1 claim submitted by an out-of-network physician or medical transport service.^c Patient's responsibility for out-of-network services reported by percentiles and

defined as the difference between the physician or medical transport charge and the amount typically paid by the insurer for an in-network service. These amounts are in addition to any other out-of-pocket payments (eg, payments for deductible and coinsurance). All dollar values are adjusted to 2018 US\$.

Table 4. Incidence and Magnitude of Out-of-Network Billing for Medical Transport Services and the 10 Most Common Physician Specialties for Inpatient Admissions

Specialty	No. of Admissions ^a	Admissions With Out-of-Network Bill, No. (%) ^b	Potential Out-of-Network Responsibility, \$ ^c					
			Mean (SD)	10th	25th	50th	75th	90th
Radiology	3 181 749	720 698 (22.6)	267 (759)	15	33	121	307	615
Emergency medicine	2 132 940	908 430 (42.6)	595 (575)	44	203	477	858	1267
Internal medicine	2 007 554	507 014 (25.3)	450 (1133)	9	65	206	483	999
Anesthesiology	1 961 192	378 239 (19.3)	1369 (1807)	0	233	794	1825	3362
Cardiology	1 701 819	333 769 (19.6)	328 (1438)	10	19	52	196	612
Unknown	1 115 844	214 992 (19.3)	544 (1489)	29	106	265	614	1136
Pathology	987 225	219 335 (22.2)	297 (542)	16	63	145	303	676
Medical transport	947 744	773 218 (81.6)	424 (2176)	0	0	44	365	832
Family practice	783 703	142 455 (18.2)	384 (1330)	0	49	148	364	798
Obstetrics & gynecology	760 049	6220 (0.8)	1228 (3457)	18	91	293	1075	1075

^a Total inpatient admissions with at least 1 claim submitted by the given specialty.^b Total inpatient admissions with at least 1 out-of-network claim submitted by the given specialty.^c Patient's responsibility for out-of-network services reported by percentiles and

defined as the difference between the physician or medical transport charge and the amount typically paid by the insurer for an in-network service. These amounts are in addition to any other out-of-pocket payments (eg, payments for deductible and coinsurance). All dollar values are adjusted to 2018 US\$.

for ambulance services (mean [SD] potential responsibility \$424 [\$2176]; median, \$44; IQR, \$0-\$365).

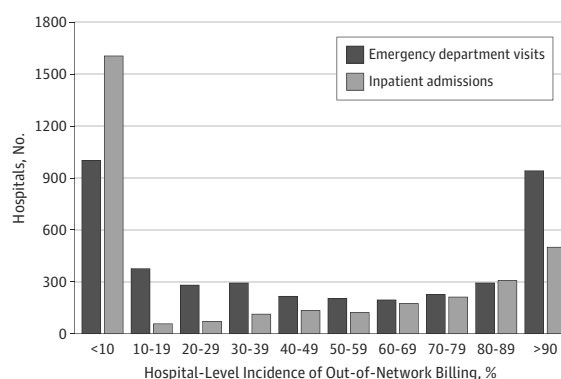
Distribution Across Hospitals

The incidence of out-of-network billing for inpatient admissions across hospitals followed a bimodal distribution (Figure). For approximately half (1606 of 3296) of hospitals, the incidence was less than 10%. The incidence of out-of-network billing for ED visits was less than 10% for approximately one-quarter (1002 of 4028) of hospitals. By comparison, more than 90% of inpatient admissions resulted in an out-of-network bill at 500 hospitals (15.2% of all hospitals), and more than 90% of ED visits were accompanied by an out-of-network bill at 942 hospitals (23.3% of all hospitals).

Subgroup and Sensitivity Analyses

In a subgroup analysis, the incidence of out-of-network billing was lower for surgical admissions (30.9% vs 42.0%; $P < .001$; eTable 3 in the Supplement), but the potential financial liabilities were higher (mean [SD] liability \$2406 [\$6108] vs \$914 [\$1962]; $P < .001$).

The sensitivity analyses performed to investigate potential mismeasurement of the potential financial liability for cases where the estimated potential financial liability was negative had qualitatively similar results to the main analysis (eTable 4 and eTable 5 in the Supplement). Sensitivity analyses that included emergency department visits where physician or ambulance service network status was unknown also had qualitatively similar results to the main analysis (eTables 6-9 in the Supplement). The analysis that was restricted to out-of-network billing by hospital-based physicians for elective inpatient admissions found a lower incidence overall of out-of-network billing (17.6% for the study period), with the incidence increasing from 13.1% to 20.5% of elective inpatient admissions during the study period (eTable 10 in the Supplement); by comparison, in the main analysis the overall incidence of out-of-network billing was 37.0%, and the incidence of out-of-network billing increased from 26.3% to 42.0% during the sample period. For patients who received an out-of-network bill, this analysis found potential financial responsibilities that were lower than in the main analysis (mean [SD], \$1190 [\$1965];

Figure. Incidence of Out-of-Network Billing Across Hospitals, 2010-2016

Shown are the number of hospitals for which the incidence of out-of-network billing (defined as an emergency department visit or inpatient admission with at least 1 claim submitted by an out-of-network physician or medical transport service) fell within the given range.

median, \$431; IQR, \$85-\$1557; main analysis mean [SD], \$1547 [\$4382]; median, \$667; IQR, \$183-\$1538).

Discussion

In a national sample of US patients with private health insurance, the incidence of out-of-network billing at in-network hospitals substantially increased between 2010 and 2016, from 32.3% to 42.8% of ED visits and from 26.3% to 42.0% of inpatient admissions. Moreover, the potential financial consequences of out-of-network billing in both settings nearly doubled during this period, and the top 10% of patients faced liabilities of more than \$1000 for ED visits and more than \$3000 for inpatient care. Sensitivity analyses suggested a lower incidence of unanticipated out-of-network billing for elective inpatient admissions, but showed a similar increase during the study period, with potential financial liabilities for patients that were similar to those in the main analysis. Overall, our findings suggest a growing risk to patients of incurring burdensome unexpected out-of-network bills.

Our study builds on previous work by characterizing the incidence and magnitude of out-of-network billing for inpatient admissions and for physicians other than emergency physicians. Previous studies¹¹⁻¹³ have found the incidence of out-of-network billing to be about 20% of ED visits, although one of these studies did not measure incidence directly¹³; by comparison, our estimate is 39%. The difference between these findings may reflect differences in the geographic area or time periods studied. In addition, some previous studies^{11,25} only considered out-of-network billing by the attending emergency physician; our study, however, examined billing by all physician specialties and medical transport services. A recent report using an alternative source of commercial claims data (the Health Care Cost Institute) from 37 states and the District of Columbia in 2016

found that the state-level incidence of out-of-network billing for inpatient admissions ranged from 1.7% in Minnesota to 26.3% in Florida (the report did not characterize the amount of financial responsibility).¹⁵

From a policy perspective, a potential benefit of balance billing is that patients have flexibility to choose to receive care from out-of-network physicians. However, inherent to this benefit is patients' awareness that balance billing may occur and their willingness to pay the additional amount. Our findings are notable because out-of-network billing was common among medical transport services and hospital-based physicians (eg, emergency physicians, radiologists, and anesthesiologists) providing care at in-network hospitals. In such circumstances, patients could easily assume that the entire hospital team is in network and thus the balance billing may come as a surprise. Further, in these contexts, patients may have limited ability to choose an in-network physician or ambulance.

Even modest unexpected bills can create financial stress for patients. A recent survey found that 4 in 10 Americans would be unable to pay an unexpected expense of \$400 without selling something or borrowing money.²⁷ The median amounts for which patients in our study were sent balance bills (\$984 for inpatient admissions and \$482 for emergency visits in 2016) exceed that level. Further, the top decile of patients with out-of-network bills faced substantial potential financial responsibility: \$4112 for inpatient admissions and \$1364 for ED visits.

Because out-of-network bills most commonly originated from clinical services (ie, medical transport, emergency medicine) about which patients have little choice, policy solutions centered on disclosure and consent at the point of care may not meaningfully address a large part of the problems patients face.²⁸ Policies that limit the ability of physicians and medical transport services to balance bill patients—for example, by shifting some portion of the patient's responsibility to insurers—offer stronger protection. Even in the absence of such interventions, greater understanding of variations in out-of-network billing across hospitals may be helpful in identifying facilities whose financial strategy involves heavy reliance on out-of-network physicians to staff core services (ie, facilities where out-of-network billing is extremely common), which may allow insurers and other parties to better inform patients about the potential financial consequences of receiving care at these facilities.

Limitations

Our study has limitations. First, unexpected out-of-network billing could not be isolated, although as previously noted, out-of-network billing could easily be unexpected among patients who present at an in-network hospital, and previous work has found that most out-of-network billing in the inpatient setting is involuntary.²⁹ Second, the data did not include information on the proportion of balance-billed amounts that patients actually paid. Physicians and medical transport services may be willing to negotiate the amount owed, although there are limited data on how often patients are able to negotiate lower payments. One study found that only 19%

of patients attempted to negotiate balance-billed amounts, and slightly more than half of patients who did so were successful in obtaining any reduction in the amount owed.³⁰ Moreover, these negotiations may not happen before the matter is sent to collections, which could jeopardize the patient's credit rating. Third, we excluded visits to out-of-network hospitals, where unexpected out-of-network billing would be harder to measure because patients may have specifically chosen the hospital and may have less expectation that physicians there would be in-network. Fourth, our analysis excluded approximately 20% of visits where the network status of at least 1 physician or medical transport service could not be determined, although subsequent sensitivity analyses including these visits showed qualitatively similar results. Fifth, our analysis may underestimate the extent of out-of-network billing, as it did

not account for billing from sources other than physicians and medical transport services (eg, laboratory charges). Sixth, in estimating the potential financial liability, we used the national mean paid in-network for a given service, which while accurate, could underestimate or overestimate the potential financial liability for any individual patient. In addition, the data were limited to a sample of patients from a single private insurer.

Conclusions

Our findings appear to support current efforts to strengthen legislative protections against out-of-network billing in circumstances that are likely to involve surprise bills.

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High air ambulance charges concentrated in private equity-owned carriers

BROOKINGS

USC-Brookings Schaeffer on Health Policy

High air ambulance charges concentrated in private equity-owned carriers

Loren Adler, Kathleen Hannick, and Sobin Lee Tuesday, October 13, 2020

Editor's Note:

This analysis is part of the USC-Brookings Schaeffer Initiative for Health Policy, which is a partnership between Economic Studies at Brookings and the University of Southern California Schaeffer Center for Health Policy & Economics. The Initiative aims to inform the national health care debate with rigorous, evidence-based analysis leading to practical recommendations using the collaborative strengths of USC and Brookings. USC-Brookings Schaeffer Initiative research on surprise medical billing was supported by Arnold Ventures.

Air ambulances – which may be either helicopters or fixed-wing aircraft – provide medical transport for sick or injured patients from the scene of an accident or from one medical facility to another, and in recent years have garnered national attention for high and fast-rising prices. This rapid growth in air ambulance prices is borne by consumers both through higher insurance premiums and more directly through cost-sharing and surprise bills from out-of-network carriers. A recent study estimates that 40% of helicopter air ambulance rides result in a potential surprise bill averaging roughly \$20,000.

Several analyses shed light on high and growing prices in the industry, but the concentration of high prices in a small number of private equity-owned carriers has not been as well explored. In this analysis, we utilize charge data submitted to Medicare and link carriers to their parent companies in order to examine billed charges by ownership structure over time. We report a standardized average charge for each carrier type that corresponds to an average distance transport to account for differences in the mix of services provided by carriers of different types. (See the Methodological Appendix for more detail.)

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High air ambulance charges concentrated in private equity-owned carriers

In 2017, we find that helicopter air ambulance carriers owned by two private equity firms, who together make up 64% of the Medicare market, had a standardized average charge of \$48,250 (7.2 times what Medicare would have paid). This is markedly higher than the \$28,800 (4.3 times what Medicare would have paid) standardized average charge for the same service by air ambulance carriers that are not part of a private equity-owned or publicly-traded company.

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High air ambulance charges concentrated in private equity-owned carriers

 Fig 1

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High air ambulance charges concentrated in private equity-owned carriers

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A similar phenomenon is also apparent in the fixed wing air ambulance market. Air ambulance carriers owned by the same two private equity firms, plus one additional small private equity-owned carrier, represent 62% of the Medicare market and had a standardized average charge of \$58,750 (8.7 times Medicare prices), while other carriers charged an average of \$38,200 (5.6 times Medicare prices).

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High air ambulance charges concentrated in private equity-owned carriers

 Fig 2

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High air ambulance charges concentrated in private equity-owned carriers

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High air ambulance charges concentrated in private equity-owned carriers

Why Charges Matter

For providers that patients do not proactively choose, such as air ambulances or emergency physicians, charges – akin to a list price – play an important role in negotiations with health plans and can directly impact out-of-network patients who may be liable for the difference between the charge and what their insurer pays – a practice known as “balance billing.” The influence of charges is likely particularly pronounced in the air ambulance market because neither insurers nor patients are able to select a preferred carrier for non-interfacility transports. Indeed, one study found that nearly 80% of helicopter air ambulance transports for commercially-insured patients are out-of-network and that for half of these out-of-network transports, the insurer pays the full charge with no apparent correlation to the magnitude of the charge. While the insurer paying the out-of-network air ambulance operator’s full charge is helpful to the individual patient, these costs are typically reflected in higher premiums and can incentivize providers to set high charges. By comparison, roughly one-quarter of out-of-network professional service bills at in-network ambulatory surgery centers had their charges paid in full. The same study also found that in-network air ambulance prices averaged 80% of billed charges, which is substantially higher than in physician specialties.

Rapid Growth in Charges

Previous studies have highlighted the rapid growth in air ambulance prices and charges, but the growth in charges (not just the level) has also been especially pronounced among private equity-owned carriers. Among helicopter providers, we find that standardized

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average charges from private equity carriers grew by 79% between 2012 and 2017 (an average of 12.4% per year), adjusted for inflation, compared to 36% growth for carriers not part of a private equity-owned or public company. Had private equity air ambulance carriers grown their charges at this lower rate, their standardized average charges in 2017 would have averaged \$36,500 rather than the actual \$48,250.

Consistent with this finding, we also note that GAO reported that Air Methods, a large helicopter air ambulance provider acquired by the private equity firm American Securities in 2017, indicated “that they have increased the average price charged per transport from \$13,000 in 2007 to \$49,800 in 2016—an increase of 283 percent over the past decade.”

While fastest for private equity-owned carriers, charge growth in the rest of the market is also notable. The 36% growth mentioned above amounts to annual real growth averaging 6.3% since 2012, far quicker than income growth or growth in most other health care prices. The highest-charging provider in 2012 had a standardized average charge of \$39,500, less than the *median* standardized average charge of \$41,900 in 2017. GAO also makes clear that this rapid growth did not begin in 2012, as they found average charges in the market doubled from \$15,000 to \$30,000 between 2010 and 2014. We estimate that the market-wide standardized average charge for a helicopter transport was \$42,250 in 2017 (and \$33,000 in 2014).

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 fig3

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High air ambulance charges concentrated in private equity-owned carriers

A similar dynamic is apparent among fixed-wing carriers. Standardized average charges from private equity operators grew by 65% between 2012 and 2017, measured in real 2017 dollars, in contrast to 19% growth among other providers. This differential growth translates to private equity fixed-wing air ambulance charges being \$16,500 higher in 2017 than had their charges grown in line with other carriers in the market.

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High air ambulance charges concentrated in private equity-owned carriers

 fig4

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High air ambulance charges concentrated in private equity-owned carriers

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Private Equity Dominance of the Air Ambulance Market

By 2017, private equity companies controlled nearly two-thirds of both the helicopter and fixed-wing air ambulance Medicare markets nationwide, buoyed by two large acquisitions that year – American Securities' acquisition of Air Methods and KKR's acquisition of Air Medical Resource Group. The latter purchase also represented a large consolidation of the fixed-wing market, growing KKR's market share of Medicare services from 20% to 53%.

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High air ambulance charges concentrated in private equity-owned carriers

 Fig 5

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High air ambulance charges concentrated in private equity-owned carriers

Discussion

Our findings add to the body of literature identifying high and fast-growing prices in the air ambulance market, and they illustrate that these trends are especially pronounced among private equity-owned carriers. It is plausible that quality differences may explain some of the differential pricing by ownership status, but any such differences seem unlikely to fully explain the very large gaps in charges across different carriers. Improvements in quality over time similarly seem unlikely to fully explain the rapid growth in charges across the entire air ambulance market, but especially among private equity carriers. Companies that operate air ambulances often attempt to defend high prices by citing what they consider underpayments by public payers. While not implausible, particularly for publicly-run carriers, empirical studies have consistently contradicted such “cost-shifting” claims in the context of hospitals. And again, even if true, it is hard to envision how changes over time in air ambulance payer mix can explain the extreme growth in prices and charges over the last decade.

More likely, certain market failures that characterize the provision of air ambulance services may help explain the high and rising prices. Air ambulance prices are less constrained by typical price competition than prices in other markets, given the common inability for patients or their health plan to select a carrier and that carriers can balance bill out-of-network patients. Increasing charges is also made more profitable by employers’ willingness to pay full charges for out-of-network provisions with seemingly little regard to the magnitude of the charge, likely due at least in part to the rarity of air ambulance services and the financial toll such a bill would place on an employee.

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High air ambulance charges concentrated in private equity-owned carriers

As a result, fixing the air ambulance market likely requires one of two approaches, discussed in greater detail in another paper. One option would follow a similar structure to proposals aimed at addressing broader surprise out-of-network billing, combining a prohibition on balance billing with a minimum payment requirement tied to a multiple of Medicare's prices – which already include adjustments for geography and bonuses for pickups in rural locations. Bipartisan Congressional proposals released by the Senate HELP Committee, House Energy & Commerce Committee, and House Education & Labor Committee include a similar approach, although with the minimum payment requirement tied to current average in-network payment rates rather than a multiple of Medicare prices. The other option is to create a competitive bidding process to award contracts to different air ambulance carriers to cover different geographic regions, similar to a public utility regulation model.

Methodological Appendix

We utilize Medicare Provider Utilization and Payment Data: Physician and Other Supplier for years 2012-2017, a public use file published by the Centers for Medicare and Medicaid Studies (CMS) that summarizes Medicare payment and utilization data at the provider name / HCPCS code / year level. These data include information by provider on the number of services provided to Medicare patients, the average Medicare allowed amount for each HCPCS code, and the average charge for each HCPCS code. We identify air ambulance providers by the HCPCS codes they bill – A0430 and A0435 are the base pickup and mileage codes for fixed wing aircraft, and A0431 and A0436 are the same for rotary wing aircraft. We restrict our analysis to providers based in the 50 U.S. states and the District of Columbia.

We then construct a crosswalk identifying the parent company of each air ambulance provider utilizing company websites, Pitchbook, and press releases. If we are unable to identify a parent company, we assume that the provider name reported to Medicare is the parent company. Additionally, we identify whether each parent company is a private equity firm, a publicly-traded company, an independent company, a hospital, a non-profit

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High air ambulance charges concentrated in private equity-owned carriers

(exclusive of hospitals), or a municipal government. Using this crosswalk, we then calculate market shares (among Medicare beneficiaries) and average charges for each parent company and ownership type, weighting by total Medicare allowed amounts.

To aid comparisons, we calculate a standardized average charge for each air ambulance provider in each year. To do this, we multiply a provider's annual mean charge-to-Medicare ratio by the average Medicare allowed amount across all providers in a given year for an average distance transport (62 miles for helicopters and 200 miles for fixed-wing air ambulances). Medicare prices differ for rural versus urban pickups, so this standardization effectively allows comparison of provider charges assuming a consistent breakdown of rural versus urban pickups. In practice, this standardization has little effect on comparisons relative to a simpler comparison that only controls for the length of transport. For example, the average private equity charge for a standardized rotary-wing transport in 2017 was \$48,241, while the average charge for an average distance non-standardized transport was \$48,159. As a result, this methodological choice has little impact on our findings.

USC-Brookings Schaeffer on Health Policy

The Initiative is a partnership between the **Economic Studies** program at Brookings and the **USC Schaeffer Center for Health Policy & Economics**, and aims to inform the national health care debate with rigorous, evidence-based analysis leading to practical recommendations using the collaborative strengths of USC and Brookings.

Letters

RESEARCH LETTER

Dispute Resolution Outcomes for Surprise Bills in Texas

A commercially insured patient who unknowingly receives out-of-network care in an emergency or at an in-network facility may face a “surprise bill” for the balance between the clinician’s charge and the insurer’s out-of-network allowed amount. Texas prohibited surprise bills for out-of-network emergency services and nonemergency ancillary services at in-network facilities among fully insured health plan enrollees, effective January 1, 2020.¹ Under this law, patients pay in-network cost sharing and health plans and out-of-network clinicians or emergency facilities resolve payment disagreements through an independent dispute resolution (IDR) process. The law provides different processes for facility and clinician services, and this study focuses on clinicians.

The Texas IDR process begins with a teleconference to attempt settlement. If unsuccessful, the case escalates to arbitration. Each party offers a final payment amount. The arbiter must select one of these offers after considering 10 factors, including the 80th percentile of charges and the median of insurers’ in-network payments for the same service(s) in the geographic area. The Texas Department of Insurance uses payment benchmarks from the independent nonprofit FAIR Health and certifies individuals with health care contract law experience as arbiters.

We assessed Texas IDR payment outcomes for clinicians and compared them with arbitration benchmarks.

Methods | Texas IDR cases occurring from January 2020 through March 2021 from multiple insurers, comprising more than half of fully insured covered lives in Texas, were analyzed. The in-

surers provided service-level (*Current Procedural Terminology* code) data for this study, including the type of service, charge, initial allowed amount, final allowed amount, local median in-network allowed amount, and 80th percentile of charges per FAIR Health’s database, as well as whether the case was settled or arbitrated. Allowed amounts include the direct plan payments to physicians and patient cost-sharing amounts.

We calculated the ratio of IDR final allowed amounts to FAIR Health’s median in-network allowed amounts and the 80th percentile of charges for each service. We computed the median and IQR of these ratios across all services and separately for settlements and arbitrations. Analyses were performed in Stata version 15 (StataCorp). The [Supplement](#) provides additional data and methodology details.

Results | The study sample included 47 280 service-level observations from 32 294 unique IDR cases involving clinicians. Services were predominantly emergency medicine (80%) and anesthesia (12%).

Disputed services in the sample had mean charges (\$2306) above the mean FAIR Health 80th percentile of charges benchmark (\$1944) and mean initial allowed amounts (\$192) below the mean FAIR Health median in-network allowed amount benchmark (\$634) (Figure 1). The mean IDR allowed amount outcome (\$635) aligned closely with the FAIR Health median in-network allowed amount benchmark. Overall, 74% of disputed services were settled through teleconference; mean charges, initial allowed amounts, arbitration benchmarks, and IDR outcomes were relatively similar across settled and arbitrated cases.

The median ratio of IDR final allowed amounts to FAIR Health median in-network allowed amounts was 1.06 (IQR, 0.89-1.25) and the ratio to the 80th percentile of charges was 0.37 (IQR, 0.30-0.46) (Figure 2). The median ratios of IDR fi-

Figure 1. Initial Charges and Allowed Amounts, FAIR Health Independent Dispute Resolution (IDR) Benchmarks, and IDR Final Allowed Amounts for IDR Cases

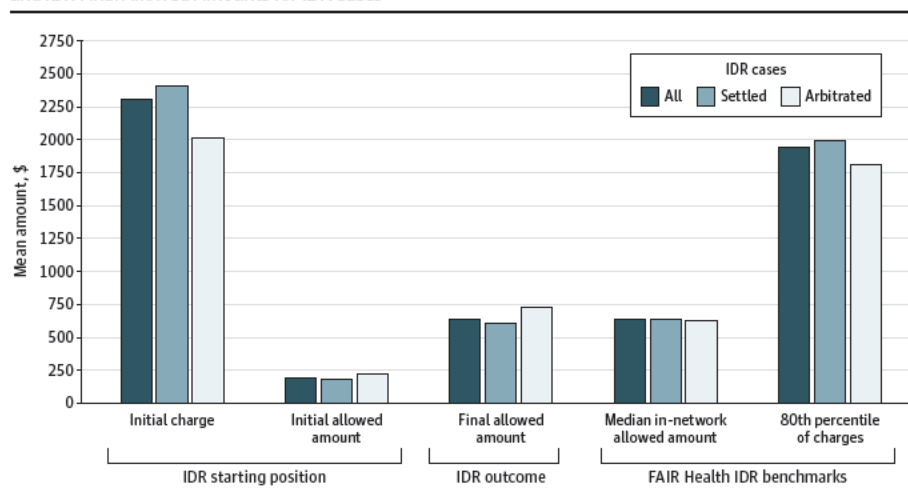
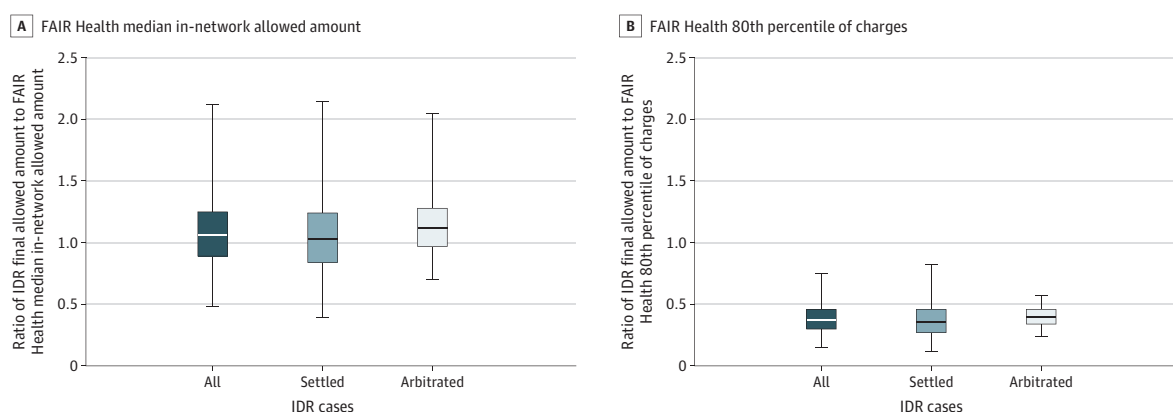


Figure 2. Ratios of Independent Dispute Resolution (IDR) Final Allowed Amounts to FAIR Health Benchmarks

The line inside the box indicates the median; the top line of the box is the upper quartile; the bottom line of the box is the lower quartile; and the whiskers extend to the 5th and 95th percentiles of the distribution.

nal allowed amounts to FAIR Health median in-network allowed amounts were modestly higher for arbitrations (1.12 [IQR, 0.97-1.28]) than for settlements (1.03 [IQR, 0.84-1.24]).

Discussion | The median final allowed amounts from Texas' IDR process were modestly higher than the FAIR Health median in-network allowed amount benchmark but were well below the benchmark of the 80th percentile of charges. Final allowed amounts resulting from IDR in Texas were lower than in New York and New Jersey, where arbiters are not shown median in-network prices, and previous research found that mean awards reflected the 80th percentile of charges benchmark.^{2,3}

Beginning in January 2022, the federal No Surprises Act prohibited surprise billing and established IDR. Initial regulatory guidance instructs arbiters to anchor decisions to median in-network prices, although ongoing lawsuits filed by hospital and physician groups seek to block its implementation. Texas IDR outcomes suggest that arbiters may anchor to a median in-network price benchmark, even if they are not instructed on how to weigh various factors.

Study limitations include the short time after policy implementation and that the sample may not be generalizable to other insurers.

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Author Contributions: Dr Duffy and Mr Adler had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: All authors.

Acquisition, analysis, or interpretation of data: All authors.

Drafting of the manuscript: Duffy.

Critical revision of the manuscript for important intellectual content: Adler, Chartock, Trish.

Statistical analysis: Duffy, Adler, Trish.

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Administrative, technical, or material support: Adler.

Supervision: Adler.

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Role of the Funder/Sponsor: The funder had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

1. TX SB1264, 2019-2020, 86th Legislature. LegiScan. Accessed November 13, 2021. <https://legiscan.com/TX/bill/SB1264/2019>

2. Adler L. Experience with New York's arbitration process for surprise out-of-network bills. Brookings. Published October 24, 2019. Accessed February 24, 2022. <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/10/24/experience-with-new-yorks-arbitration-process-for-surprise-out-of-network-bills/>

3. Chartock BL, Adler L, Ly B, Duffy E, Trish E. Arbitration over out-of-network medical bills: evidence from New Jersey payment disputes. *Health Aff (Millwood)*. 2021;40(1):130-137. doi:10.1377/hlthaff.2020.00217

Receipt of COVID-19 Booster Dose Among Fully Vaccinated Pregnant Individuals Aged 18 to 49 Years by Key Demographics

Booster doses of COVID-19 vaccines were recommended for people aged 18 years or older in November 2021 following the recommendation of an additional primary dose of COVID-19 vaccine for select immunocompromised populations on August 13, 2021.¹ As of February 26, 2022, more than 93 million booster doses of COVID-19 vaccines had been administered in the US²; however, data on receipt of booster doses among pregnant individuals are lacking. We



36872

Federal Register / Vol. 86, No. 131 / Tuesday, July 13, 2021 / Rules and Regulations

**OFFICE OF PERSONNEL
MANAGEMENT****5 CFR Part 890**

RIN 3206-AO30

DEPARTMENT OF THE TREASURY**Internal Revenue Service****26 CFR Part 54**

[TD9951]

RIN 1545-BQ04

DEPARTMENT OF LABOR**Employee Benefits Security
Administration****29 CFR Part 2590**

RIN 1210-AB99

**DEPARTMENT OF HEALTH AND
HUMAN SERVICES****45 CFR Parts 144, 147, 149, and 156**

[CMS-9909-IFC]

RIN 0938-AU63

**Requirements Related to Surprise
Billing; Part I**

AGENCY: Office of Personnel Management; Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Interim final rules with request for comments.

SUMMARY: This document sets forth interim final rules implementing certain provisions of the No Surprises Act, which was enacted as part of the Consolidated Appropriations Act, 2021. These interim final rules amend and add provisions to existing rules under the Internal Revenue Code, the Employee Retirement Income Security Act, the Public Health Service Act, and the Federal Employees Health Benefits Act. These interim final rules implement provisions of the No Surprises Act that protect participants, beneficiaries, and enrollees in group health plans and group and individual health insurance coverage from surprise medical bills when they receive emergency services, non-emergency services from nonparticipating providers at participating facilities, and air ambulance services from nonparticipating providers of air

ambulance services, under certain circumstances. In this rulemaking, the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury (collectively, the Departments) are issuing interim final rules with largely parallel provisions that apply to group health plans and health insurance issuers offering group or individual health insurance coverage. HHS is also issuing in this rulemaking additional interim final rules that apply to emergency departments of hospitals and independent freestanding emergency departments, health care providers and facilities, and providers of air ambulance services related to the protections against surprise billing. The Office of Personnel Management (OPM) is issuing in this rulemaking interim final rules that specify how certain provisions of the No Surprises Act apply to health benefits plans offered by carriers under the Federal Employees Health Benefits Act (FEHBA).

DATES: *Effective date:* These regulations are effective on September 13, 2021.

Applicability date: The regulations are generally applicable for plan years (in the individual market, policy years) beginning on or after January 1, 2022. The HHS-only regulations that apply to health care providers, facilities, and providers of air ambulance services are applicable beginning on January 1, 2022. The OPM-only regulations that apply to health benefits plans are applicable to contract years beginning on or after January 1, 2022.

Comment date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on September 7, 2021.

ADDRESSES: Written comments may be submitted to the addresses specified below. Any comment that is submitted will be shared among the Departments and OPM. Please do not submit duplicates.

Comments will be made available to the public. Warning: Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. Comments are posted on the internet exactly as received and can be retrieved by most internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records. Comments may be submitted anonymously.

In commenting, refer to file code CMS-9909-IFC. Because of staff and resource limitations, we cannot accept

comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation at <https://www.regulations.gov> by entering the file code in the search window and then clicking on "Comment".

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-9909-IFC, P.O. Box 8016, Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-9909-IFC, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Padma Babubhai Shah, Office of Personnel Management, at 202-606-4056; Kari DiCecco, Internal Revenue Service, Department of the Treasury, at 202-317-5500; Matt Litton or David Sydlík, Employee Benefits Security Administration, Department of Labor, at 202-693-8335; Lindsey Murtagh, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at 301-492-4106.

Customer Service Information:

Information from OPM on health benefits plans offered under the Federal Employees Health Benefits (FEHB) Program can be found on the OPM website (www.opm.gov/healthcare-insurance/healthcare/). Individuals interested in obtaining information from the DOL concerning employment-based health coverage laws may call the Employee Benefits Security Administration (EBSA) Toll-Free Hotline at 1-866-444-EBSA (3272) or visit the DOL's website (www.dol.gov/ebsa). In addition, information from HHS on private health insurance coverage and coverage provided by non-federal governmental group health plans can be found on the Centers for Medicare & Medicaid Services (CMS) website (www.cms.gov/ccio), and information on health care reform can be found at www.HealthCare.gov.

SUPPLEMENTARY INFORMATION: Inspection of Public Comments: Comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post comments received before the close of the comment period on the following website as soon as possible after they have been received: <https://regulations.gov>. Follow the search instructions on that website to view public comments.

I. Background

A. Patient Protections and Requirements Related to Emergency Services Under Section 2719A of the Public Health Service Act

The Patient Protection and Affordable Care Act (Pub. L. 111–148), was enacted on March 23, 2010 and the Health Care and Education Reconciliation Act of 2010, Public Law 111–152, was enacted on March 30, 2010 (these statutes are collectively known as the “Affordable Care Act” or “ACA”). The Affordable Care Act reorganizes, amends, and adds to the provisions of part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets.¹ The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. Sections 2701 through 2728 of the PHS Act are incorporated into ERISA and the Code.

Under section 2719A of the PHS Act, as added by the Affordable Care Act and incorporated into ERISA and the Code, if a non-grandfathered group health plan or health insurance issuer offering non-grandfathered group or individual health insurance coverage provides any benefits with respect to emergency services in an emergency department of a hospital, the plan or issuer must cover emergency services without the individual or the health care provider having to obtain prior authorization (including when the emergency services are provided out-of-network) and without regard to whether the health care provider furnishing the emergency services is an in-network provider with

respect to the services. The emergency services must be provided without regard to any other term or condition of the plan or health insurance coverage other than the exclusion or coordination of benefits, an affiliation or waiting period permitted under the Code, ERISA, and the PHS Act, or applicable cost-sharing requirements. For a plan or health insurance coverage with a network of providers that provides benefits for emergency services, the plan or issuer may not impose any administrative requirement or limitation on benefits for out-of-network emergency services that is more restrictive than the requirements or limitations that apply to in-network emergency services. In addition, carriers offering FEHB plans must comply with requirements described in section 2719A of the PHS Act in the same manner as they apply to a plan or issuer.

For purposes of the requirements under section 2719A of the PHS Act, emergency services mean, with respect to an emergency medical condition, (1) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and (2) that is within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the Social Security Act to stabilize the patient.

Regulations implementing section 2719A of the PHS Act include these consumer protections.² Section 2719A of the PHS Act did not prohibit balance billing. Balance billing refers to the practice of out-of-network providers billing patients for the difference between (1) the provider's billed charges, and (2) the amount collected from the plan or issuer plus the amount collected from the patient in the form of cost sharing (such as a copayment, coinsurance, or amounts paid toward a deductible). To avoid the circumvention of the protections of section 2719A of the PHS Act, in the implementing regulations, the Departments determined it was necessary that a reasonable amount be paid by a plan or issuer before a patient becomes responsible for a balance billing amount.³ Therefore, under the

Departments' final regulations published in the **Federal Register** on November 18, 2015 (Patient Protections Final Rule), a plan or issuer satisfies the out-of-network emergency care cost-sharing limitations in the statute if it provides benefits for out-of-network emergency services in an amount at least equal to the greatest of the following three amounts (adjusted for in-network cost sharing): (1) The median amount negotiated with in-network providers for the emergency service; (2) the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable (UCR) amount); or (3) the amount that would be paid under Medicare Part A or Part B for the emergency service (collectively, minimum payment standards).⁴ The Departments' regulations clarify that the cost-sharing requirements create a minimum payment requirement for the plan or issuer.⁵ The Departments also clarified that the cost-sharing requirements do not prohibit a group health plan or health insurance issuer from providing benefits with respect to an emergency service that are greater than the amounts specified in the regulations. However, those regulations address balance billing with respect to only emergency services and, even in that context, they serve only to minimize the amount of a balance bill by requiring that plans and issuers must pay a reasonable amount for emergency services before a patient becomes responsible for a balance billing amount. Prior to the enactment of the No Surprises Act, these minimum payment standards were the only federal consumer protections to reduce potential amounts of balance billing for individuals enrolled in group health plans and group and individual health insurance coverage.

⁴ 26 CFR 54.9815–2719A(b)(3); 29 CFR 2590.715–2719A(b)(3); 45 CFR 147.138(b)(3).

⁵ If state law prohibits balance billing, or in cases in which a group health plan or health insurance issuer is contractually responsible for balance billing amounts, plans and issuers are not required to satisfy the minimum payment standards set forth in the regulations, but may not impose any copayment or coinsurance requirement for out-of-network emergency services that is higher than the copayment or coinsurance requirement that would apply if the services were provided in-network. See 26 CFR 54.9815–2719A(b)(3)(iii); 29 CFR 2590.715–2719A(b)(3)(iii); 45 CFR 147.138(b)(3)(iii); FAQs about Affordable Care Act Implementation (Part I), Q15 (Sept. 20, 2010), available at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/aca-implementation-faqs>; www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca-implementation-faqs.html.

² 26 CFR 54.9815–2719A(b); 29 CFR 2590.715–2719A(b); 45 CFR 147.138(b).

³ 75 FR 37188, 37194 (June 28, 2010); see also 80 FR 72192 (Nov. 18, 2015). Additional clarification of these rules was also provided in 2018. See 83 FR 19431 (May 3, 2018).

¹ The term “group health plan” includes both insured and self-insured group health plans.

The No Surprises Act added section 9816 of the Code, section 716 of ERISA, and section 2799A–1 of the PHS Act, which expand the patient protections related to emergency services under section 2719A of the PHS Act, in part, by providing additional consumer protections related to balance billing.⁶ The No Surprises Act amended section 2719A of the PHS Act to include a sunset provision effective for plan years beginning on or after January 1, 2022, when the new protections under the No Surprises Act take effect.

Additionally, the No Surprises Act recodified the patient protections regarding choice of health care professional from section 2719A(a), (c), and (d) of the PHS Act at new section 9822 of the Code, section 722 of ERISA, and section 2799A–7 of the PHS Act. If a plan or issuer requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, these provisions permit individuals to designate any participating primary care providers available to accept them, including pediatricians, and prohibit the plan or issuer from requiring authorization or referral for obstetrical or gynecological care.

B. Surprise Billing and the Need for Greater Consumer Protections

Most group health plans, and health insurance issuers offering group or individual health insurance coverage, have a network of providers and health care facilities (participating providers or preferred providers) who agree by contract to accept a specific amount for their services.⁷ By contrast, providers and facilities that are not part of a plan or issuer's network (nonparticipating providers) usually charge higher amounts than the contracted rates that plans and issuers have negotiated with participating providers and facilities. When a participant, beneficiary, or enrollee receives care from a nonparticipating provider, the individual's plan or issuer may decline to pay for the service or may pay an amount that is lower than the provider's billed charges, and may subject the

individual to greater cost-sharing requirements than would have been charged had the services been furnished by a participating provider. Prior to the No Surprises Act, the nonparticipating provider could generally balance bill the individual for the difference between the provider's billed charges and the sum of the amount paid by the plan or issuer and the cost sharing paid by the individual, unless otherwise prohibited by state law.

A balance bill may come as a surprise for the individual. A surprise medical bill is an unexpected bill from a health care provider or facility that occurs when a covered person receives medical services from a provider or facility that, usually unknown to the participant, beneficiary, or enrollee, is a nonparticipating provider or facility with respect to the individual's coverage. Surprise billing occurs both for emergency and non-emergency care. In an emergency, a person usually goes (or is taken by emergency transport) to a nearby emergency department. Even if they go to a participating hospital or facility for emergency care, they may receive care from nonparticipating providers working at that facility. For non-emergency care, a person may choose a participating facility (and possibly even a participating provider), but not know that at least one provider involved in their care (for example, an anesthesiologist or radiologist) is a nonparticipating provider. In either circumstance, the person might not be in a position to choose the provider, or to ensure that the provider is a participating provider. Therefore, in addition to a bill for their cost-sharing amount, which tends to be higher for out-of-network services, the person might receive a balance bill from the nonparticipating provider or facility. This scenario also plays out frequently for air ambulance services, where individuals generally do not have the ability to select a provider of air ambulance services, and, therefore, have little or no control over whether the provider is in-network with their plan or coverage.

When individuals are unable to avoid nonparticipating providers, it raises health care costs and exposes patients to financial risk.⁸ The evidence suggests that the ability to balance bill is used as leverage by some providers to obtain higher in-network payments, which results in higher premiums, higher cost sharing for individuals, and increased

health care expenditures overall.⁹ Studies have shown that surprise bills can be large. For example, a recent study found that physicians collected, on average, 65 percent of the total charged amount for emergency department visits that likely included surprise bills, compared to 52 percent of the total charged amount for emergency department visits that likely did not include surprise bills. The study also found that nine percent of the individuals who likely received surprise bills paid physicians an amount more than \$400, which may cause financial hardship to many individuals.¹⁰ In addition, out-of-network cost sharing and payments for surprise bills usually do not count towards an individual's deductible and maximum out-of-pocket expenditure limits. Therefore, individuals with surprise bills may have difficulty reaching those limits, even after a significant health care event.

Another study using claims data from a large commercial issuer for the period 2010–2016 found that over 39 percent of emergency department visits to in-network hospitals resulted in an out-of-network bill, and the incidence increased from 32.3 percent in 2010 to 42.8 percent in 2016. The average potential amount of surprise medical bills also increased from \$220 in 2010 to \$628 in 2016. During the same period, 37 percent of inpatient admissions to in-network hospitals resulted in at least one out-of-network bill, increasing from 26.3 percent in 2010 to 42 percent in 2016, and the average potential surprise medical bill increased from \$804 to \$2,040.¹¹

Although some states have enacted laws to reduce or eliminate balance billing, these efforts have created a patchwork of consumer protections. Even within a state that has enacted such protections, those protections typically apply only to individuals enrolled in individual and group health insurance coverage, as ERISA generally

⁶ These new protections apply regardless of whether the plan or coverage is a grandfathered health plan under section 1251 of the Affordable Care Act. The No Surprises Act also amended 5 U.S.C. 8902(p) to ensure that covered individuals enrolled in FEHB plans receive these protections.

⁷ These interim final rules refer to providers both in terms of their participation (participating provider) and in terms of a network (in-network provider). In both situations, the intent is to refer to a provider that has a contractual relationship or other arrangement with a plan or issuer to provide health care items and services for participants, beneficiaries, and enrollees of the plan or issuer.

⁸ Cooper Z et al., Out-of-Network Billing and Negotiated Payments for Hospital-Based Physicians, *Health Affairs* 39, No. 1, 2020. doi: 10.1377/hlthaff.2019.00507.

⁹ See Cooper, Z. et al., Surprise! Out-Of-Network Billing For Emergency Care in the United States, NBER Working Paper 23623, 20173623; Duffy, E. et al., Policies to Address Surprise Billing Can Affect Health Insurance Premiums. *The American Journal of Managed Care* 26.9 (2020): 401–404.; and Brown E.C.F., et al., The Unfinished Business of Air Ambulance Bills, *Health Affairs Blog* (March 26, 2021), DOI: 10.1377/hblog20210323.911379, available at <https://www.healthaffairs.org/doi/10.1377/hblog20210323.911379/full/>.

¹⁰ Biener, A. et al., Emergency Physicians Recover a Higher Share of Charges From Out-Of-Network Care Than From In-Network Care, *Health Affairs* 40, No. 4 (2021): 622–628.

¹¹ Sun EC, Mello MM, Moshfegh J, Baker LC, Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-Network Hospitals. *JAMA Intern Med.* 2019; 179(11):1543–1550 (2019). doi:10.1001/jamainternmed.2019.3451.

preempts state laws that regulate self-insured group health plans sponsored by private employers. In addition, states are limited in their ability to address surprise bills that involve an out-of-state provider.

Surprise medical bills can lead to medical debt for individuals who have difficulty paying their bills. The impact is most keenly felt by those communities experiencing poverty and other social risk factors, as surprise medical bills and medical debt can negatively affect individuals' abilities to eliminate debt and create wealth, and ultimately can affect a family for generations.¹² A recent survey reported that while 68 percent of respondents said that it was difficult to pay a surprise bill, the likelihood of such difficulty was higher for middle income respondents (77 percent) and African Americans (74 percent). In addition, while 11 percent of survey respondents were unable to pay the surprise bill, 21 percent of low income respondents, 19 percent of African Americans, and 17 percent of respondents in rural areas were unable to do so.¹³ In addition, individuals are often confused by medical bills. A 2016 survey found that 61 percent of individuals are confused by medical bills, and for 49 percent of individuals surveyed, the amount owed was a surprise.¹⁴ These challenges are exacerbated for underserved communities, which are more likely to experience poor communication, underlying mistrust of the medical system, and lower levels of patient engagement than other populations.¹⁵

¹² Taylor, J. Racism, inequality, and health care for African Americans. The Century Foundation: Report (December 19, 2019). <https://tcf.org/content/report/racism-inequality-health-care-african-americans/>; Chavis, B. Op-Ed: Big insurance must help end surprise medical billing. blackpressUSA (February 24, 2020).

¹³ Families USA, Surprise Medical Bills, Results from a National Survey, November 2019. <https://familiesusa.org/wp-content/uploads/2019/11/Surprise-Billing-National-Poll-Report-FINAL.pdf>.

¹⁴ Gooch, Kelly. 61% of patients confused by medical bills, survey finds. Becker's Hospital Review (July 14, 2016). <https://www.beckershospitalreview.com/finance/61-of-patients-confused-by-medical-bills-survey-finds.html>.

¹⁵ See Butler S, Sherriff N. How poor communication exacerbates health inequities and what to do about it. Brookings Institution: Report (February 22, 2021). <https://www.brookings.edu/research/how-poor-communication-exacerbates-health-inequities-and-what-to-do-about-it/>; Hamel, L., Lopes, L., Muñana, C., Artiga, S., Brodie, M. Race, Health, and COVID-19: The Views and Experiences of Black Americans. Kaiser Family Foundation (October 2020). <https://files.kff.org/attachment/Report-Race-Health-and-COVID-19-The-Views-and-Experiences-of-Black-Americans.pdf>; Shen M.J., Peterson E.B., Costas-Muñiz R. et al. The Effects of Race and Racial Concordance on Patient-Physician Communication: A Systematic Review of the Literature. *J. Racial and*

Effective, culturally, and linguistically tailored communication at appropriate literacy levels, coupled with policies that address the social risk factors and other barriers underserved communities face to accessing, trusting, and understanding health care costs and coverage, can reduce disparities and promote health equity.¹⁶

Communication among providers, plans, consumers, communities, and consumer advocates must be consistent with and reinforce all relevant consumer protections related to surprise bills. Such communication must be accessible, linguistically tailored, and at an appropriate literacy level. This includes compliance with requirements to provide effective communication for individuals with disabilities under the Americans with Disabilities Act of 1990,¹⁷ section 504 of the Rehabilitation Act of 1973¹⁸ and, where applicable, section 1557 of the Affordable Care Act,¹⁹ as well as compliance with race, color, and national origin protections under title VI of the Civil Rights Act of 1964²⁰ and section 1557 of the Affordable Care Act. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex (including sexual orientation and gender identity), age, or disability in covered health programs or activities, including requiring covered entities to take reasonable steps to ensure meaningful access for individuals with limited English proficiency.

On January 20, 2021, President Biden issued Executive Order 13985, "On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government,"²¹ directing that as a policy matter, the federal government should pursue a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Executive Order 13985 also directs HHS to assess whether, and to what extent, its programs and policies

Ethnic Health Disparities 5, 117–140 (2018). <https://doi.org/10.1007/s40615-017-0350-4>.

¹⁶ Pérez-Stable EJ, El-Toukhy S. Communicating with diverse patients: How patient and clinician factors affect disparities. *Patient Educ Couns*. 2018;101(12):2186–2194. doi:10.1016/j.pec.2018.08.021; McNally, M. Confronting disparities in access to healthcare for underserved populations. MedCity News (February 22, 2021). <https://medcitynews.com/2021/02/confronting-disparities-in-access-to-healthcare-for-underserved-populations-in-2021/>.

¹⁷ 42 U.S.C. 12101 et seq.

¹⁸ 29 U.S.C. 794 and 794d.

¹⁹ 42 U.S.C. 18116(a).

²⁰ 42 U.S.C. 2000d.

²¹ 86 FR 7009 (Jan. 25, 2021).

perpetuate systemic barriers to opportunities and benefits for people of color and other underserved groups. Consistent with Executive Order 13985, regulations issued pursuant to the No Surprises Act must ensure that communication from plans, issuers, providers, facilities, and providers of air ambulance services recognizes these inequities and upholds all relevant consumer protections. Regulations issued pursuant to the No Surprises Act should ensure that all individuals, particularly those from underserved and minority communities, trust and believe information they receive related to costs and network coverage. Regulations and policies should enable and encourage regulated entities to address barriers to accessing care, including mistrust of the health care system. They should also encourage entities to communicate with individuals in a language they can understand, in a respectful way that addresses cultural differences, and at an appropriate literacy level. To ensure all consumers, particularly those in minority and underserved communities, are able to understand and benefit from these consumer protections, deliberate attention must be paid to the unique barriers and challenges underserved communities face in understanding and accessing health care. The Departments seek comment from those who are members of, advocate for, and work with underserved communities regarding the impact of these interim final rules.

C. Preventing Surprise Medical Bills Under the Consolidated Appropriations Act, 2021

On December 27, 2020, the Consolidated Appropriations Act, 2021 (CAA), which included the No Surprises Act, was signed into law. The No Surprises Act provides federal protections against surprise billing and limits out-of-network cost sharing under many of the circumstances in which surprise bills arise most frequently.²²

The CAA added provisions that apply to group health plans and health insurance issuers in the group and individual market in a new Part D of title XXVII of the PHS Act, and also added new provisions to part 7 of ERISA, and subchapter B of chapter 100 of the Code. Section 102 of the No Surprises Act added section 9816 of the Code, section 716 of ERISA, and section 2799A–1 of the PHS Act, which contain limitations on cost sharing, and requirements for initial payments for emergency services and for non-emergency services provided by

²² Public Law 116–260.

nonparticipating providers at certain participating health care facilities. Section 103 of the No Surprises Act amended section 9816 of the Code, section 716 of ERISA, and section 2799A–1 of the PHS Act to establish an independent dispute resolution (IDR) process that allows plans and issuers and nonparticipating providers and nonparticipating emergency facilities to resolve disputes over out-of-network rates. Section 105 of the No Surprises Act added section 9817 of the Code, section 717 of ERISA, and section 2799A–2 of the PHS Act, which contain limitations on cost sharing and requirements for initial payments to nonparticipating providers of air ambulance services, and allow plans and issuers and such providers of air ambulance services to access the IDR process. The CAA also amended the FEHBA, as discussed in more detail in section I.D. of this preamble.

The CAA provisions that apply to health care providers and facilities and providers of air ambulance services, such as cost-sharing requirements, prohibitions on balance billing for certain items and services, and requirements related to disclosures about balance billing protections, were added to title XXVII of the PHS Act in a new part E.

The Departments are issuing regulations in several phases implementing provisions of title I (No Surprises Act) and title II (Transparency) of Division BB of the CAA. Later this year, the Departments intend to issue regulations regarding the federal IDR process (sections 103 and 105 of Division BB), patient protections through transparency and the patient-provider dispute resolution process (section 112), and price comparison tools (section 114). The Departments also intend to undertake rulemaking this year to propose the form and manner in which plans, issuers, and providers of air ambulance services would report information regarding air ambulance services (section 106). In addition, HHS intends to undertake rulemaking to implement requirements on health insurance issuers offering individual health insurance coverage or short-term, limited-duration insurance to disclose and report information regarding direct or indirect compensation provided to agents and brokers (section 202(c)), as well as provisions related to HHS enforcement of requirements on issuers, non-federal governmental group health plans, providers, facilities, and providers of air ambulance services.

The CAA also includes provisions regarding transparency in plan and insurance identification cards (section

107), continuity of care (section 113), accuracy of provider network directories (section 116), and prohibition on gag clauses (section 201) that are applicable for plan years beginning on or after January 1, 2022; and pharmacy benefit and drug cost reporting (section 204) that is required by December 27, 2021. The Departments intend to undertake rulemaking to fully implement these provisions, but rulemaking regarding some of these provisions might not occur until after January 1, 2022. The Departments note that any such rulemaking to fully implement these provisions will include a prospective applicability date that provides plans, issuers, providers, and facilities, as applicable, a reasonable amount of time to comply with new or clarified requirements. Until rulemaking to fully implement these provisions is finalized and effective, plans and issuers are expected to implement the requirements using a good faith, reasonable interpretation of the statute. The Departments intend to issue guidance in the near future regarding their expectations related to good faith compliance with these provisions.

D. Preventing Surprise Medical Bills for Federal Employees Health Benefits Plans

The No Surprises Act also amended the FEHBA, 5 U.S.C. 8901 *et seq.*, by adding a new subsection (p) to 5 U.S.C. 8902. Under this new provision, each FEHB Program contract must require a carrier to comply with provisions of sections 9816, 9817, and 9822 of the Code; sections 716, 717, and 722 of ERISA; and sections 2799A–1, 2799A–2, and 2799A–7 of the PHS Act (as applicable) in the same manner as they apply with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage. Likewise, the provisions of sections 2799B–1, 2799B–2, 2799B–3, and 2799B–5 of the PHS Act apply to health care providers, facilities, and providers of air ambulance services with respect to covered individuals in FEHB plans in the same manner as they apply to participants, beneficiaries, or enrollees in group health plans or coverage offered by health insurance issuers.

OPM is charged with administering the FEHB Program and maintains oversight and enforcement authority with respect to FEHB health benefits plans, which are federal governmental plans. Generally, under 5 U.S.C. 8902(p), each FEHB contract must require a carrier to comply with certain PHS Act, ERISA, and Code requirements in the same manner as they apply to a

group health plan or health insurance issuer.

II. Executive Summary

These interim final rules implement provisions of the No Surprises Act that: (1) Apply to group health plans, health insurance issuers offering group or individual health insurance coverage, and carriers in the FEHB Program to provide protections against balance billing and out-of-network cost sharing with respect to emergency services, non-emergency services furnished by nonparticipating providers at certain participating health care facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services; (2) prohibit nonparticipating providers, health care facilities, and providers of air ambulance services from balance billing participants, beneficiaries, and enrollees in certain situations, and permit these providers and facilities to balance bill individuals if certain notice and consent requirements in the No Surprises Act are satisfied; (3) require certain health care facilities and providers to provide disclosures of federal and state patient protections against balance billing; (4) recodify certain patient protections that initially appeared in the ACA and that the No Surprises Act applies to grandfathered plans; and (5) set forth complaints processes with respect to violations of the protections against balance billing and out-of-network cost sharing under the No Surprises Act.

These interim final rules protect individuals from surprise medical bills for emergency services, air ambulance services furnished by nonparticipating providers, and non-emergency services furnished by nonparticipating providers at participating facilities in certain circumstances. Among other requirements, these interim final rules require emergency services to be covered without any prior authorization, without regard to whether the health care provider furnishing the emergency services is a participating provider or a participating emergency facility with respect to the services, and without regard to any other term or condition of the plan or coverage other than the exclusion or coordination of benefits or a permitted affiliation or waiting period. Additionally, emergency services include certain services in an emergency department of a hospital or an independent freestanding emergency department, as well as post-stabilization services in certain instances.

With respect to emergency services, air ambulance services furnished by nonparticipating providers, and non-

emergency services furnished by nonparticipating providers at participating facilities, these interim final rules limit cost sharing for out-of-network services to in-network levels, require such cost sharing to count toward any in-network deductibles and out-of-pocket maximums, and prohibit balance billing, as required by the No Surprises Act.

These interim final rules specify that cost-sharing amounts for such services furnished by nonparticipating emergency facilities and nonparticipating providers at participating facilities must be calculated based on one of the following amounts: (1) An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act; (2) if there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law; or (3) if there is no such applicable All-Payer Model Agreement or specified state law, the lesser of the billed charge or the plan's or issuer's median contracted rate, referred to as the qualifying payment amount (QPA). Cost-sharing amounts for air ambulance services provided by nonparticipating providers must be calculated using the lesser of the billed charge or the QPA, and the cost-sharing requirement that would apply if such services were provided by a participating provider.

Under these interim final rules, balance billing for services covered by the rules generally is prohibited, and the total amount to be paid to the provider or facility, including any cost sharing, is based on: (1) An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act; (2) if there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law; (3) if there is no such applicable All-Payer Model Agreement or specified state law, an amount agreed upon by the plan or issuer and the provider or facility; or (4) if none of those three conditions apply, an amount determined by an IDR entity.

In general, under the No Surprises Act and these interim final rules, the protections that limit cost sharing and prohibit balance billing do not apply to certain post-stabilization services, or to certain non-emergency services performed by nonparticipating providers at participating health care facilities, if the provider or facility provides notice to the participant, beneficiary, or enrollee, and obtains the individual's consent to waive the balance billing protections. However, providers and facilities may not provide

such notice or seek consent from individuals in certain circumstances where surprise bills are likely to occur, such as for ancillary services provided by nonparticipating providers in connection with non-emergency care in a participating facility. In such circumstances, balance billing is prohibited, and the other protections of the No Surprises Act, such as in-network cost-sharing requirements, continue to apply.

Neither the No Surprises Act, nor these interim final rules, universally protect individuals from every high or unexpected medical bill. For example, an individual may be enrolled in a group health plan or health insurance coverage that provides little or no coverage for their particular health care condition or the items and services necessary to treat that condition. In addition, balance billing continues to be permitted, unless prohibited by state law or contract, in circumstances where these interim final rules do not apply, such as for non-emergency items or services provided at facilities that are not included within the definition of health care facility in these interim final rules. Nonetheless, the No Surprises Act and these interim final rules provide relief from some of the more common scenarios where a participant, beneficiary, or enrollee might otherwise be faced with high and unexpected medical costs.

These interim final rules establish a complaints process for receiving and resolving complaints related to these new balance billing protections.

These interim final rules also implement the requirement of the No Surprises Act that certain health care providers and facilities make publicly available, post on a public website, and provide a one-page notice to individuals regarding: (1) The requirements and prohibitions applicable to the provider or facility under sections 2799B-1 and 2799B-2 of the PHS Act and their implementing regulations; (2) any applicable state balance billing requirements; and (3) how to contact appropriate state and federal agencies if the individual believes the provider or facility has violated the requirements described in the notice.

Section 116 of the No Surprises Act also added section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, which include similar disclosure requirements applicable to plans and issuers. In general, under these provisions, plans and issuers must make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits for an item or

service with respect to which the requirements under section 9816 of the Code, section 716 of ERISA, and section 2799A-1 of the PHS Act apply, information on the requirements applied under these aforementioned sections, as applicable; on the requirements and prohibitions applied under sections 2799B-1 and 2799B-2 of the PHS Act; on other applicable state laws on out-of-network balance billing; and on contacting appropriate state and federal agencies in the case that an individual believes that such a provider or facility has violated the prohibition against balance billing. These disclosure requirements are applicable for plan years beginning on or after January 1, 2022. To reduce burden and facilitate compliance with these disclosure requirements, the Departments are concurrently issuing a model disclosure notice that health care providers, facilities, group health plans, and health insurance issuers may, but are not required to, use to satisfy the disclosure requirements regarding the balance billing protections. The Departments will consider use of the model notice in accordance with the accompanying instructions to be good faith compliance with the disclosure requirements of section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, if all other applicable requirements are met. In addition, HHS will consider use of the model notice in accordance with the accompanying instructions to be good faith compliance with the disclosure requirements of section 2799B-3 of the PHS Act and 45 CFR 149.430, if all other applicable PHS Act requirements are met. The Departments may address the requirements under section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, as added by the No Surprises Act, in more detail in future guidance or rulemaking. Until further guidance is issued, plans and issuers are expected to implement the requirements of section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act using a good faith, reasonable interpretation of the law. The Departments will take into account the statutory applicability date and the timeframe for implementation when determining good faith compliance with the law.

These interim final rules generally apply to group health plans and health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans) with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022, as

well as to health care providers and facilities, and providers of air ambulance services beginning on January 1, 2022.

In the OPM interim final rules included in this rulemaking, OPM adopts all provisions of the Departments' interim final rules that address the sections of the Code, ERISA, and the PHS Act that are referenced in 5 U.S.C. 8902(p). In the OPM interim final rules, OPM defines terms unique to the FEHB Program, adapts some of the Departments' rules as necessary to properly integrate with the existing FEHB Program regulatory and contractual structure, sets forth the circumstances in which OPM will enforce these rules against FEHB carriers, and sets forth the types of court actions involving the FEHB Program that may be brought against OPM with respect to the No Surprises Act.

In effectuating compliance with 5 U.S.C. 8902(p), FEHB contract terms that relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) supersede and preempt state law or local law, or any regulation issued thereunder, which relates to health insurance or plans.²³ OPM contracts with FEHB carriers may include terms that adopt state law as governing for a particular purpose.

III. Overview of the Interim Final Rules—Departments of HHS, Labor, and the Treasury

A. Definitions

The provisions of the Code, ERISA, and the PHS Act added by the No Surprises Act, as well as these interim final rules, include defined terms that are specific to the requirements and implementation of the law. Definitions of these key terms are described throughout this preamble. These terms help define the scope of the balance billing protections and how cost-sharing amounts and payment levels are determined.

The Departments note that these interim final rules define the term “physician or health care provider” to mean a physician or other health care provider who is acting within the scope of practice of that provider’s license or certification under applicable state law, but the definition specifically excludes providers of air ambulance services. The Departments recognize that, although the No Surprises Act does not define “provider,” it uses the term in a manner that includes providers of air ambulance services in some provisions. For

example, the No Surprises Act added section 2799B–4 of the PHS Act, which specifically includes providers of air ambulance services when referencing providers. However, certain other provisions in the No Surprises Act apply only to providers of air ambulance services, or apply to health care providers generally, but by their terms are inapplicable to providers of air ambulance services. As an example of the latter, the No Surprises Act added section 2799B–2 of the PHS Act, which generally prohibits balance billing by nonparticipating health care providers furnishing non-emergency services at participating health care facilities. Although this provision does not explicitly exclude providers of air ambulance services, providers of air ambulance services would not furnish non-emergency services at participating health care facilities. Therefore, the provision does not apply to providers of air ambulance services (such providers are, however, prohibited from balance billing under section 2799B–5 of the PHS Act). Similarly, section 2799B–3 of the PHS Act, which requires a health care provider to inform individuals of the requirements and prohibitions on such health care provider in sections 2799B–1 and 2799B–2 of the PHS Act (neither of which apply to providers of air ambulance services), does not by its terms apply to providers of air ambulance services. Therefore, these interim final rules define “physician or health care provider” to exclude providers of air ambulance services, in order to help clarify which provisions of the No Surprises Act and interim final rules apply to providers of air ambulance services. In instances where provisions under the No Surprises Act, as implemented in these interim final rules, apply to providers of air ambulance services, the provisions explicitly reference air ambulance providers. Conversely, where providers of air ambulance services are not explicitly mentioned, the provisions do not apply.

The Departments seek comment on the terms defined in these interim final rules, including the appropriateness and usability of the definitions, and whether additional terms should be defined in future rulemaking.

B. Preventing Surprise Medical Bills

1. Scope of the New Surprise Billing Protections

i. Emergency Services

Under section 9816(a) of the Code, section 716(a) of ERISA, and section 2799A–1(a) of the PHS Act, and these interim final rules, if a group health

plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department, the plan or issuer must cover emergency services as defined in these interim final rules and such coverage must be provided in accordance with these interim final rules.

A plan or issuer providing coverage of emergency services must do so without the individual or the health care provider having to obtain prior authorization (including when the emergency services are provided out-of-network) and without regard to whether the health care provider furnishing the emergency services is a participating provider or a participating emergency facility with respect to the services. The emergency services must be provided without regard to any other term or condition of the plan or coverage other than the exclusion or coordination of benefits (to the extent not inconsistent with benefits for an emergency medical condition as defined in these interim final rules), an affiliation or waiting period as permitted under the Code, ERISA, or the PHS Act, or applicable cost-sharing requirements. For a plan or health insurance coverage with a network of providers that provides benefits for emergency services, the plan or issuer may not impose any administrative requirement or limitation on coverage for emergency services received from nonparticipating providers or nonparticipating emergency facilities that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers or participating emergency facilities. In addition, such plan or health insurance coverage must comply with the requirements regarding cost sharing, payment amounts, and processes for resolving billing disputes described elsewhere in this preamble.

The terms “emergency medical condition,” “emergency services,” and “to stabilize” generally have the meaning given to them under the Emergency Medical Treatment and Labor Act (EMTALA), section 1867 of the Social Security Act.²⁴ Emergency services include: (1) An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including ancillary services

²³ 5 U.S.C. 8902(m)(1); see *Coventry Health Care of Missouri, Inc. v. Nevils*, 137 S. Ct. 1190 (2017).

²⁴ 42 U.S.C. 1395dd.

routinely available to the emergency department, to evaluate whether an emergency medical condition exists; and (2) such further medical examination and treatment as may be required to stabilize the individual (regardless of the department of the hospital in which the further medical examination and treatment is furnished) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department.

Under section 2719A of the PHS Act, emergency services were defined to include: (1) A medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (2) such further medical examination and treatment as are required under section 1867 of the Social Security Act to stabilize the patient within the capabilities of the staff and facilities available at the hospital. HHS has previously interpreted the obligations on hospitals under EMTALA to provide medical examination and stabilization services to end when a patient is formally admitted in good faith.²⁵ Section 9816(a) of the Code, section 716(a) of ERISA, and section 2799A–1(a) of the PHS Act expand the definition of emergency services (as compared to section 2719A of the PHS Act) to include stabilization services “regardless of the department of the hospital in which the further medical examination and treatment is furnished.” Therefore, the definition of emergency services in these interim final rules includes pre-stabilization services that are provided after the patient is moved out of the emergency department and admitted to a hospital, and these services will be subject to the protections of the No Surprises Act.

Section 102 of the No Surprises Act further broadens the definition of emergency services to include emergency services provided at an independent freestanding emergency department. An independent freestanding emergency department is a health care facility (not limited to those described in the definition of health care facility at section 9816(b)(2)(A)(ii) of the Code, section 716(b)(2)(A)(ii) of ERISA, and section 2799A–1(b)(2)(A)(ii) of the PHS Act, as applicable) that provides emergency services, and is geographically separate and distinct

from a hospital, and separately licensed as such by a state. The definition of “independent freestanding emergency department” is intended to include any health care facility that is geographically separate and distinct from a hospital, and that is licensed by a state to provide emergency services, even if the facility is not licensed under the term “independent freestanding emergency department.”

Regulation of health care facilities varies by state. In particular, state regulation of urgent care centers varies significantly, and is evolving as these types of centers become more common.²⁶ If under state licensure laws, urgent care centers are permitted to provide emergency services, then urgent care centers in that state that are geographically separate and distinct from a hospital would fall within the definition of independent freestanding emergency department for purposes of these interim final rules. In contrast, if state licensure of urgent care centers does not permit such facilities to provide emergency services as defined in these interim final rules, then urgent care centers in that state would not be treated as independent freestanding emergency departments for purposes of these interim final rules. Finally, the definition of emergency services also includes additional post-stabilization services, as discussed in section III.B.1.ii of this preamble.

The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in EMTALA, including (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.²⁷ This definition includes mental health conditions and substance use disorders.

The Departments are aware that some plans and issuers currently deny coverage of certain services provided in the emergency department of a hospital

by determining whether an episode of care involves an emergency medical condition based solely on final diagnosis codes, such as International Classification of Diseases, Tenth Revision, Clinical Modification (ICD–10–CM) codes. In addition, some plans and issuers might automatically deny coverage based on a list of final diagnosis codes initially, without regard to the individual’s presenting symptoms or any additional review. Following an initial denial, plans and issuers might then provide for complete consideration of the claim, and apply the prudent layperson standard, only as part of an appeals process if the participant, beneficiary, or enrollee appeals. These practices are inconsistent with the emergency services requirements of the No Surprises Act and the ACA.²⁸ This is true even if the process for complete consideration of the claim following an initial denial is not designated as a formal appeal. Instead, the determination of whether the prudent layperson standard is met must be made on a case-by-case basis before an initial denial of an emergency services claim.

These interim final rules make clear that if a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department, the plan or issuer must cover emergency services without limiting what constitutes an emergency medical condition (as defined in these interim final rules) solely on the basis of diagnosis codes. When a plan or issuer denies coverage, in whole or in part, for a claim for payment of a service rendered in the emergency department of a hospital or independent freestanding emergency department, including services rendered during observation or surgical services, the determination of whether the prudent layperson standard has been met must be based on all pertinent documentation and be focused on the presenting symptoms (and not solely on the final diagnosis). This determination must take into account that the legal standard

²⁵ 42 CFR 489.24(a)(1)(ii); 68 FR 53221–53264 (Sept. 9, 2003); 73 FR 48654–48668 (Aug. 19, 2008).

²⁶ Association of State and Territorial Health Officials. As Urgent Care Centers Increase, Licensing Authority Falling Under State Health Agencies, (Oct. 11, 2018) available at <https://www.astho.org/StatePublicHealth/As-Urgent-Care-Centers-Increase-Licensing-Authority-Falling-Under-State-Health-Agencies/10-11-18/>.

²⁷ See 42 U.S.C. 1395dd(e)(1)(A).

²⁸ See also *Am. Coll. of Emergency Physicians v. Blue Cross & Blue Shield of Georgia*, No. 20–11511, 2020 WL 6165852 (11th Cir. Oct. 22, 2020) (per curiam) (reversing dismissal of plaintiffs’ ACA and ERISA claims alleging defendants violated prudent layperson standard where review process was based upon physician review of medical records and diagnostic codes; prudent layperson standard ignores a patient’s final diagnosis and instead asks whether a person with average medical knowledge would reasonably think they need emergency services to address their symptoms).

regarding the decision to seek emergency services is based on whether a prudent layperson (rather than a medical professional) would reasonably consider the situation to be an emergency.²⁹ In covering emergency services, plans and issuers must also ensure that they do not restrict the coverage of emergency services by imposing a time limit between the onset of symptoms and the presentation of the participant, beneficiary, or enrollee at the emergency department. Similarly, plans and issuers also may not restrict the coverage of emergency services because the patient did not experience a sudden onset of the condition.

The Departments are also aware that some plans and issuers that generally provide coverage for emergency services have nonetheless denied benefits for such services based on other general plan exclusions. For example, the Departments are aware of some plans and issuers denying claims for emergency services provided to dependent women who are pregnant, based on a general plan exclusion for dependent maternity care. As explained previously, both the coverage of emergency services rules issued under section 2719A of the PHS Act and the new emergency services requirements included in these interim final rules provide, in part, that if a plan or issuer provides or covers any benefits with respect to services in an emergency department of a hospital (or under these interim final rules, in an independent freestanding emergency department), emergency services must be provided “without regard to any other term or condition of the plan or coverage (other than the exclusion or coordination of benefits . . .).” The Departments clarify that this provision does not permit plans and issuers to exclude benefits for items and services that would otherwise constitute benefits for an emergency medical condition as defined under these interim final rules. This provision does not permit plans and issuers that cover emergency services to deny benefits for a participant, beneficiary, or enrollee with an emergency medical condition that receives emergency services, based on a general plan exclusion that would apply to items and services other than emergency services.

ii. Post-Stabilization Services

Under section 9816(a)(3)(C)(ii) of the Code, section 716(a)(3)(C)(ii) of ERISA, and section 2799A–1(a)(3)(C)(ii) of the PHS Act, emergency services include any additional items and services that are covered under a plan or coverage and furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items and services are furnished) after a participant, beneficiary, or enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the other emergency services are furnished. Such additional items and services (referred to in this preamble as post-stabilization services) are considered emergency services subject to surprise billing protections unless the conditions enumerated in section 9816(a)(3)(C)(ii)(II)(aa)–(cc) of the Code, section 716(a)(3)(C)(ii)(II)(aa)–(cc) of ERISA, or section 2799A–1(a)(3)(C)(ii)(II)(aa)–(cc) of the PHS Act, as applicable, are met, as well as such other conditions as specified by the Departments under paragraph (dd) of the respective sections. Therefore, these interim final rules provide that post-stabilization services are emergency services unless all of the following conditions are met.

First, the attending emergency physician or treating provider must determine that the participant, beneficiary, or enrollee is able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into consideration the individual’s medical condition. The HHS interim final rules codify this requirement at 45 CFR 149.410(b)(1). For this purpose, a treating provider is a physician or health care provider who has evaluated the individual. It is generally expected that a treating provider with medical training and experience related to the individual’s specific medical condition will determine if the individual is able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance. This determination is based on all the relevant facts and circumstances and the individual should be involved in the decision-making process, if possible. The determination by the attending emergency physician or treating provider is binding on the facility for purposes of this requirement. This

requirement is based on the Departments’ understanding that such provider is in the best position to make this determination.

For individuals receiving care in or near their plan’s or issuer’s covered service area, as well as individuals with coverage that uses a national network of providers and facilities, the statutory criterion would generally be sufficient to ensure that an individual can freely choose, based on their medical condition, to receive post-stabilization services at a participating facility or participating provider. The additional requirement in these interim final rules that the individual be able to travel to an available participating provider or facility located within a reasonable travel distance, taking into consideration the individual’s medical condition, is necessary and appropriate to carry out the provision of the No Surprises Act, as the requirement is intended to address the common situations in which an individual has received emergency services in a geographic region far from where any participating providers or facilities are located. In cases where the individual cannot travel using nonmedical transportation or nonemergency medical transportation, or cases where there are no participating facilities or participating providers located within a reasonable travel distance, taking into account the individual’s medical condition, the Departments are of the view that individuals are unable to provide consent freely and, therefore, balance billing protections continue to apply.

In addition, the Departments recognize that an individual’s transportation options may vary based on the individual’s location, social risk, and other risk factors. In cases of underserved and geographically isolated communities and those with social risk factors related to income and transportation options, individuals may face additional barriers to obtaining post-stabilization services without a disruption in care. For example, individuals may not have the ability to pay for a taxi, may not have access to a car, may not be able to safely take public transit due to their medical condition, or may not have public transit options available. In these cases, the net effect would be the same: The individual would face unreasonable travel burdens that could prevent them from being able to consent freely to a waiver of the otherwise applicable balance billing protections. The Departments expect the attending emergency physician or treating provider to consider such factors when

²⁹ However, nothing in the statute or these interim final rules prevents a plan or issuer from approving coverage for emergency services solely on the basis of diagnosis codes, or from taking diagnostic codes into account when deciding payment for a claim for emergency services, provided a denial of coverage is not based solely on diagnosis codes.

assessing the individual's ability to travel to a participating provider or facility. The Departments seek comment on the definition of "reasonable travel distance" and whether specific standards or examples should be provided regarding what constitutes an unreasonable travel burden. For example, should reasonable travel distance take into account only mileage, or also other factors, such as traffic or other route conditions that might make traveling difficult, time consuming, or hazardous?

In contrast to situations where a participant, beneficiary, or enrollee is able to travel using nonmedical transportation or nonemergency medical transportation following stabilization, in the event that the individual requires medical transportation to travel, including transportation by either ground or air ambulance vehicle, the individual is not in a condition to receive notice or provide consent. Therefore, the surprise billing protections continue to apply to post-stabilization services provided in connection with the visit for which the individual received emergency services.

Second, the provider or facility furnishing post-stabilization services must satisfy the notice and consent criteria of section 2799B–2(d) of the PHS Act with respect to such items and services (which are implemented in HHS-only interim final rules at 45 CFR 149.410(b)(2), and incorporate by reference the criteria for notice and consent in 45 CFR 149.420(c) through (g)).

Third, the individual (or the individual's authorized representative) must be in a condition to receive the information in the notice described in section 2799B–2 of the PHS Act (which is also implemented in 45 CFR 149.410(b)(3)) and to provide informed consent under such section, in accordance with applicable state law. Whether an individual is in a condition to receive the information in the notice is determined by the attending physician or treating provider using appropriate medical judgment. It is generally expected that an attending physician or treating provider with medical training and experience related to the individual's specific medical condition will make this determination based on all the relevant facts and circumstances. In addition to applying any requirements under state law, such medical professionals should apply the same principles as they would when determining if a patient is able to provide informed consent for

treatment.³⁰ They should assess whether an individual is capable of understanding the information provided in the notice and the implications of consenting. Consideration must be given to the individual's state of mind after receiving the emergency services and the individual's emotional state at the time of consent. For example, consideration must be given to the effect of any alcohol or drug use by the individual, including the use or administration of prescribed medications, as well as to any pain the individual is experiencing, and the impact of those factors on the patient's state of mind. If the individual is experiencing a mental or behavioral health episode or displaying symptoms of a mental or behavioral health disorder, or is impaired by a substance abuse disorder, consideration should also be given as to whether the individual's condition impairs their ability to receive the information in the notice and provide informed consent. In addition, consideration must be given to cultural and contextual factors that may affect the informed decision-making and consent process for members of underserved communities, including lack of trust arising from historical inequities, misinformation about the informed consent process, or barriers to comprehension of the information given through the informed consent process and after the informed consent document is signed.³¹ These barriers may include accessibility, language, and literacy barriers. In addition, the informed consent must be obtained in a way that adheres to all civil rights protections cited within this rulemaking, ensuring that all individuals including those from underserved, underrepresented communities, with limited English proficiency, and with disabilities, are

able to understand and freely make informed decisions.

Consent must be made voluntarily, meaning the individual must be able to consent freely, without undue influence, fraud, or duress. If post-stabilization services must be provided quickly after the emergency services are provided, it may be challenging for the individual or their authorized representative to have adequate time to make a clear-minded decision regarding consent. Consent obtained through a threat of restraint or immediacy of the need for treatment is not voluntary. In addition, the emergency physician or treating provider should consider whether the individual has reasonable options regarding post-stabilization services, transport, or service provider or facility. The Departments are of the view that the post-stabilization notice and consent procedures should generally be applied in limited circumstances, where the individual knowingly and purposefully seeks care from a nonparticipating provider or facility (such as deciding to go under the care of a specific provider or facility that the individual is familiar or comfortable with), and that the process should not be permitted to circumvent the consumer protections in the No Surprises Act.

Fourth, the provider or facility must satisfy any additional requirements or prohibitions as may be imposed under applicable state law. These interim final rules include this criterion recognizing that some state laws do not permit exceptions to state balance billing protections, such as allowing individuals to consent to waive protections. Thus, states may impose stricter standards by which post-stabilization services will be exempted from the surprise billing protections under these interim final rules, or states might not permit exceptions at all. This requirement is codified in the HHS interim final rules at 45 CFR 149.410(b)(5).

The No Surprises Act authorizes the Departments to specify other conditions that must be satisfied for post-stabilization services to be excepted from the definition of emergency services for purposes of the No Surprises Act. The Departments solicit comments on the conditions described earlier in this section. The Departments also seek comment on whether there are any additional conditions that would be appropriate to designate under the definition of emergency services, such as conditions relating to coordinating care transitions to participating providers and facilities. The Departments also solicit comments on

³⁰ Ethics guidance for physicians, published by the American Medical Association, states that physicians should "[a]ssess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision" as part of the process of seeking informed consent. American Medical Association, Code of Medical Ethics Opinion 2.1.1, available at <https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-2.pdf> (last visited April 5, 2021). See also Gostin, LO. Public Health Law, 217–218 (2000) (discussing the four elements of the doctrine of informed consent: Information, competency, voluntariness, and specificity).

³¹ For a discussion of strategies to improve informed consent processes for minority communities, see Quinn, S.C., et al. Improving Informed Consent with Minority Participants: Results from Researcher and Community Surveys, *Journal of Empirical Research on Human Research Ethics*, 7(5): 44–55 (Dec. 2012).

what guidelines, beyond state laws regarding informed consent, may be needed to determine when an individual is in a condition to receive the written notice and provide consent. For example, are standards needed to account for individuals who are experiencing severe pain, intoxication, incapacitation, or dementia after being stabilized following an emergency medical condition?

iii. Non-Emergency Services Performed by Nonparticipating Providers at Participating Health Care Facilities

Section 9816(b) of the Code, section 716(b) of ERISA, section 2799A-1(b) of the PHS Act, and these interim final rules, apply surprise billing protections in the case of non-emergency services furnished by nonparticipating providers during a visit by a participant, beneficiary, or enrollee at a participating health care facility, unless the notice and consent requirements, as specified in these interim final rules, have been met.

Specifically, if a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers benefits with respect to items and services (other than emergency services to which section 9816(a) of the Code, section 716(a) of ERISA, or section 2799A-1(a) of the PHS Act applies), the plan or issuer must cover such items and services furnished to a participant, beneficiary, or enrollee of the plan or coverage by a nonparticipating provider with respect to a visit at a participating health care facility in accordance with these interim final rules, including the requirements regarding cost sharing, payment amounts, and processes for resolving billing disputes described elsewhere in this preamble.

iv. Health Care Facilities

These interim final rules, consistent with section 9816(b)(2)(A) of the Code, section 716(b)(2)(A) of ERISA, and section 2799A-1(b)(2)(A) of the PHS Act, define a participating health care facility, in the context of non-emergency services, as a health care facility that has a contractual relationship directly or indirectly with a group health plan or health insurance issuer offering group or individual health insurance coverage setting forth the terms and conditions on which a relevant item or service is provided to a participant, beneficiary, or enrollee under the plan or coverage, respectively. These interim final rules also specify that a single case agreement between a health care facility and a plan or issuer, used to address unique situations in which a participant,

beneficiary, or enrollee requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement with respect to the particular individual involved. Thus, when non-emergency services are furnished by a nonparticipating provider at a health care facility that has a single case agreement in place with respect to the individual being treated, as opposed to an agreement or contract that would apply to all the plan's or issuer's participants, beneficiaries, or enrollees, those non-emergency services would be subject to the protections described in 26 CFR 54.9816-5T, 29 CFR 2590.716-5, and 45 CFR 149.120, as applicable, and the corresponding requirements on providers at 45 CFR 149.420. The Departments are of the view that it is reasonable that an individual would expect items and services delivered at a health care facility that has a single case agreement in place with respect to the individual's care to be delivered on an in-network basis. Thus, these interim final rules apply the same protections in this circumstance as would apply at health care facilities that participate in the plan or issuer's network.³² The facility is considered a participating facility only with respect to items and services furnished to the individual whose care is covered by the single case agreement. Similarly, these interim final rules define a participating emergency facility to include a facility that has a single case agreement in place with a plan or issuer with respect to a specific individual's care. The Departments seek comment on this approach.

For this purpose, a health care facility described in the statute is each of the following, in the context of non-emergency services: (1) A hospital (as defined in 1861(e) of the Social Security Act); (2) a hospital outpatient department; (3) a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); or (4) an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

In addition, section 9816(b)(2)(A)(ii)(V) of the Code, section 716(b)(2)(A)(ii)(V) of ERISA, and section 2799A-1(b)(2)(A)(ii)(V) of the PHS Act authorize the Departments to designate additional facilities as health care facilities. The Departments solicit comments on other facilities that would be appropriate to designate as health

care facilities. The Departments are interested in comments identifying types of facilities in which surprise bills frequently arise, and are particularly interested in comments regarding whether urgent care centers or retail clinics should be designated as health care facilities for purposes of these interim final rules.

The Departments recognize that state regulation of urgent care centers varies significantly, as does the type of services they are permitted to provide under state law. Under these interim final rules, emergency services provided at urgent care centers that are licensed in a manner that brings them within the definition of independent freestanding emergency department would be subject to cost-sharing and balance billing protections, among others. However, given significant variation in state law definitions, urgent care centers are not included within the definition of health care facilities, in the context of non-emergency services. Thus, in cases where non-emergency services are furnished at participating urgent care centers by nonparticipating providers, those services would not receive the protections under these interim final rules. However, the Departments are of the view that it is possible that individuals may be using urgent care centers (regardless of how they are licensed) in a similar way to how they use independent freestanding emergency departments, in which case it may be appropriate to designate urgent care centers as health care facilities. The Departments seek comment on the degree to which individuals may be using urgent care centers in a similar way to how they use independent freestanding emergency departments. The Departments seek data on how frequently surprise bills arise in the context of urgent care centers. The Departments also seek comment on whether plans and issuers generally contract separately with urgent care centers and the providers who work at the centers, and how frequently contracting practices result in nonparticipating providers furnishing services at participating urgent care centers. The Departments also seek comment on potential definitions of the term urgent care center.

v. Items and Services Within the Scope of a Visit

In addition to items and services furnished by a provider at the facility, a "visit" to a participating health care facility includes the furnishing of equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and

³² In contrast, as discussed in section III.B.2.vi of this preamble, these interim final rules do not include negotiated rates under single-case agreements in the methodology for calculating the qualifying payment amount.

postoperative services, regardless of whether the provider furnishing such items or services is at the facility. These services are not limited based on whether the provider furnishing the services is physically located at the facility. For example, if a sample is collected during an individual's hospital visit and sent to an off-site laboratory, the laboratory services would be considered to be part of the individual's visit to a participating health care facility, if laboratory services are covered by the plan or coverage. Similarly, if an individual receives a consultation with a specialist via telemedicine during a visit to a participating hospital, those telemedicine services would be considered part of the individual's visit to a participating health care facility. The statutory definition of "visit" also provides authority for the Departments to specify other items and services. The Departments solicit comments regarding other items and services that would be appropriate to include within the scope of a visit for purposes of these interim final rules.

The No Surprises Act and these interim final rules provide for exceptions to the balance billing prohibitions and cost-sharing requirements if the participant, beneficiary, or enrollee is provided a compliant written notice and consents to receive such services from a nonparticipating provider at a participating health care facility. However, these exceptions do not apply with respect to certain ancillary services (in the context of non-emergency services) and other services under certain conditions, as discussed later in this preamble.

vi. Air Ambulance Services

Section 105 of the No Surprises Act added section 9817 of the Code, section 717 of ERISA, and section 2799A-2 of the PHS Act to address surprise air ambulance bills. These provisions apply in the case of a participant, beneficiary, or enrollee who receives services from a nonparticipating provider of air ambulance services, meaning medical transport by a rotary-wing air ambulance, as defined in 42 CFR 414.605, or fixed-wing air ambulance, as defined in 42 CFR 414.605. These interim final rules apply these provisions where a plan or coverage generally has a network of participating providers and provides or covers any benefits for air ambulance services, even if the plan or coverage does not have in its network any providers of air ambulance services. With respect to air ambulance services furnished by

nonparticipating providers (including inter-facility transports), plans and issuers must comply with the requirements regarding cost sharing, payment amounts, and processes for resolving billing disputes described elsewhere in this preamble, if such services would be covered if provided by a participating provider with respect to such plan or coverage.

2. Determination of the Cost-Sharing Amount and Payment Amount to Providers and Facilities

i. In General

Under section 9816(a) of the Code, section 716(a) of ERISA, section 2799A-1(a) of the PHS Act, and these interim final rules, if a plan or issuer provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department, the cost-sharing requirement for such services performed by a nonparticipating provider or nonparticipating emergency facility must not be greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility. Additionally, if a plan or issuer provides or covers any benefits for non-emergency items and services furnished by a nonparticipating provider with respect to a visit at a participating health care facility, unless the provider has satisfied certain notice and consent criteria with respect to such items and services, the plan or issuer may not impose a cost-sharing requirement for such items and services that is greater than the cost-sharing requirement that would apply had such items or services been furnished by a participating provider. Similarly, if a plan or issuer provides or covers benefits for air ambulance services, the plan or issuer must cover such services from a nonparticipating provider in such a manner that the cost-sharing requirement with respect to such services must be the same requirement that would apply if such services were provided by a participating provider. For example, if a plan or issuer imposes a 20 percent coinsurance rate for emergency services from participating providers or participating emergency facilities, the plan or issuer may not impose a coinsurance rate on emergency services from nonparticipating providers or facilities that exceeds 20 percent. Stakeholders have reported that network participation rates are low among providers of air ambulance services. In instances where a plan or issuer does not have an established cost-

sharing requirement that applies specifically to participating providers, the plan or issuer must calculate the cost-sharing amount using the generally applicable cost-sharing requirement for the relevant item or service under the plan or coverage.

Under sections 9816(a) and (b) and 9817(a) of the Code, sections 716(a) and (b) and 717(a) of ERISA, sections 2799A-1(a) and (b) and 2799A-2(a) of the PHS Act, and these interim final rules, any cost-sharing payments for emergency services, non-emergency services furnished by a nonparticipating provider in a participating health care facility, and air ambulance services furnished by a nonparticipating provider must be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage (including the annual limitation on cost sharing under section 2707(b) of the PHS Act) (as applicable), respectively (and these in-network deductibles and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to services furnished by a participating provider or facility.

ii. Cost-Sharing Amount

Section 9816(a)(1)(C)(iii) of the Code, section 716(a)(1)(C)(iii) of ERISA, section 2799A-1(a)(1)(C)(iii) of the PHS Act, and these interim final rules also specify that for emergency services furnished by a nonparticipating emergency facility, and for non-emergency services furnished by nonparticipating providers in a participating health care facility, cost sharing is generally calculated as if the total amount that would have been charged for the services by a participating emergency facility or participating provider were equal to the recognized amount for such services, as defined by the statute and in these interim final rules.

The "recognized amount" is: (1) An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act; (2) if there is no applicable All-Payer Model Agreement, an amount determined by a specified state law; or (3) if there is no applicable All-Payer Model Agreement or specified state law, the lesser of the amount billed by the provider or facility or the QPA, which under these interim final rules generally is the median of the contracted rates of the plan or issuer for the item or service in the geographic region.

By requiring plans and issuers to calculate the cost-sharing amount using the recognized amount, rather than the

amount the plan or issuer ultimately pays the nonparticipating provider or nonparticipating emergency facility for the furnished items or services, the No Surprises Act and these interim final rules limit the effect of provider-payer disputes about payment amounts on participant, beneficiary, or enrollee cost sharing. Under the statute and these interim final rules, the provider or facility and plan or issuer separately determine the total payment amount for the furnished items or services, but that amount generally does not affect the cost-sharing amount the individual must pay.

The Departments are aware that there may be some instances where a nonparticipating health care provider or facility might bill a plan or issuer for an item or service that is subject to these surprise billing protections in an amount less than the QPA. For example, this might be a relatively common occurrence for items whose patent expires after 2019, in instances where the QPA is based off the median of the contracted rates from 2019. In these instances, assuming the plan or issuer would not pay more than the billed charge, calculating cost sharing based on the QPA would require a participant, beneficiary, or enrollee to pay a higher percentage in cost sharing than if the items or services had been furnished by a participating provider. However, section 9816(a)(1)(C)(ii) of the Code, section 716(a)(1)(C)(ii) of ERISA, and section 2799A-1(a)(1)(C)(ii) of the PHS Act expressly prohibit plans and issuers from applying a cost-sharing requirement that is greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility. Therefore, under these interim final rules, in circumstances where a specified state law or All-Payer Model Agreement does not apply to determine the cost-sharing amount, cost sharing must be based on the lesser of the QPA or the amount billed by the provider for the item or service. The different methods for determining the recognized amount are discussed in separate sections of this section III.B.2 of this preamble.

With respect to air ambulance services furnished by nonparticipating providers, the recognized amount is not used for purposes of determining cost sharing. Rather, the statute specifies that the cost-sharing requirement with respect to such services must be the same requirement that would apply if such services were provided by a participating provider, and any coinsurance or deductible must be based on rates that would apply for such

services if they were furnished by a participating provider. These interim final rules require that plans and issuers base any coinsurance and deductible for air ambulance services provided by a nonparticipating provider on the lesser of the QPA or the billed amount. The Departments have concluded that this policy is consistent with the statute's general intent to protect participants, beneficiaries, and enrollees from excessive bills, and to remove the individuals as much as possible from disputes between plans and issuers and providers of air ambulance services. In addition, using the QPA is one method of ensuring that any coinsurance or deductible is based on rates that would apply for the services if they were furnished by a participating provider, given that the QPA is generally based on median contracted rates, as opposed to rates charged by nonparticipating providers, and is one basis used for determining the cost-sharing amount in the context of emergency services and items and services furnished by nonparticipating providers at participating health care facilities.

As discussed in this preamble, the Airline Deregulation Act of 1978 (ADA) broadly preempts state laws that relate to air ambulance providers, and the Departments are unaware of any instances in which an All-Payer Model Agreement or a specified state law might apply. In addition, since an All-Payer Model Agreement or a specified state law would not need to follow an approach based on rates that would apply for such services if they were furnished by a participating provider (for example, Medicare rates could be used instead), it is the Departments' view that Congress did not intend to apply the concept of the recognized amount to nonparticipating providers of air ambulance services. The Departments seek comment on any potential alternate approaches for calculating the cost-sharing amount for air ambulance services furnished by nonparticipating providers of air ambulance services.

iii. Out-of-Network Rate

In addition to establishing requirements related to cost sharing, the No Surprises Act and these interim final rules also establish requirements related to the total amount paid by a plan or issuer for items and services subject to these provisions, referred to as the out-of-network rate. The plan or issuer must make a total payment equal to one of the following amounts, less any cost sharing from the participant, beneficiary, or enrollee: (1) An amount determined by an applicable All-Payer Model

Agreement under section 1115A of the Social Security Act; (2) if there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law; (3) in the absence of an applicable All-Payer Model Agreement or specified state law, if the plan or issuer and the provider or facility have agreed on a payment amount, the agreed on amount; or (4) if none of those three conditions apply, and the parties enter into the IDR process and do not agree on a payment amount before the date when the IDR entity makes a determination of the amount, the amount determined by the IDR entity. These four approaches for determining the out-of-network rate are discussed more fully later in this preamble.

The requirements related to cost sharing and to the out-of-network rate apply when a group health plan or coverage provides or covers benefits for services subject to these provisions. The Departments interpret this to mean that the requirements apply when a plan or issuer provides coverage for such items and services, pursuant to the terms of the plan or coverage, even in cases where an individual has not satisfied their deductible.³³ Because the cost-sharing amount is calculated using the recognized amount (or for air ambulance services the lesser of the QPA or the billed amount) that is calculated separately from the determination of the out-of-network rate, these requirements may result in circumstances where a plan or issuer must make payment prior to an individual meeting their deductible. Specifically, where the surprise billing protections apply, and the out-of-network rate exceeds the amount upon which cost sharing is based, a plan or issuer must pay the provider or facility the difference between the out-of-network rate and the cost-sharing amount (the latter of which in this case would equal the recognized amount, or the lesser of the QPA or the billed amount), even in cases where an individual has not satisfied their deductible, as illustrated in the following example.

Example. An individual is enrolled in a high deductible health plan with a \$1,500 deductible and has not yet accumulated any costs towards the deductible at the time the individual receives emergency services at an out-of-network facility. The plan determines that the recognized amount for the services is \$1,000. Because the

³³ Absent the balance billing protections under the No Surprises Act and these interim final rules, the plan or issuer would not generally be expected to make a payment to the provider or facility prior to an individual satisfying the deductible.

individual has not satisfied the deductible, the individual's cost-sharing amount is \$1,000, which accumulates towards the deductible. The out-of-network rate is subsequently determined to be \$1,500. Under the requirements of the statute and these interim final rules, the plan is required to pay the difference between the out-of-network rate and the cost-sharing amount. Therefore, the plan pays \$500 for the emergency services, even though the individual has not satisfied the deductible. The individual's out-of-pocket costs are limited to the amount of cost-sharing originally calculated using the recognized amount (that is, \$1,000).

Although such a payment would generally cause a high deductible health plan to lose its status as a high deductible health plan, the No Surprises Act added section 223(c)(2)(F) to the Code to specify that a plan shall not fail to be treated as a high deductible health plan by reason of providing benefits for medical care in accordance with section 9816 or 9817 of the Code, section 716 or 717 of ERISA, or section 2799A–1 or 2799A–2 of the PHS Act (the provisions added by the No Surprises Act related to surprise medical and air ambulance bills), or any state law providing similar protections to individuals, prior to the satisfaction of the deductible.³⁴

iv. Specified State Law

Under section 9816(a)(3)(I) of the Code, section 716(a)(3)(I) of ERISA, section 2799A–1(a)(3)(I) of the PHS Act, and these interim final rules, a specified state law is a state law that provides a method for determining the total amount payable under a group health plan or group or individual health insurance coverage to the extent the state law applies. This includes instances where the Departments have interpreted this term to include state laws where the state law applies because the state has allowed a plan that is not otherwise subject to applicable state law an opportunity to opt in to a program established under state law, subject to section 514 of ERISA, for an item or service furnished by a nonparticipating provider or nonparticipating emergency facility. In cases where a specified state law applies, the recognized amount (the amount upon which cost sharing is based) and out-of-network rate for emergency and non-emergency services subject to the surprise billing

protections is calculated based on such specified state law.

In order for a state law to determine the recognized amount or out-of-network rate, any such law must apply to: (1) The plan, issuer, or coverage involved, including where a state law applies because the state has allowed a plan that is not otherwise subject to applicable state law an opportunity to opt in, subject to section 514 of ERISA; (2) the nonparticipating provider or nonparticipating emergency facility involved (and in the case of state out-of-network rate laws, the nonparticipating provider of air ambulance services involved); and (3) the item or service involved. In instances where a state law does not satisfy all of these criteria, the state law does not apply to determine the recognized amount or out-of-network rate. For example, where a particular state surprise billing law that governs the recognized amount and out-of-network rate applies to a particular plan or coverage but does not apply to nonparticipating neonatologists, who provide a specified ancillary service under section 2799B–2(b)(2) of the PHS Act, the consumer protections under federal law would determine the recognized amount and out-of-network rate with respect to neonatology services while the state law would apply with respect to other provider specialties covered under that state law. Similarly, where a state's surprise billing laws apply only to health maintenance organizations (HMOs), federal protections against surprise billing would govern with respect to other types of coverage while the state protections would apply to HMOs for purposes of determining the recognized amount and out-of-network rate.

The same definition of “out-of-network rate”—including the reference to specified state laws—applies to air ambulance services as to other services. The Departments note, however, that the ADA states in relevant part: “. . . a State, political subdivision of a State, or political authority of at least 2 States may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation under this subpart.”³⁵ Assuming that a provider of air ambulance services is an “air carrier” covered by this provision, as is typical,³⁶ the provision preempts

state laws that would limit the amount of payment that the provider of air ambulance services would otherwise be entitled to receive.³⁷ Given the applicability of the ADA, the Departments are not aware of any state laws that would meet the criteria to set the out-of-network rate for nonparticipating providers of air ambulance services when providing services subject to the protections in the No Surprises Act.

The Departments also seek comment on whether health insurance issuers, health care providers, or health care facilities, in instances where they are not otherwise subject to a specified state law that provides for a method for determining the total amount payable under a group health plan or group or individual health insurance coverage, should have an opportunity, for purposes of these interim final rules, to opt in to a program established under state law, with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility. The Departments seek comment on whether this approach would allow for more flexibility for state laws to apply when, for example, by their terms, they apply to the health insurance issuer and item and service in question, but not to the provider; whether an issuer, provider, or facility would still be subject to any specified state laws in their “home” state if they opt in to a program established under another state's law; and whether an issuer, provider, or facility should be permitted to opt in on an episodic basis. The Departments are concerned that allowing providers and facilities to opt in to a program established under state law could increase health care prices if providers and facilities selectively opt in to state programs that favor providers and facilities in the determination of the out-of-network rate. The Departments seek comment on the potential impact of expanding the ability to opt in to a state program to providers and facilities. The Departments specifically seek comment from health insurance issuers, health care providers, or health care facilities located within or serving

have such authority under the provisions of 14 CFR part 298. See, e.g., *Scarlett v. Air Methods Corp.*, 922 F.3d 1053 (10th Cir. 2019); *Air Evac EMS v. Cheatham*, 910 F.3d 751 (4th Cir. 2018).

³⁷ See, e.g., *Guardian Flight LLC v. Godfred*, 991 F.3d 916, 921 (8th Cir. 2021) (holding that ADA preempted state law prohibiting out-of-network air ambulance providers from balance billing and requiring them to accept amounts paid by insurers); *Bailey v. Rocky Mountain Holdings, LLC*, 889 F.3d 1259, 1269–72 (11th Cir. 2018) (holding that ADA preempted state law that prohibited air ambulance providers from collecting more than amount specified in fee schedule).

³⁴ See section IV.A.5 of this preamble for a discussion of HHS-only interim final rules addressing catastrophic plans' compliance with these requirements.

³⁵ 49 U.S.C. 41713(b).

³⁶ An air ambulance provider is a covered “air carrier” if it has economic authority from the Department of Transportation to provide interstate air transportation. Most air ambulance providers

underserved and rural communities, and other communities facing a shortage of providers on the impact of these provisions on services, coverage, and payment for and within medically underserved, rural, and urban communities.

a. State Law Interaction With ERISA

Under the general preemption clause of section 514(a) of ERISA, state laws are preempted to the extent that they “relate” to employee benefit plans subject to title I of ERISA. There are, however, a number of exceptions to this broad preemption provision. Section 514(b)(2)(A), referred to as the “savings clause,” provides in pertinent part that “nothing in this title (title I of ERISA) shall be construed to exempt or relieve any person from any law of any State which regulates insurance. . . .” Additionally, the preemption provisions of section 731 of ERISA (implemented in 29 CFR 2590.731(a)) apply so that the requirements of part 7 of ERISA are not to be “construed to supersede any provision of state law which establishes, implements, or continues in effect any standard or requirement solely relating to issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a ‘requirement’ of a federal standard.” The conference report accompanying the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which applied this preemption standard to state laws with respect to its title I health insurance reform provisions, indicates that this preemption is intended to be the “narrowest” preemption of states’ laws.³⁸ States may therefore continue to apply state law requirements to issuers except to the extent they prevent the application of ERISA requirements. Additionally, states have significant latitude to impose requirements on issuers that are more restrictive than the federal law. State laws that impose comparable or additional requirements on health insurance issuers would generally constitute a “specified state law” notwithstanding section 514 of ERISA and would continue to apply.

While section 514(b)(2)(A) saves from ERISA preemption state laws regulating insurance, section 514(b)(2)(B) of ERISA, referred to as the “deemer clause,” provides that a state law “purporting to regulate insurance” generally cannot deem an employee benefit plan to be an insurance company

(or in the business of insurance) for the purpose of regulating such a plan as an insurance company (section 514(b)(6)(A) creates a partial exception to the deemer clause for employee welfare benefit plans that are also multiple employer welfare arrangements (MEWAs)). Thus, to the extent that a state law has a “reference to” or an impermissible connection with ERISA plans (such as laws that govern the payment of benefits), these laws are preempted, to the extent they apply to self-insured plans sponsored by private employers.³⁹ However, section 514 of ERISA does not prevent states from expanding access to a state program and allowing self-insured, ERISA-covered plans to choose to voluntarily comply with it. For example, the Departments allowed such plans to comply with their obligations for external review under section 2719 of the PHS Act by voluntarily opting in to the state external review process.⁴⁰ Similarly, these interim final rules allow self-insured plans (including non-federal governmental plans) to voluntarily opt in to state law that provides for a method for determining the cost-sharing amount or total amount payable under such a plan, where a state has chosen to expand access to such plans, to satisfy their obligations under section 9816(a)–(d) of the Code, section 716(a)–(d) of ERISA, and section 2799A–1(a)–(d) of the PHS Act. A group health plan that opts in to such a state law must do so for all items and services to which the state law applies. Under these interim final rules, a self-insured plan that has chosen to opt in to a state law must prominently display in its plan materials describing the coverage of out-of-network services a statement that the plan has opted in to a specified state law, identify the relevant state (or states), and include a general description of the items and services provided by nonparticipating facilities and providers that are covered by the specified state law.

b. Examples Involving Specified State Laws

The following examples illustrate how state laws may or may not apply. In each example, assume there is no applicable All-Payer Model Agreement that would determine the recognized amount or out-of-network rate.

Example 1. (i) Facts. A health insurance issuer licensed in State A covers a specific non-emergency service

that is provided to an enrollee by a nonparticipating provider in a participating health care facility, both of which are also licensed in State A. State A has a law that prohibits balance billing for non-emergency services provided to individuals by nonparticipating providers in a participating health care facility, and provides for a method for determining the cost-sharing amount and total amount payable. The state law applies to health insurance issuers and providers licensed in State A. The state law also applies to the type of service provided.

(ii) Conclusion. In this Example 1, State A’s law would apply to determine the recognized amount and the out-of-network rate.

Example 2. (i) Facts. Same facts as Example 1, except that the nonparticipating provider and participating health care facility are located and licensed in State B. State A’s law does not apply to the provider, because the provider is licensed and located in State B.

(ii) Conclusion. In this Example 2, State A’s law would not apply to determine the recognized amount and out-of-network rate. Instead, the lesser of the billed amount or QPA would apply to determine the recognized amount, and either an amount determined through agreement between the provider and issuer or an amount determined by an IDR entity would apply to determine the out-of-network rate.

Example 3. (i) Facts. An individual receives emergency services at a nonparticipating hospital located in State A. The emergency services furnished include post-stabilization services, as described in 26 CFR 54.9816–4T(c)(2)(ii), 29 CFR 2590.716–4(c)(2)(ii), and 45 CFR 149.110(c)(2)(ii). The individual’s coverage is through a health insurance issuer licensed in State A, and the coverage includes benefits with respect to services in an emergency department of a hospital. State A has a law that prohibits balance billing for emergency services provided to an individual at a nonparticipating hospital located in State A and provides a method for determining the cost-sharing amount and total amount payable in such cases. The law applies to issuers licensed in State A. However, State A’s law has a definition of emergency services that does not include post-stabilization services.

(ii) Conclusion. In this Example 3, State A’s law would apply to determine the cost-sharing amount and out-of-network rate for the emergency services, as defined under State A’s law. State A’s

³⁸ See House Conf. Rep. No. 104–736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018.

³⁹ See *Gobeille v. Liberty Mutual Ins. Co.* 577 U.S. 312 (2015); *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001).

⁴⁰ See, e.g., Technical Release 2010–01; 76 FR 37208, 37211 fn. 13 (June 24, 2011).

law would not apply for purposes of determining the cost-sharing amount and out-of-network rate for the post-stabilization services. Instead, the lesser of the QPA or billed amount would apply to determine the recognized amount, and either an amount determined through agreement between the hospital and issuer or an amount determined by an IDR entity would apply to determine the out-of-network rate, with respect to post-stabilization services.

Example 4. (i) Facts. A self-insured plan, subject to ERISA, covers a specific non-emergency service that is provided to a participant by a nonparticipating provider in a participating health care facility, both of which are licensed in State A. State A has a law that prohibits balance billing for non-emergency services provided to individuals by nonparticipating providers in a participating health care facility, and provides for a method for determining the cost-sharing amount and total amount payable. The law applies to health insurance issuers and providers licensed in State A, and provides that plans that are not otherwise subject to the law may opt in. The law also applies to the type of service provided. The self-insured plan has opted in.

(ii) Conclusion. In this Example 4, State A's law would apply to determine the recognized amount and the out-of-network rate.

The Departments are of the view that it would be uncommon for laws of more than one state to each apply to the same health insurance issuer, and to the same provider for a particular item or service. Therefore, the Departments do not foresee many instances where there might be a question as to which state's law applies to determine the recognized amount or out-of-network rate. However, in such uncommon scenarios, one approach might be for the states involved to make that decision. Another approach might be that the law enacted by the state in which the service is provided would apply. Yet another approach would be for the QPA to apply to determine the recognized amount, and either a negotiated amount or an amount determined by an IDR entity to apply to determine the out-of-network rate. The Departments seek comment on these and any other approaches for resolving this choice-of-law question. The Departments also seek comment on how states have handled such questions prior to the enactment of the No Surprises Act, should these types of conflicts exist.

The Departments are of the view that Congress intended that where state law provides a method for determining the

total amount payable under a plan or coverage, the state law regarding balance billing would govern, rather than the alternative method for determining the out-of-network rate under the No Surprises Act. The Departments interpret the statutory phrase "a State law that provides for a method for determining the total amount payable under such a plan, coverage, or issuer, respectively" broadly as referring not only to state laws that set a mathematical formula for determining the out-of-network rate, or that set a predetermined amount for an out-of-network item or service. Rather, the Departments interpret that language to also include, for example, state laws that require or permit a plan or issuer and a provider or facility to negotiate, and then to engage in a state arbitration process to determine the out-of-network rate. Such state laws provide a process for determining the total amount payable, and in such instances, the timeframes and processes under such a state law related to negotiations and arbitration would apply, as opposed to the timeframes and IDR process under the No Surprises Act.

In addition, the Departments are of the view that Congress did not intend for the No Surprises Act to preempt provisions in state balance billing laws that address issues beyond how to calculate the cost-sharing amount and out-of-network rate. To the extent state laws do not prevent the application of a federal requirement or prohibition on balance billing, the Departments are of the view that such state laws are consistent with the statutory framework of the No Surprises Act and would not be preempted.⁴¹ This view extends to any state law that provides balance billing protections beyond what these interim final rules provide. In fact, Congress specifically indicated that such state balance billing laws may continue in effect along with the balance billing protections set forth in the statute, by requiring in new section 2799B–3 of the PHS Act that providers must disclose to participants, beneficiaries, and enrollees information about federal balance billing protections, plus any other protections that apply under state law. A more detailed discussion of the disclosure requirements appears in section IV.A.3

⁴¹ Section 731(a) of ERISA and section 2724(a) of the PHS Act. As noted above, the HIPAA conference report indicates that this preemption standard is intended to be the "narrowest" preemption of states' laws. See House Conf. Rep. No. 104–736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018.

of this preamble, which discusses the provisions codified in 45 CFR 149.430.

v. All-Payer Model Agreements

As described earlier, in instances where an All-Payer Model Agreement is applicable, the recognized amount (the amount upon which cost sharing is based with respect to items and services furnished by nonparticipating emergency facilities, and nonparticipating providers of nonemergency items and services in participating facilities) and the out-of-network rate are determined using the amount that the state approves under the All-Payer Model Agreement for such items or services.

An All-Payer Model Agreement is an agreement between the Centers for Medicare & Medicaid Services (CMS) and a state to test and operate systems of all-payer payment reform for the medical care of residents of the state, under the authority granted under section 1115A the Social Security Act. Under the terms of section 1115A of the Social Security Act, such Agreements may waive specific provisions of titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and 1934 (other than subsections (b)(1)(A) and (c)(5) of such section) as may be necessary solely for the purposes of testing the Model. All-Payer Model Agreements can vary significantly by state, including in using different approaches for approving payment amounts for items or services covered by the Agreements. The Departments are of the view that it is important to maximally preserve states' abilities to test all-payer payment reform through these Agreements, including their abilities to do so using varied approaches to setting payment amounts. These interim final rules defer to the state to determine the circumstances under which, and how, it will approve an amount for an item or service under a payment system established by an All-Payer Model Agreement. Participating in an all-payer model governed by an All-Payer Model Agreement may be voluntary or mandatory for a given payer; the system of all-payer payment reform may apply statewide or only in certain regions, such as rural regions; and payments under the system of all-payer payment reform may apply only to certain providers or facilities and certain items and services.⁴² To account

⁴² See, e.g., CMS, Vermont All-Payer ACO Model, (updated Apr. 8, 2020) available at <https://innovation.cms.gov/innovation-models/vermont-all-payer-aco-model>; CMS, Pennsylvania Rural Health Model, (updated Jan. 1, 2021) available at <https://innovation.cms.gov/innovation-models/pa-rural>.

Continued

for potential variations among All-Payer Model Agreements, the Departments are proposing to take a similar approach that these interim final rules establish with respect to state laws. Specifically, in order for an All-Payer Model Agreement to determine the recognized amount or out-of-network rate, any such Agreement must apply to the coverage involved; to the nonparticipating provider or nonparticipating emergency facility involved (and in the case of the out-of-network rate, to the nonparticipating provider of air ambulance services involved); and to the item or service involved. In instances where an All-Payer Model Agreement does not satisfy all of these criteria, the Agreement does not apply to determine the recognized amount or out-of-network rate, and, unless a specified state law applies, the recognized amount would be determined by the QPA (or the billed charge if less than the QPA), and the out-of-network rate would be the amount determined through agreement between the provider or facility and plan or issuer or the IDR process.

Under these interim final rules, an All-Payer Model Agreement is treated as applicable to a given provider or facility and plan or issuer if the terms of the Agreement, or any agreements described in that Agreement, are binding upon the provider, facility, plan, or issuer, which may occur through different mechanisms. For example, under the All-Payer Model Agreement for the Maryland Total Cost of Care Model and under the Maryland state all-payer law, all payers (including group health plans and health insurance issuers offering group or individual health insurance coverage) pay the amount determined under the Agreement with respect to hospital services covered by the Agreement.⁴³ However, the Agreement generally does not apply to the amount paid to a provider, such as a physician, who furnishes services at a hospital. In Maryland, therefore, the recognized amount and out-of-network rate would be set by the All-Payer Model Agreement for all plans and issuers for

hospital charges covered under the Agreement. But, the All-Payer Model Agreement would generally not be used to set the recognized amount or out-of-network rate with respect to a nonparticipating provider's charges, unless the All-Payer Model Agreement, or any agreements described in that Agreement, specify the payment amount in a particular instance.

Although under state law plans and issuers in Maryland do not have discretion regarding whether to participate in the all-payer rate setting system under the Maryland Total Cost of Care Model, participation in other state-based models governed by All-Payer Model Agreements is voluntary. For example, under the All-Payer Model Agreement for the Vermont All-Payer Accountable Care Organization (ACO) Model, participation by providers, facilities, group health plans, and health insurance issuers is voluntary.⁴⁴ To the extent that both the provider or facility and plan or issuer has opted to participate in the Vermont All-Payer ACO Model and the Vermont All-Payer Model Agreement, or an agreement described in that Agreement, applies to a specific item or service, then that All-Payer Model Agreement would determine the recognized amount and out-of-network rate. But, for example, if a plan has opted to participate, but the provider furnishing the service has not, then the All-Payer Model Agreement would not be used to determine either the recognized amount or out-of-network rate. Instead, if a state law is applicable, the state law would apply. If no state law is applicable, then the recognized amount would be determined using the QPA,⁴⁵ and the out-of-network rate would be the amount agreed upon by the parties or determined through the IDR process established in the No Surprises Act, as discussed further elsewhere in this preamble.

vi. Methodology for Calculating the Qualifying Payment Amount

The No Surprises Act directs the Departments to establish through rulemaking the methodology that a group health plan or health insurance issuer offering group or individual health insurance coverage must use to determine the qualifying payment amount (QPA). As discussed earlier in this preamble, the No Surprises Act and

these interim final rules require cost-sharing requirements imposed by plans and issuers in connection with emergency services furnished by a nonparticipating emergency facility or nonparticipating provider, or in connection with non-emergency services performed by nonparticipating providers at certain participating facilities to be based on the lesser of the billed charge or the QPA where an All-Payer Model Agreement under section 1115A of the Social Security Act or a specified state law does not apply. In addition, IDR entities are directed by statute to consider the QPA when selecting between the offer submitted by a plan or issuer and the offer submitted by a facility or provider in order to determine the total payment for emergency services furnished by a nonparticipating emergency facility or nonparticipating provider, or non-emergency services performed by nonparticipating providers at certain participating facilities that are items and services subject to the IDR process.

In general, under section 9816(a)(3)(E) of the Code, section 716(a)(3)(E) of ERISA, and section 2799A-1(a)(3)(E) of the PHS Act, for a given item or service, the QPA is the median of the contracted rates recognized by the plan or issuer on January 31, 2019, for the same or similar item or service that is provided by a provider in the same or similar specialty and provided in a geographic region in which the item or service is furnished, increased for inflation. The median contracted rate is determined with respect to all group health plans of the plan sponsor or all group or individual health insurance coverage offered by the health insurance issuer that are offered in the same insurance market, consistent with the methodology established by the Departments.

The No Surprises Act specifies an alternative methodology for determining the QPA in cases where a plan or issuer has insufficient information to calculate a median contracted rate for an item or service. The statute, however, envisions that these alternative methodologies, such as use of a third-party database, will be used in only limited circumstances where the plan or issuer cannot rely on its contracted rates as a reflection of the market dynamics in a geographic region. Consistent with this statutory goal, these interim final rules generally seek to ensure that plans and issuers can meet the sufficient-information standard when determining the QPA and that use of alternative methodologies is minimized wherever possible.

The Departments seek comment on all aspects of the methodology established

health-model; CMS. Maryland Total Cost of Care Model available at <https://innovation.cms.gov/innovation-models/md-tccm>.

⁴³ See CMS. Maryland Total Cost of Care Model, (updated Oct. 22, 2020) available at <https://innovation.cms.gov/innovation-models/md-tccm>. Under Maryland law, hospitals regulated by the Maryland Health Services Cost Review Commission (HSCRC) must charge payers the rates set by HSCRC, and payers, including group health plans and issuers offering individual or group health insurance, must pay the rates set by HSCRC. Maryland Code, Health-General Article §§ 19-212 and 19-219(a)(3) and (b)(2)(i) and Maryland Code, Insurance Article § 15-604.

⁴⁴ <https://innovation.cms.gov/innovation-models/vermont-all-payer-aco-model>.

⁴⁵ See prior explanation regarding the requirement that when the surprise billing protections apply, in the event the billed charge is less than the recognized amount, cost sharing would be based on the billed charge.

in these interim final rules for determining the QPA. In particular, the Departments seek comment on whether there are any considerations or factors that are not sufficiently accounted for in the methodology established in these interim final rules; the impact of the methodology on cost sharing, payment amounts, and provider network participation; and whether there are areas where commenters believe additional rulemaking or guidance is necessary. The Departments also seek comment as to the impact of large consolidated health care systems on contracted rates, and the impact of such contracted rates on prices and the QPA. The Departments are concerned that the contracting practices of such health care systems could inflate the QPA, and seek comment on whether adjustments to the QPA methodology are needed.

a. Median Contracted Rate

These interim final rules establish the methodology that plans and issuers must use to calculate the median of contracted rates. The plan or issuer will generally then apply an inflation adjustment to determine the QPA for items and services furnished in the relevant year.

In general, the median contracted rate for an item or service is calculated by arranging in order from least to greatest the contracted rates of all plans of the plan sponsor (or of the administering entity, if applicable) or all coverage offered by the issuer in the same insurance market for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the geographic region in which the item or service is furnished, and selecting the middle number. These interim final rules define each of the relevant terms, as discussed in more detail in this section of the preamble.

In determining the median contracted rate, the amount negotiated under each contract is treated as a separate amount. For example, assume the contracted rates for all plans of a sponsor in the same insurance market for a particular item or service provided by a provider in the same or similar specialty in a specified geographic region are \$475, \$490, and \$510. The median contracted rate for this service is \$490. If there are an even number of contracted rates, the median contracted rate is the average of the middle two contracted rates. If, in the previous example, there were a fourth contracted rate in the amount of \$515, the median contracted rate would be the average of the two middle amounts (\$490 and \$510), or \$500

(((\$490+\$510)/2)). If the same amount is paid under two or more separate contracts, each contract is counted separately. Thus, in the previous example, if there were a fifth contracted rate also in the amount of \$515, the median contracted rate would be \$510, since there are two contracted rates below that amount (\$475 and \$490) and two contracted rates above that amount (\$515 and \$515).

Contracted Rate

The interim final rules define a “contracted rate” as the total amount (including cost sharing) that a group health plan or health insurance issuer has contractually agreed to pay a participating provider, facility, or provider of air ambulance services for covered items and services, whether directly or indirectly, including through a third-party administrator or pharmacy benefit manager.⁴⁶

The No Surprises Act envisions that each contracted rate for a given item or service be treated as a single data point when calculating a median contracted rate. Therefore, if a plan or issuer has a contract with a provider group or facility, the rate negotiated with that provider group or facility under the contract is treated as a single contracted rate, if the same rate applies to all providers of such provider group or facility under the single contract. Likewise, the rate negotiated under a contract constitutes a single contracted rate regardless of the number of claims paid at that contracted rate. However, if a plan or issuer has a contract with multiple providers, with separate negotiated rates with each particular provider for a given item or service, each unique contracted rate constitutes a single contracted rate for purposes of determining the median contracted rate.⁴⁷ Further, if a plan or issuer has separate contracts with individual providers, the contracted rate under each such contract constitutes a single

contracted rate (even if the same amount is paid to other providers under separate contracts).

The Departments understand that some plans or issuers may rent provider networks or otherwise contract with third parties to manage provider networks. In these situations, contracted rates between providers and the entity responsible for managing the provider network on behalf of a plan or issuer would be treated as the plan’s or issuer’s contracted rates for purposes of calculating the QPA. The Departments seek comment on whether additional guidance or special rules are needed regarding how to define a contract in this situation.

The Departments also understand that plans and issuers sometimes enter into special agreements with providers and facilities that generally are not otherwise contracted to participate in any of the networks of the plan or issuer. For example, a plan or issuer may negotiate an ad hoc arrangement with a nonparticipating provider or facility to supplement the network of the plan or coverage for a specific participant, beneficiary, or enrollee in unique circumstances. These interim final rules specify that solely for purposes of the definition of contracted rate, a single case agreement, letter of agreement, or other similar arrangement between a plan or issuer and a provider, facility, or provider of air ambulance services does not constitute a contract, and the rate paid under such an agreement should not be counted among the plan’s or issuer’s contracted rates. The term “contracted rate” refers only to the rate negotiated with providers and facilities that are contracted to participate in any of the networks of the plan or issuer under generally applicable terms of the plan or coverage and excludes rates negotiated with other providers and facilities. The Departments are of the view that this definition most closely aligns with the statutory intent of ensuring that the QPA reflects market rates under typical contract negotiations.⁴⁸

Insurance Market

In calculating the median contracted rate for a given item or service, the plan

⁴⁶ This definition is substantially similar to the definition of “negotiated rate” used for purposes of the transparency in coverage regulations at 26 CFR 54.9815–2715A1(a)(2)(xvi), 29 CFR 2590.715–2715A1(a)(2)(xvi), and 45 CFR 147.210(a)(2)(xvi).

⁴⁷ If a plan or issuer has a contract with multiple providers, with separate negotiated rates with several subgroups of providers, each unique contracted rate will generally constitute a single contracted rate for purposes of determining the median contracted rate. However, as discussed later in this section of the preamble, these interim final rules specify that if a plan or issuer has contracted rates that vary based on provider specialty for a service code, the median contracted rate is calculated separately for each provider specialty, as applicable. In such cases, the QPA for the particular item or service would take into account only the contracted rates for the applicable provider specialty, and would disregard other unique contracted rates under the same contract.

⁴⁸ In contrast, as discussed earlier in this preamble, these interim final rules specify that a single case agreement constitutes a contractual relationship for purposes of the definition of participating health care facility and participating emergency facility. The Departments are of the view that it is reasonable that an individual would expect items and services delivered at a health care facility that has a single case agreement in place with respect to the individual’s care to be delivered on an in-network basis, and therefore, that the balance billing protections should apply.

or issuer must take into account the contracted rates under all group health plans of the sponsor or all group or individual health insurance coverage offered by the issuer that are offered in the same insurance market.⁴⁹ The term “insurance market” for purposes of these interim final rules means one of the following: The individual market, small group market, or large group market (each as defined under section 2791(e) of the PHS Act). The relevant insurance market is determined irrespective of the state. For example, in calculating the QPA for an item or service furnished to an enrollee in individual health insurance coverage, an issuer must take into account the contracted rates with providers or facilities in the applicable geographic region across the issuer’s individual market offerings, inclusive of contracted rates for all individual health insurance coverage offered by the issuer in all states in which the issuer offers coverage in the individual market.

With respect to self-insured group health plans, these interim final rules define the term “insurance market” to mean all self-insured group health plans (other than account-based plans and plans that consist solely of excepted benefits) of the plan sponsor, or at the option of the plan sponsor, all self-insured group health plans administered by the same entity (including a third-party administrator contracted by the plan), to the extent otherwise permitted by law, that is responsible for calculating the QPA on behalf of the plan. The Departments understand that many self-insured group health plans are administered by entities other than the plan sponsor (such as a third-party administrator contracted by the plan) that would be responsible for calculating the QPA on behalf of the sponsor. To reduce the burden imposed on sponsors of self-insured group health plans, these interim final rules permit sponsors of self-insured group health plans to allow their third-party administrators to determine the QPA for the sponsor by calculating the median contracted rate using the contracted rates recognized by all self-insured group health plans administered by the third-party administrator (not only those of the particular plan sponsor). Under this approach, the Departments anticipate

there will be fewer instances where a self-insured group health plan sponsor will lack sufficient information to calculate a median contracted rate for an item or service.

The Departments seek comment on the definition of insurance market with respect to self-insured group health plans and whether any contractual or other issues may prevent an entity, such as a third-party administrator, from using contracted rates from the different self-insured plans it administers to calculate the QPA for a particular self-insured group health plan. DOL also seeks comment on the ability of self-insured group health plan fiduciaries to monitor the calculation of the QPA by the administering entities for compliance with the applicable requirements (for example, by ensuring the entities are using the correct contracted rates).

The Departments have determined that including rates negotiated under other more limited forms of coverage, such as excepted benefits, short-term, limited-duration insurance, and account-based plans, including health reimbursement arrangements, could skew the calculation of the median contracted rate, and these forms of coverage should not be included in the definition of the applicable insurance market. Furthermore, the definition of “qualifying payment amount” under section 2799A–1(a)(3)(E)(i)(I) of the PHS Act refers to individual health insurance coverage, and the term individual health insurance coverage, as defined under section 2791(b)(5) of the PHS Act, excludes short-term, limited-duration insurance.⁵⁰ Therefore, under these interim final rules, when referring to coverage offered by an issuer within the same insurance market for purposes of determining the QPA, the individual market excludes short-term, limited-duration insurance (as defined in 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103). In addition, under these interim final rules, all markets exclude coverage that consists solely of excepted benefits (as described in section 9832 of the Code, section 733 of ERISA, and section 2791 of the PHS Act). While excepted benefits can be offered in the individual or group markets, they are exempt from the federal insurance market reforms,⁵¹ and Congress amended the statutory

exemption for these products to include the additional coverage provisions established under new Part D of title XXVII of the PHS Act.⁵² Account-based plans, including health reimbursement arrangements as described in 26 CFR 54.9815–2711(d)(6)(i), 29 CFR 2590.715–2711(d)(6)(i), and 45 CFR 147.126(d)(6)(i), make reimbursements subject to a maximum fixed dollar amount for a period, such that the benefit design of these coverage options makes concepts related to surprise billing and choice of health care professionals inapplicable. Therefore, under these interim final rules, for purposes of calculating the QPA, all group markets similarly exclude coverage provided under account-based plans.

The Departments also clarify that any plan or coverage that is not a “group health plan” or “group or individual health insurance coverage” offered by a “health insurance issuer,” as those terms are defined in the Code, ERISA, and the PHS Act, such as a Medicare Advantage or Medicaid managed care organization plan, must also not be included in any insurance market for purposes of determining the QPA. This approach is consistent with the statutory requirement that the median contracted rate is determined with respect to all “group health plans” of the sponsor or all “group or individual health insurance coverage” offered by a health insurance issuer in the same insurance market.

Same or Similar Item or Service

Section 9816(a)(3)(E) of the Code, section 716(a)(3)(E) of ERISA, section 2799A–1(a)(3)(E) of the PHS Act, and these interim final rules provide that a plan or issuer must calculate the median contracted rate for an item or service using contracted rates for the same or similar item or service. Under the interim final rules, the term “same or similar item or service” means a health care item or service billed under the same service code, or a comparable code under a different procedural code system. Service code means the code that describes an item or service, including a Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), or Diagnosis-Related Group (DRG) code. A service code is a unique identifier, typically consisting of a string of numeric digits or alphanumeric characters, that corresponds to a standardized description, which is used

⁴⁹ The term “health insurance issuer” has the meaning given the term in section 2791(b) of the PHS Act, which, in relevant part, defines a health insurance issuer as an entity that is licensed to engage in the business of insurance in a state. Thus, an issuer is the licensed entity and the contracted rates of separate licensees under the same holding company are not taken into account.

⁵⁰ Since short-term, limited duration insurance is not individual health insurance coverage, it is also generally not subject to the federal individual market reforms. See, e.g., 81 FR 75316 at 75317 (Oct. 31, 2016) and 83 FR 38212 at 38213 (Aug. 3, 2018).

⁵¹ Section 9831 of the Code, section 732 of ERISA, and sections 2722 and 2763 of the PHS Act.

⁵² These amendments add the phrase “and Part D” to section 2722(b), (c)(1), (c)(2), and (c)(3) of the PHS Act.

to identify with specificity the item or service that was furnished to a patient. Different codes may be assigned to the same general service on the basis of certain variations in the provider's method or approach, the complexity of the procedure or medical decision-making, and patient acuity level. Payers, providers, and facilities understand these service codes and commonly use them for billing and paying claims (including for both individual items and services, and for items and services provided under a bundled payment arrangement). Thus, defining "same or similar item or service" by service code will make it easier for plans and issuers to calculate the QPA, and for providers and facilities to understand the QPA.

These interim final rules include specific requirements to account for modifiers (when applicable), which are codes applied to the service code that provide a more specific description of the furnished item or service and that may adjust the payment rate or affect the processing or payment of the code billed. For example, modifiers include hospital revenue codes, which indicate the department or place in the hospital in which a procedure or treatment is performed, as well as codes indicating whether services or procedures were performed by certain types of providers, such as physician assistants, nurse practitioners, certified registered nurse anesthetists, or assistant surgeons. In addition, modifiers can be used to indicate that the work required to provide a service in a particular instance was significantly greater—or significantly less—than the service typically requires. The Departments are of the view that it is important that the QPA methodology account for modifiers that affect payment rates under contracts with participating providers and facilities.

Under the methodology established in these interim final rules, plans and issuers must calculate separate median contracted rates for CPT code modifiers that distinguish the professional services component ("26") from the technical component ("TC"). This will result in separate median contracted rates being calculated for services when billed by a facility versus a provider. In addition, where a plan's or issuer's contracted rates otherwise vary based on applying a modifier code, the plan or issuer must calculate a separate median contracted rate for each such service code-modifier combination. Modifiers that do not cause contracted rates to vary must not be taken into account when calculating the median contracted rate. These rules are intended to ensure that if a plan or issuer adjusts contracted

rates with participating providers and facilities based on modifier codes, those payment adjustments are appropriately reflected in the median contracted rate.

Provider in the Same or Similar Specialty

These interim final rules specify that if a plan or issuer has contracted rates for a service code that vary based on provider specialty, the median contracted rate is calculated separately for each provider specialty, as applicable. These interim final rules define "provider in the same or similar specialty" as the practice specialty of a provider, as identified by the plan or issuer consistent with the plan's or issuer's usual business practice. This definition is intended to provide plans or issuers with the flexibility necessary to calculate the median contracted rate, relying on their contracting practices with participating providers. If a plan's or issuer's usual business practice for identifying a provider's practice specialty differs for contracting purposes and other business needs, the plan or issuer should use the method of identifying the practice specialty that it uses for contracting purposes.

The Departments considered requiring a plan or issuer to calculate separate median contracted rates for every provider specialty, but concluded that this approach would lead to more instances in which the plan or issuer would not have sufficient information to calculate the QPA using its contracted rates. In addition, the Departments understand that not all plans or issuers vary contracted rates by provider specialty, in which case requiring plans and issuers to calculate separate median contracted rates for each provider specialty would increase the burden associated with calculating the QPA without adding specificity to the QPA. Given that the No Surprises Act generally relies on using contracted rates to determine the QPA, the Departments conclude that plans and issuers should be required to calculate median contracted rates separately by provider specialty only where the plan or issuer otherwise varies its contracted rates based on provider specialty.

With respect to air ambulance services, all providers of air ambulance services (including inter-facility transports) are considered to be a single provider specialty for purposes of these interim final rules. The Departments understand that contracted rates may vary depending on whether the air ambulance services are provided using a fixed-wing or rotary-wing aircraft. However, these distinctions based on vehicle type are accounted for in the

QPA methodology established under these interim final rules through the use of service codes that are specific to fixed-wing or rotary-wing aircraft. Therefore, the Departments anticipate that median contracted rates for fixed-wing and rotary-wing aircraft would be determined separately based on the requirement under these interim final rules that median contracted rates be based on the contracted rates for the same or similar item or service, and concluded that it would be redundant to require plans and issuers to also calculate separate median contracted rates on the basis of vehicle type.

The Departments also understand that hospital-based air ambulance providers sometimes have lower contracted rates than independent, non-hospital-based air ambulance providers. The Departments, however, are of the view that because participants, beneficiaries, and enrollees frequently do not have the ability to choose their air ambulance provider, they should not be required to pay higher cost-sharing amounts (such as coinsurance or a deductible) solely because the air ambulance provider assigned to them has negotiated higher contracted rates in order to cover its higher costs, or because it has a different revenue model, than other types of air ambulance providers. This approach is consistent with the approach these interim final rules take with respect to facilities, discussed in the following section of this preamble, which also generally does not provide for separate median contracted rates to be calculated based on characteristics of a particular facility. The Departments have concluded that this interpretation is consistent with the statute's intent to protect individuals from surprise medical bills.

Facility of the Same or Similar Facility Type

If a plan or issuer has contracted rates for emergency services that vary based on the type of facility (that is, whether a facility is an emergency department of a hospital or an independent freestanding emergency department), the median contracted rate is calculated separately for each such facility type. Plans and issuers subject to the protections in the No Surprises Act are required to cover emergency services at both types of facilities. However, the Departments are aware that plans and issuers have not typically contracted with independent freestanding emergency departments, which may be a reflection of independent freestanding emergency departments' historical ability (prior to the enactment of the No Surprises Act) to charge higher rates for

services furnished on an out-of-network basis, and to balance bill enrollees when the charges were denied in part or in full.⁵³ The Departments are also aware that there may be appreciable differences in the case-mix and level of patient acuity between these types of facilities.⁵⁴ Therefore, where a plan or issuer has established contracts with both hospital emergency departments and independent freestanding emergency departments, and its contracts vary the payment rate based on the facility type, the median contracted rate is to be calculated separately for each facility type. The Departments are of the view that this approach will maintain the ability of plans and issuers to develop QPAs that are appropriate to the different types of emergency facilities specified by statute. The Departments seek comment on this approach, and whether it would be more appropriate for plans and issuers to always calculate separate QPAs for hospital emergency departments and independent freestanding emergency departments regardless of whether the plan or issuer varies the payment rate based on facility type, or whether a plan or issuer should never calculate separate QPAs for hospital emergency departments and independent freestanding emergency departments.

However, these interim final rules do not allow plans or issuers to separately calculate a median contracted rate based on other characteristics of facilities that might cause contracted rates to vary, such as whether a hospital is an academic medical center or teaching hospital. Given that participants, beneficiaries, and enrollees with emergency medical conditions typically go (or are taken) to the nearest or most convenient emergency department, the Departments are of the view that, individuals generally should not be required to pay higher cost sharing (such as coinsurance or a deductible) based on features of the emergency facility that may have a bearing on its contracted rate with plans and issuers, but which are unrelated or incidental to the facility's role as a provider of emergency services.

Geographic Regions

Under the No Surprises Act, plans and issuers must calculate the median contracted rate for an item or service using contracted rates for the same or

similar item or service provided in the geographic region in which the item or service is furnished. The No Surprises Act directs the Departments, in consultation with the National Association of Insurance Commissioners (NAIC), to establish through rulemaking the geographic regions to be applied when determining the QPA, taking into account access to items and services in rural and underserved areas, including health professional shortage areas, as defined in section 332 of the PHS Act.⁵⁵

In consulting on the geographic regions to be applied under the No Surprises Act, the NAIC recommended that geographic regions correspond to the applicable rating area used for purposes of the individual market and small group market rating rules under section 2701 of the PHS Act, implemented at 45 CFR 147.102, while allowing states the flexibility to establish alternative geographic regions. However, some states define rating area by county, resulting in large numbers of rating areas in a state, some of which might include very few, if any, facilities and providers. Therefore, adopting the rating area definitions as the standard for geographic regions could lead to a large number of geographic regions for which a plan or issuer would have to calculate separate median contracted rates, a large number of geographic regions without sufficient information, as well as a large number of geographic regions in which the median contracted rate is influenced by outliers.

After consultation with the NAIC, the Departments are establishing geographic regions under these interim final rules that reflect differences in health care costs based on whether care is provided in urban or rural areas. The Departments are of the view that these geographic regions take into account access to items and services in rural and underserved areas, including health professional shortage areas, as defined at section 332 of the PHS Act. The Departments intend to monitor the effect of these geographic regions and periodically update such

regions, as appropriate, taking into account the findings of the report submitted under section 109(a) of the No Surprises Act, which addresses, among other things, access to health care items and services in rural areas and health professional shortage areas.

In defining "geographic regions," the Departments have sought not only to minimize instances in which a plan or issuer lacks sufficient information to calculate the median of contracted rates in any particular geographic region, but also to limit the instances in which a plan or issuer has only the minimum amount of information to meet the sufficient information standard, as discussed later in this preamble. Using larger geographic regions, for which plans and issuers are likely to have more information, is expected to reduce the likelihood that the median of contracted rates would be skewed by contracts under which the parties have agreed to particularly high or low payment amounts.

Under these interim final rules, for items and services other than air ambulance services, a geographic region is generally defined as one region for each metropolitan statistical area (MSA) in a state and one region consisting of all other portions of the state. The delineations for MSAs are described by the U.S. Office of Management and Budget (OMB) and published by the U.S. Census Bureau.⁵⁶ MSAs encompass at least one urbanized area with a population of 50,000 or more people, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties. MSAs are always established along county boundaries, but may include counties from more than one state. Under this definition, MSAs that cross state boundaries are divided between the respective states, with all the counties in a particular MSA in each state counted as a geographic region.

However, under this definition, if a plan or issuer does not have sufficient information to calculate the median of contracted rates for an item or service provided in an MSA, the plan or issuer must consider all MSAs in the state to be a single region when calculating the median of contracted rates for the item

⁵³ See Medicare Payment Advisory Commission, Report to the Congress: Medicare and the Health Care Delivery System, ch. 8, Stand-alone Emergency Departments, June 2017, available at http://www.medpac.gov/docs/default-source/reports/jun17_ch8.pdf (last visited June 19, 2021).

⁵⁴ See *id.*

⁵⁵ Under section 332 of the PHS Act, a health professional shortage area is (A) an area in an urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services) which the Secretary of HHS determines has a health manpower shortage and which is not reasonably accessible to an adequately served area, (B) a population group which the Secretary determines has such a shortage, or (C) a public or nonprofit private medical facility or other public facility which the Secretary determines has such a shortage. All Federally qualified health centers and rural health clinics, as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)), that meet the requirements of section 254g of title 42 shall be automatically designated as having such a shortage.

⁵⁶ OMB Bulletin No. 20-01. "Revised Delineations of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and Guidance on Uses of the Delineations of These Areas" (Mar. 6, 2020), available at <https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf>. U.S. Census Bureau, Delineation Files, available at <https://www.census.gov/geographies/reference-files/time-series/demo/metro-micro/delineation-files.html>.

or service provided in that MSA. In such cases, all MSAs in the state will constitute one geographic region, and all other portions of the state will continue to constitute a different region. If after applying these broader regions, a plan or issuer continues to have insufficient information to calculate the median of contracted rates, geographic regions will be based on Census divisions, with one region consisting of all MSAs in the Census division, and one region consisting of all other portions of the Census division. There are nine Census divisions, as published by the U.S. Census Bureau.⁵⁷ This approach will help to reduce instances in which a plan or issuer cannot rely on its own contracted rates to determine the QPA in cases where the plan or issuer is not limited to operating within a single state but instead has provider contracts in a multi-state region.

These interim final rules establish alternate geographic regions with respect to air ambulance services. Given the nature of air ambulance services, the infrequency with which they are provided relative to the other types of items and services subject to the No Surprises Act, and the lower prevalence of participating providers of air ambulance services, the Departments have determined not to apply a definition of geographic regions based on MSAs, as narrow regions would result in more instances of insufficient information.

Thus, for air ambulance services, a geographic region means one region consisting of all MSAs in the state, and one region consisting of all other portions of the state. If a plan or issuer does not have sufficient information to calculate the median of the contracted rates for an air ambulance service using that definition of a geographic region, these interim final rules apply broader regions based on Census divisions—that is, one region consisting of all MSAs in each Census division and one region consisting of all other portions of the Census division. Because air ambulance services can be furnished over large distances, these interim final rules provide that the geographic region to be applied for air ambulance services is determined based on the point of pick-up, meaning the location of the individual at the time the individual is placed on board the air ambulance. This approach is generally consistent with prevailing market practices among both private and public payers.

⁵⁷ U.S. Department of Commerce Economics and Statistics Administration, U.S. Census Bureau, available at https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf.

Non-Fee-for-Service Contractual Arrangements

The No Surprises Act provides that rulemaking to establish the methodology used to determine the QPA must take into account payments that are made by a plan or issuer that are not on a fee-for-service basis. The Departments are aware that many types of alternative reimbursement models exist that are not standard fee-for-service arrangements. For example, under a bundled payment arrangement, plans and issuers may reimburse a provider for multiple items and services under a single billing code. Other payers have capitation arrangements, under which a provider or panel of providers is paid a fixed amount per member per month.

The Departments understand that when a plan or issuer has a fully- or partially-capitated payment arrangement, the plan or issuer also typically has an internal methodology used to value claims for those payments made on a capitated basis. For example, a plan or issuer with capitation arrangements may have an underlying fee schedule that is used to calculate an individual's cost sharing. The Departments are of the view that, when a plan or issuer has an underlying fee schedule used to determine cost sharing under non-fee-for-service contracts, it is reasonable for the plan or issuer to use the same methodology to assign a value to the item or service for purposes of determining the QPA. This approach is used by plans and issuers in other similar contexts, including when providing data for the risk adjustment program⁵⁸ and when making publicly available in-network rates under the transparency in coverage regulations.⁵⁹

Therefore, in the case of these alternative payment models, such as bundled and fully or partially capitated arrangements, where payment made by a plan or issuer is not fully on a fee-for-service basis, these interim final rules provide that the plan or issuer must calculate a median contracted rate for each item or service using the

⁵⁸ See 45 CFR 153.710(c) (requiring an issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a state in which HHS is operating the risk adjustment or reinsurance program, as applicable, that does not generate individual enrollee claims in the normal course of business to derive the costs of all applicable provider encounters using its principal internal methodology for purposes of pricing those encounters).

⁵⁹ See 26 CFR 54.9815–2715A3(b)(1)(C); 29 CFR 2590.715–2715A3(b)(1)(C); 45 CFR 147.212(b)(1)(C) (requiring plans and issuers that use underlying fee schedule rates for calculating cost sharing to make publicly available on an internet website the underlying fee schedule rates for all covered items and services).

underlying fee schedule rates for the relevant items and services, if underlying fee schedule rates are available. The term “underlying fee schedule rate” means the rate for a covered item or service from a particular participating provider, providers, or facility that a group health plan or health insurance issuer uses to determine a participant's, beneficiary's, or enrollee's cost-sharing liability for the item or service, when that rate is different from the contracted rate.⁶⁰ If there is no underlying fee schedule rate for an item or service, these interim final rules provide that the plan or issuer must calculate the median contracted rate using a derived amount, which, consistent with the definition in the transparency in coverage regulations, is the price that a plan or issuer assigns an item or service for the purpose of internal accounting, reconciliation with providers, or for the purpose of submitting data in accordance with the requirements of 45 CFR 153.710(c).

The Departments considered alternative approaches to account for non-fee-for-service contractual arrangements, such as requiring plans and issuers to calculate median contracted rates for service bundles, or allowing plans or issuers to disregard certain types of non-fee-for-service contracts for purposes of calculating the median contracted rate. However, the approach specified in these interim final rules will ensure that the median contracted rate calculation accounts for a range of different contractual arrangements, including instances where a plan or issuer uses different types of contracting models with different providers and facilities. Using an underlying fee schedule or derived amount will allow plans or issuers to, in essence, convert each of their non-fee-for-service contracts into fee-for-service arrangements for purposes of calculating the median contracted rate. By avoiding instances where plans or issuers might have been required to disregard some of their contracts, this approach minimizes the number of instances in which a plan or issuer would not have sufficient information to calculate a median contracted rate and ensures that arrangements that pay for value over service volume are reflected in the QPA. In addition, this approach will result in the calculation of a QPA that aligns with a service code (or service-code modifier

⁶⁰ This definition is substantially similar to the definition of “underlying fee schedule rate” in the transparency in coverage regulations at 26 CFR 54.9815–2715A1(a)(2)(xxii), 29 CFR 2590.715–2715A1(a)(2)(xxii), and 45 CFR 147.210(a)(2)(xxii).

combination). The Departments anticipate this result will be helpful to nonparticipating providers and facilities in understanding how much cost sharing they are permitted to charge for a given item or service, and as they negotiate with the plan or issuer to determine the out-of-network rate.

It is the Departments' understanding that under certain capitated and bundled payment arrangements, providers' payments may be reconciled retrospectively to account for utilization, value adjustments, or other weighting factors that can affect the final payment to a provider. In addition, payers and providers may agree to certain incentive payments during the contracting process to promote the provision of higher-quality, lower-cost health care to participants, beneficiaries, or enrollees over time. These interim final rules specify that when calculating median contracted rates, plans and issuers must exclude risk sharing, bonus, or penalty, and other incentive-based and retrospective payments or payment adjustments. The Departments are of the view that excluding these payments and payment adjustments from the median contracted rates used to determine cost sharing for items and services furnished by nonparticipating providers or facilities is consistent with how cost sharing is typically calculated for in-network items and services, where the cost-sharing amount is customarily determined at or near the time an item or service is furnished, and is not subject to adjustment based on changes in the amount ultimately paid to the provider or facility as a result of any incentives or reconciliation process.

b. Indexing

The No Surprises Act provides that, in instances when the median contracted rate is determined as of January 31, 2019, the QPA for items and services furnished during 2022 is calculated by increasing the median contracted rate by the percentage increase in the consumer price index for all urban consumers (U.S. city average) (CPI-U) over 2019, the percentage increase over 2020, and the percentage increase over 2021. The No Surprises Act further provides that the QPA for 2022 is then adjusted annually for items and services furnished during 2023 or a subsequent year. Therefore, the increase for any year is the CPI-U for the year, as so defined, divided by the CPI-U for the prior year. The combined percentage increase for 2019, 2020, and 2021 to determine the amount for 2022 is the product of the CPI-U increases for 2019, 2020, and 2021 multiplied together. For any year, the factor will be the quotient

of CPI-U for the current year divided by the CPI-U for the prior year. For example, for an item or service provided in 2023, the 2023 QPA is the 2022 QPA multiplied by the CPI-U 2022/CPI-U 2021.

These interim final rules provide specifications for calculating the percentage increase in CPI-U to ensure that all plans and issuers adjust the percentage in a uniform manner. In order to ensure that uniformity, these interim final rules provide that plans and issuers will calculate the increases using the factors determined by the Treasury Department and the IRS, and published in guidance by the IRS. In determining the factors, these interim final rules provide that the percentage increase for any year is calculated by using the CPI-U published by the Bureau of Labor Statistics of the DOL. For this purpose, the CPI-U for each calendar year is the average of the CPI-U as of the close of the 12-month period ending on August 31 of the calendar year, rounded to 10 decimal places. This allows the Departments to provide the percentage increase factor before January 1 of each applicable year with sufficient time to adjust the QPAs for the year.

c. Special Rules for Unit-Based Services

These interim final rules provide special rules for calculating the QPA for items or services for which a plan or issuer generally determines the reimbursement level for the same or similar items or services by multiplying the contracted rate by another unit, such as time or mileage. In these cases, indexing the median contracted rate to calculate the QPA would result in an amount that does not reflect the other units that are generally considered when calculating the in-network payment amount. Therefore, when reimbursement levels are determined using this approach, these interim final rules specify that the QPA is calculated by determining the median contracted rate used for that item or service, indexing that median amount in accordance with the otherwise applicable rules regarding indexing, and then applying the pertinent multipliers. These interim final rules also include specific instructions for calculating the QPA for anesthesia services and for certain service codes for air ambulance services.

Anesthesia Services

Payers generally calculate payment amounts for anesthesia services by multiplying the negotiated rate for the anesthesia conversion factor that has been negotiated between the payer and

the provider (expressed in dollars per unit) by (1) the base unit for the anesthesia service code, (2) the time unit, and (3) the physical status modifier unit. The base unit, time unit, and physical status modifier unit are specific to the individual receiving the anesthesia services. These units are not expressed in dollars per unit, nor do they vary by contract. The base units for an anesthesia service code are the American Society of Anesthesiologists Relative Value Guide base units for that service code. The time unit represents the length of time during which the anesthesia services were furnished, and for purposes of the QPA methodology, is measured in 15-minute increments or a fraction thereof. The physical status modifier on a claim is a standard modifier describing the physical status of the patient and is used to distinguish between the various levels of complexity of the anesthesia services provided, and is expressed as a unit with a value between zero (0) and three (3).

These interim final rules include a methodology for calculating the QPA for these anesthesiology services that reflects the manner in which providers are generally paid for these services. To calculate the QPA for anesthesia services furnished during 2022, these interim final rules require the plan or issuer to, first, take the median contracted rate for the anesthesia conversion factor (determined in accordance with the methodology for calculating median contracted rates for service code-modifier combinations) for the same or similar item or service as of January 31, 2019, and increase that amount to account for changes in the CPI-U, using the methodology described earlier in this section of the preamble. This amount is referred to as the indexed median contract rate. The plan or issuer must then multiply this indexed median contracted rate for the anesthesia conversion factor by the sum of the base unit (using the value specified in the most recently published edition (as of the date of service) of the American Society of Anesthesiologists Relative Value Guide), time unit, and physical status modifier units of the participant, beneficiary, or enrollee to whom anesthesia services are furnished to determine the QPA.

To calculate the QPA for anesthesia services furnished during 2023 or a subsequent year, the plan or issuer must use the indexed median contracted rate for the anesthesia conversion factor, and adjust that amount by the percentage increase in the CPI-U over the previous year using the methodology described earlier in this section of the preamble.

The plan or issuer must then multiply that amount by the sum of the base unit (using the value specified in the most recently published edition (as of the date of service) of the American Society of Anesthesiologists Relative Value Guide), time unit, and physical status modifier units for the participant, beneficiary, or enrollee to whom anesthesia services are furnished to determine the QPA.

Air Ambulance Services

Payers often reimburse for air ambulance services in part by using air mileage service codes (A0435 and A0436) and reimbursement levels that reflect the number of miles an individual is transported by the air ambulance, which are referred to as loaded miles. Payment amounts are calculated by multiplying the negotiated rate for the service code, referred to in this rule as the air mileage rate, by the number of loaded miles. These interim final rules include a methodology for calculating the QPA for these air mileage service codes that reflects the manner in which providers are generally paid for the service codes.

To calculate the QPA for the portion of air ambulance services billed using the air mileage service codes that are furnished during 2022, the plan or issuer must first increase the median contracted rate, in accordance with 26 CFR 54.9816–6T(c)(1)(i), 29 CFR 2590.716–6(c)(1)(i), or 45 CFR 149.140(c)(1)(i), as applicable. This amount is referred to as the indexed median air mileage rate. The plan or issuer must then multiply the indexed median air mileage rate by the number of loaded miles provided to the participant, beneficiary, or enrollee to determine the QPA.

To calculate the QPA for air ambulance services billed using the air mileage service codes (A0435 and A0436) that are furnished during 2023 or a subsequent year, the plan or issuer must increase the indexed median air mileage rate, determined for such services furnished in the immediately preceding year, using the methodology described in 26 CFR 54.9816–6T(c)(1)(ii), 29 CFR 2590.716–6(c)(1)(ii), or 45 CFR 149.140(c)(1)(ii), as applicable. The plan or issuer must then multiply the indexed median air mileage rate by the number of loaded miles provided to the participant, beneficiary, or enrollee to determine the QPA.

d. Cases With Insufficient Information

Section 9816(a)(3)(E)(iii) of the Code, section 716(a)(3)(E)(iii) of ERISA, and section 2799A–1(a)(3)(E)(iii) of the PHS

Act, as added by the No Surprises Act, specify an alternative process to determine the QPA in cases where a group health plan or health insurance issuer offering group or individual health insurance coverage lacks sufficient information to calculate the median of contracted rates in 2019, as well as for newly covered items or services in the first coverage year after 2019.

Definition of Sufficient Information

Under these interim final rules, a plan or issuer is considered to have sufficient information to calculate the median of contracted rates if the plan or issuer has at least three contracted rates on January 31, 2019, to calculate the median of the contracted rates in accordance with the methodology in these interim final rules. In the Departments' view, while a median contracted rate could be calculated with a smaller number of contracts, requiring a minimum of three contracted rates is supported by the statute's direction to calculate a median, rather than a mean. Furthermore, the Departments have determined that three contracted rates for a particular item or service in a geographic region represents the minimum number of contracts necessary to reasonably reflect typical market negotiations while reducing the potential for outlier rates to unduly influence the calculation of the QPA.

Under section 9816(a)(3)(E)(iii) of the Code, section 716(a)(3)(E)(iii) of ERISA, section 2799A–1(a)(3)(E)(iii) of the PHS Act, and these interim final rules, where a plan or issuer that initially does not have sufficient information to calculate the median contracted rate based on January 31, 2019 contracted rates (or for new plans and coverage or new service codes, as discussed in more detail in this section of the preamble) later gains sufficient information, the plan or issuer must calculate the QPA using the median contracted rate for the first sufficient information year. The first sufficient information year is defined as: (1) In the case of an item or service for which a plan or issuer does not have sufficient information to calculate the median of contracted rates in 2019, the first year after 2022 for which the plan or issuer has sufficient information to calculate the median of contracted rates in the year immediately preceding that first year after 2022; and (2) in the case of a newly covered item or service, the first year after the first coverage year for such item or service with respect to such plan or coverage for which the plan or issuer has sufficient information to calculate the median of the contracted rates in the year immediately preceding that first year.

In cases in which contracted rates for a year after 2019 must be used to calculate the median contracted rate, a plan or issuer will be considered to have sufficient information to calculate the median contracted rate for a year if, with respect to that year, both of the following conditions are met: (1) The plan or issuer has at least three contracted rates on January 31 of the year immediately preceding that year to calculate the median of the contracted rates in accordance with the methodology in these interim final rules; and (2) the contracted rates account (or are reasonably expected to account) for at least 25 percent of the total number of claims paid for that item or service for that year with respect to all plans of the sponsor (or of the administering entity, if applicable) or all coverage offered by the issuer that are offered in the same insurance market.

The requirement that a plan or issuer have at least three contracted rates for a particular item or service in a geographic region is the same as the requirement that applies when determining whether there is sufficient information to calculate a median contracted rate for items and services furnished during 2022 using the median of contracted rates as of January 31, 2019. The 25 percent minimum claims volume requirement, however, applies where only contracted rates for years after 2019 are used to determine whether a plan or issuer has sufficient information to calculate the median contracted rate in the first sufficient information year. While the Departments are not concerned about manipulation of the QPA in the majority of cases where the median contracted rate is based on 2019 contracted rates, the Departments recognize the potential for plans and issuers to engage in selective contracting practices that artificially change the median contracted rate in cases where subsequent year contracted rates are used to determine the QPA. Therefore, this requirement will help to ensure that when contracted rates for years after 2019 are used to calculate a median contracted rate, those network contracts represent a reasonable proportion of a plan's or issuer's total claims and are not designed to manipulate the QPA.

Eligible Databases

In cases in which a plan or issuer does not have "sufficient information" to calculate a median contracted rate, the No Surprises Act directs the plan or issuer to determine the QPA through use of any database that is determined, in accordance with rulemaking issued by the Departments, to not have any

conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region (such as a state all-payer claims database).

These interim final rules establish standards for databases, referred to as eligible databases, that may be used to determine the QPA. State all-payer claims databases are categorically eligible under these interim final rules because they are specifically identified as not having any conflicts of interest and as having sufficient information reflecting allowed amounts in section 9816(a)(3)(E)(iii)(I) of the Code, section 716(a)(3)(E)(iii)(I) of ERISA, and section 2799–1(a)(3)(E)(iii)(I) of the PHS Act. Other third-party databases may also be eligible, provided all of the following conditions are satisfied.

First, the database or the organization maintaining the database cannot be affiliated with, or owned or controlled by, any health insurance issuer, or a health care provider, facility, or provider of air ambulance services, or any member of the same controlled group as, or under common control with, any such entity. For example, if a majority of the members on the governing board of a database or the organization maintaining the database are associated with a health insurance issuer, the database would be considered to have a conflict of interest under these interim final rules, since it is controlled by the issuer. As another example, if an issuer owns 40 percent of the stock of the organization that maintains a database, and its subsidiary owns an additional 20 percent of the stock of the organization that maintains the database, the database would be considered to have a conflict of interest under these interim final rules, since it is effectively controlled by the issuer. As a third example, if an issuer and the organization that maintains a database are both subsidiaries of the same parent organization, the database would be considered to have a conflict of interest under these interim final rules, since it is affiliated with the issuer. In the Departments' view, this standard is critical to ensuring the independence of any database used to determine the QPA. The Departments solicit comment on whether a database should not be affiliated with, or owned or controlled by, other entities, such as plan sponsors or third-party administrators, in order to avoid a conflict of interest. The Departments also seek comment on whether to establish a specific threshold that a party's minority ownership interest must meet or exceed in order to

create a conflict of interest for purposes of these interim final rules.

For purposes of applying the controlled group rules to eligible databases, a controlled group means a group of two or more persons that is treated as a single employer under Code sections 52(a), 52(b), 414(m), or 414(o). The Treasury Department and the IRS are considering whether further guidance is needed under section 52(a) or (b) of the Code to address either organizations exempt from tax under section 501(a) of the Code or nonprofit organizations that, although not exempt from tax under section 501(a) of the Code, do not have members or shareholders that are entitled to receive distributions of the organization's income or assets (including upon dissolution) or that otherwise retain equity interests similar to those generally held by owners of for-profit entities. Until further guidance is issued, those two types of organizations may either rely on a reasonable, good-faith application of section 52(a) and (b) of the Code (taking into account the reasons for which the controlled group rules are incorporated into the definition of eligible database) or apply the rules set forth in 26 CFR 1.414(c)–5(a) through (d) (but substituting “more than 50 percent” in place of “at least 80 percent” each place it appears in 26 CFR 1.414(c)–5).

Second, the database must have sufficient information reflecting in-network amounts paid by group health plans or health insurance issuers offering group or individual health insurance coverage to providers, facilities, or providers of air ambulance services for relevant items and services furnished in the applicable geographic region. The Departments recognize that for a database to be used to calculate the QPA, the database should contain sufficient data to reflect the true market dynamics in a given geographic region. However, in order to provide flexibility in the initial implementation of the No Surprises Act, these interim final rules do not establish a specific definition of when a database is considered to have sufficient information. The Departments seek comment on how to define when a database has sufficient information, including whether to establish specific criteria that a claims database would need to satisfy in order to demonstrate that it has sufficient information reflecting in-network payment amounts for providers or facilities in the applicable geographic region, such as a requirement that the database represents a specified minimum percentage of the claims volume for the region.

Third, the database must have the ability to distinguish amounts paid to participating providers and facilities by commercial payers, such as group health plans and health insurance issuers offering group or individual health insurance coverage, from all other claims data, such as amounts billed by nonparticipating providers or facilities and amounts paid by public payers, including the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of the Social Security Act (or a demonstration project under title XI of the Social Security Act),⁶¹ and the Children's Health Insurance Program under title XXI of the Social Security Act.

To calculate the QPA for an item or service furnished during 2022 (or in the case of newly covered items or services, in the first coverage year) using an eligible database, the plan or issuer must first identify the rate in the database that is equal to the median of the in-network allowed amounts for the same or similar item or service in the geographic region in the year immediately preceding the year in which the item or service is furnished (or in the case of a newly covered item or service, the year immediately preceding the first coverage year). It is the Departments' view that in-network allowed amounts for items and services are a reasonable proxy for contracted rates, and that where there is insufficient information to calculate the QPA based on the median of a plan's or issuer's own contracted rates, using the median of in-network allowed amounts for all private payers in an eligible database is a reasonable method for approximating the median contracted rate for items and services in the applicable geographic region. The Departments are also of the view that determining the QPA for an item or service using the median of in-network allowed amounts for the same or similar item or service in the geographic region in the year immediately preceding the year in which the item or service is furnished is reasonably likely to result in levels of cost sharing that are

⁶¹ Under section 1115 of the Social Security Act, the Secretary of HHS has the authority to approve experimental, pilot, or demonstration projects that, in his judgment, are likely to assist in promoting the objectives of the Medicaid statute. Under section 1115 authority, the Secretary may waive compliance with certain provisions of Medicaid and CHIP law and may authorize federal matching funds for state expenditures that would not otherwise be federally matchable under the Medicaid and CHIP statutes. Many states have section 1115 demonstrations under which they cover services that would not otherwise be covered under the Medicaid or CHIP programs.

generally in line with the cost-sharing liability incurred by participants, beneficiaries, and enrollees in plans with similar levels of in-network cost-sharing for the same or similar items or services.

Once the median in-network allowed amount has been identified, that rate is then increased by the percentage increase in the CPI-U over the previous year using the methodology described earlier in this section of the preamble. For each subsequent year before the first sufficient information year, the plan or issuer must increase the QPA applicable to items or services furnished in the immediately preceding year by the percentage increase in CPI-U over the preceding year. Plans and issuers must continue to use this methodology until the first sufficient information year, at which point the plan or issuer must calculate the median contracted rate and determine the QPA using the standard methodology discussed earlier in this section of the preamble.

These interim final rules require that plans and issuers use a consistent methodology when relying on an eligible database. Specifically, for any particular item or service, a plan or issuer using a database must use the same database to determine the QPA for that item or service through the last day of the calendar year, and if a different database is selected for some items or services, the basis for that selection must be one or more factors not directly related to the rate of those items or services (such as sufficiency of data for those items or services).⁶² This consistency requirement is designed to ensure that when relying on an eligible database to determine the QPA for an item or service, a plan or issuer cannot vary the database selected due to the rates associated with that item or service. The Departments seek comment on this consistency requirement and whether additional standards or guidance are needed to ensure compliance and prevent abuse.

Finally, these interim final rules codify section 9816(d) of Code, section 716(d) of ERISA, and section 2799A-1(d) of PHS Act, as added by the No Surprises Act, which provide that a plan or issuer that uses an eligible database to determine the QPA by reason of having insufficient information is responsible for any costs associated with accessing such database. The Departments solicit comment on ways

to help ensure that plans and issuers are charged only reasonable costs for accessing such databases and that entities that provide eligible databases are transparent about their fees and fee structures associated with this process.

New Plans and Coverage

The No Surprises Act directs the Departments to establish a methodology for the sponsor of a group health plan or a health insurance issuer that did not offer any plan or coverage in a geographic region in 2019 to determine QPAs for the first year in which the plan or coverage will be offered in the geographic region. For each subsequent year, that amount is increased by the percentage increase in the consumer price index for all urban consumers over the previous year.

The Departments recognize that while a sponsor or issuer may be newly offering coverage in a geographic region, the sponsor or issuer may have sufficient existing provider contracts under other current coverage in the geographic region where an item or service is furnished to calculate the QPA. The Departments clarify that it is not necessary to establish special procedures to calculate the QPA in these situations. Therefore, under these interim final rules, if the plan or issuer newly offering coverage in a geographic region for a year after 2019 otherwise has sufficient information to calculate a median contracted rate in 2019 in the geographic region where the item or service is furnished, the QPA is determined using the standard methodology for calculating median contracted rates discussed earlier in this section of the preamble.

The Departments recognize that the standard methodology would not be available, however, in cases where the plan or issuer does not have sufficient information to calculate a median contracted rate in the geographic region in which the item or service is furnished, such as in situations where the sponsor or issuer did not offer any plan or coverage in 2019. In this case, the plan or issuer must determine the QPA in accordance with the rules applicable to plans or issuers with insufficient information, or for newly covered items and services, including the use of an eligible database, as discussed earlier in this section of the preamble.

For each subsequent year the plan or coverage is offered in the geographic region, the plan or issuer must increase the QPA for items or services furnished in the immediately preceding year by the percentage increase in the CPI-U over the previous year to determine the

QPA for items and services furnished in that year. Under this approach, new plans and coverage that initially do not have sufficient information to calculate a median contracted rate must use a QPA based on information for the first year of coverage from an eligible database indefinitely, updated only by the inflation adjustment. The Departments seek comment on whether the methodology should instead allow new plans and coverage to transition to calculating a QPA using median contracted rates in an applicable first sufficient information year.

New Service Codes

When service codes are created, plans and issuers may be unable to calculate the QPA using the approaches discussed earlier, because neither the plan or issuer nor any eligible databases have sufficient information regarding the new service code. This situation may occur for new service codes when the service codes describe items or services that have not previously been widely furnished. This situation may also occur when service codes are substantially revised, resulting in new service codes or new descriptors for existing service codes that substantially alter the types of services that would be billed using the original service codes. In this case, the plan, issuer, or eligible database may have sufficient information regarding rates for items and services billed under the service code prior to the revision, but that information may no longer reflect the rates associated with the items and services billed under the revised service code. The No Surprises Act does not specify a methodology for calculating the QPA in these circumstances. However, in the Departments' view, it is necessary that these interim final rules establish a methodology that plans and issuers can rely on for calculating QPAs for new service codes during periods of time when no eligible databases would reasonably be expected to have sufficient data to calculate a QPA.

These interim final rules define "new service code" to mean a service code that was created or substantially revised in a year after 2019. In situations in which a plan or issuer is billed for a covered item or service using a new service code, the plan or issuer must first identify a reasonably related service code that existed in the immediately preceding year. For example, a reasonably related service code might be another service code within the same family of codes, or might involve services that represent similar relative value units. This related service code will be used as a benchmark for

⁶² For example, these interim final rules permit a plan or issuer to rely on different state all-payer claims databases, based on the geographic region in which an item or service is furnished, as state all-payer claims databases may not have sufficient data for items and services furnished outside of the state.

determining the QPA for the new service code. The Departments seek comment on whether additional rules are needed regarding how plans and issuers should be required to identify a reasonably related service code, and on whether the Departments should develop a crosswalk methodology to identify related service codes for each new service code.

The Departments are of the view that, although Medicare payment rates may differ substantially from rates paid by plans and issuers, it is reasonable to use Medicare payment rates to approximate the relative cost of two different but reasonably related service codes. Therefore, if CMS has established a payment rate under the Medicare program for an item or service billed under the new service code, the plan or issuer must calculate the ratio of the rate that Medicare pays for the item or service billed under the new service code compared to the rate that Medicare pays for the item or service under the related service code (with both rates disregarding any adjustments for value-based purchasing arrangements that could lead to bonuses or deductions), and multiply that ratio by the QPA for the related service code for the year in which the item or service is furnished.

The Departments recognize that in some cases the Medicare program might not immediately establish a payment rate for items and services billed under a new service code. Therefore, these interim final rules establish a secondary approach to determine the QPA in these situations. Specifically, for items and services billed using a new service code for which Medicare has not established a payment rate, the plan or issuer must calculate the QPA by first calculating the ratio of the rate that the plan or issuer reimburses for an item or service billed under the new service code compared to the rate that the plan or issuer reimburses for an item or service under the related service code (the relativity ratio), and then multiplying the relativity ratio by the QPA for the item or service billed under the related service code. These interim final rules do not specify a particular method that plans and issuers must use to calculate this relativity ratio. However, the Departments expect plans and issuers to use a reasonable method for making the calculation, and seek comment on whether future rulemaking should specify additional requirements for determining the relativity ratio. For example, plans and issuers could be required to calculate the ratio using the medians or means of the contracted rates for each of the two services. However, the Departments recognize

that it may take time for plans and issuers to enter into negotiated rates for new service codes, and therefore the medians or means may change over time. Alternatively, plans and issuers could be required to calculate the relativity ratio using rates from one contract, based on the assumption that negotiated rates within any given contract would generally produce a similar relativity ratio. The Departments are of the view that using rates from two different contracts would not constitute a reasonable method for calculating the relativity ratio, as this approach could introduce into the relativity ratio, variation from factors that are unrelated to the relative cost of furnishing the item or service, such as the negotiating power of the parties to the contract.

Under the methodology in these interim final rules, for items or services furnished in any subsequent year (before the first sufficient information year for such item or service with respect to such plan or coverage or before the first year for which an eligible database has sufficient information in the immediately preceding year), the plan or issuer must calculate the QPA by increasing the QPA calculated for the prior year by the percentage increase in CPI-U over the immediately preceding year.

However, for an item or service billed using a new service code, and furnished in the first sufficient information year for such item or service with respect to such plan or coverage, or furnished in the first year for which an eligible database has sufficient information to enable the plan or issuer to calculate the QPA using the processes that generally apply when an issuer or plan has insufficient information, the plan or issuer must calculate the QPA in accordance with 26 CFR 54.9816-6T(c)(3), 29 CFR 2590.716-6(c)(3), or 45 CFR 149.140(c)(3), as applicable. Thus, once the plan or issuer or an eligible database has sufficient information to calculate a QPA, the QPA for a new service code would be calculated using the median contracted rate of the plan or issuer, or the median of the in-network allowed amounts in the eligible database.

The Departments seek comment on any alternate approaches that could be used to determine the QPA for new service codes.

e. Information To Be Shared About the QPA

The No Surprises Act directs the Departments to specify the information that a plan or issuer must share with a nonparticipating provider or nonparticipating emergency facility, as

applicable, when making a determination of a QPA.

The Departments recognize that providers, emergency facilities, and air ambulance providers subject to the surprise billing rules need transparency regarding how the QPA was determined. This information is also important in informing the negotiation process. In addition, IDR entities are directed by statute to consider the QPA when selecting an offer submitted by the parties through the IDR process. Therefore, to decide whether to initiate the IDR process and what offer to submit, a provider, emergency facility, or provider of air ambulance services must know not only the value of the QPA, but also certain information on how it was calculated.

The Departments seek to ensure transparent and meaningful disclosure about the calculation of the QPA while minimizing administrative burdens on plans and issuers. These interim final rules therefore require that plans and issuers make certain disclosures with each initial payment or notice of denial of payment, and that plans and issuers must provide additional information upon request of the provider or facility. This information must be provided in writing, either on paper or electronically, to a nonparticipating provider, emergency facility, or provider of air ambulance services, as applicable, when the QPA serves as the recognized amount.

First, a plan or issuer must provide the QPA for each item or service involved.

Second, a plan or issuer must provide a statement certifying that, based on the determination of the plan or issuer: (1) The QPA applies for purposes of the recognized amount (or, in the case of air ambulance services, for calculating the participant's, beneficiary's, or enrollee's cost sharing), and (2) each QPA shared with the provider or facility was determined in compliance with the methodology outlined in these interim final rules. These interim final rules require a statement from the plan or issuer that the QPA applies for purposes of the recognized amount so that providers and facilities will understand that the plan or issuer has determined that neither an All-Payer Model Agreement nor a specified state law applies for purposes of calculating a participant's, beneficiary's, or enrollee's cost-sharing liability, but rather that cost-sharing liability has been calculated using the QPA. With respect to air ambulance services, the statement will ensure providers of air ambulance services understand that the QPA, rather than the billed charge, applies for

purposes of calculating the cost-sharing liability, because the plan or issuer has determined that the QPA is lower than the billed charge. The Departments expect that in most if not all cases where the QPA serves as the basis for determining the recognized amount, the federal IDR process will govern any dispute over payment instead of a specified state law or process. Therefore, this notice will also serve to direct providers or facilities to the federal IDR process if the parties cannot agree on an out-of-network rate.

Third, a plan or issuer must provide a statement that if the provider or facility, as applicable, wishes to initiate a 30-day open negotiation period for purposes of determining the amount of total payment, the provider or facility may contact the appropriate person or office to initiate open negotiation, and that if the 30-day open negotiation period does not result in a determination, generally, the provider or facility may initiate the IDR process within 4 days after the end of the open negotiation period. The plan or issuer must also provide contact information, including a telephone number and email address, for the appropriate office or person to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service.

In addition, upon request of the provider or facility, a plan or issuer must provide, in a timely manner, information about whether the QPA includes contracted rates that were not set on a fee-for-service basis for the specific items and services at issue and whether the QPA for those items and services was determined using underlying fee schedule rates or a derived amount. If a related service code was used to determine the QPA for a new service code, a plan or issuer must provide information to identify which related service code was used. Similarly, if an eligible database was used to determine the QPA, a plan or issuer must provide information to identify which database was used to determine the QPA.

Finally, if applicable upon request, a plan or issuer must provide a statement that the plan's or issuer's contracted rates include risk-sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments for the items and services involved that were excluded for purposes of calculating the QPA. Having information about whether the median contracted rate excludes these types of payment adjustments will better inform the open negotiation and IDR process.

The Departments seek comment on these disclosure requirements and on what additional information a plan or issuer should be required to share with a provider or facility about the QPA, either in all cases or upon request. The Departments also seek comment on whether a specific definition or standard is needed to ensure that information provided upon request is disclosed in a timely manner.

f. Audits

The No Surprises Act requires rulemaking to establish a process under which group health plans and health insurance issuers offering group or individual health insurance coverage are audited by the applicable Secretary or applicable state authority to ensure that such plans and coverage are in compliance with the requirement of applying a QPA and that the QPA applied satisfies the definition under the No Surprises Act with respect to the year involved.⁶³

The enforcement responsibilities of HHS and the states with respect to oversight of health insurance issuer compliance with the federal insurance market reforms are set forth in the PHS Act. Pursuant to section 2723(a)(1) of the PHS Act, as amended by the No Surprises Act, states have primary enforcement authority over health insurance issuers regarding the provisions of Parts A and D of title XXVII of the PHS Act. Under this framework, HHS has enforcement authority over issuers in a state if the Secretary of HHS makes a determination that the state is failing to substantially enforce a provision (or provisions) of Part A or D of title XXVII of the PHS Act.⁶⁴

DOL and the Treasury Department generally have primary enforcement authority over private sector employment-based group health plans. The IRS has jurisdiction over certain church plans. HHS also has primary enforcement authority over non-federal governmental plans, such as those sponsored by state and local government employers.⁶⁵ OPM has jurisdiction over FEHB plans, which are federal governmental plans.

The Departments will generally use existing processes to ensure compliance with Code, ERISA, and PHS Act requirements that apply to group health

plans and health insurance issuers, including the provisions added by the No Surprises Act. HHS's enforcement procedures related to the PHS Act federal insurance market reforms are set forth in section 2723 of the PHS Act and 45 CFR 150.101 *et seq.*, including bases for initiating investigations and performing market conduct examinations. Section 504 of ERISA provides DOL with authority to determine whether any person has violated or is about to violate any provision of ERISA or any regulation or order thereunder. The interim final rules include an audit provision establishing that HHS's existing enforcement procedures will apply with respect to ensuring that a plan or coverage is in compliance with the requirement of determining and applying a QPA consistent with these interim final rules. HHS intends to amend its enforcement regulations through future notice and comment rulemaking to reflect the amendments made to the PHS Act by the No Surprises Act. OPM will audit FEHB plans to ensure that such plans are in compliance with the requirement of determining and applying a QPA.

vii. Determination of Out-of-Network Rate in the Absence of a Specified State Law or an Applicable All-Payer Model Agreement

In instances in which a specified state law or All-Payer Model Agreement does not apply for purposes of specifying the out-of-network rate, the out-of-network rate is determined either through agreement between the provider or facility and plan or issuer; or through an IDR process, if agreement cannot be reached and such process is initiated. If the parties agree to an amount of payment prior to the date on which a certified IDR entity makes a determination with respect to such items or services, that agreed upon amount is the out-of-network rate. Otherwise, the out-of-network rate is the amount of payment determined by the certified IDR entity for the items or services.⁶⁶

3. Additional Plan and Issuer Requirements Regarding Making Initial Payments or Providing a Notice of Denial

The No Surprises Act and these interim final rules establish several procedural requirements that apply to group health plans and health insurance issuers to ensure that billing disputes

⁶³ See section 9816(a)(2)(A) of the Code; section 2799A-1(a)(2)(A) of the PHS Act. The DOL and OPM will rely on the existing agency processes to ensure compliance with the No Surprises Act, as discussed in this section of the preamble.

⁶⁴ Section 2723(a)(2) and (b)(1)(A) of the PHS Act. See also 45 CFR 150.203.

⁶⁵ See section 2723(b)(1)(B) of the PHS Act.

⁶⁶ As noted previously, the Departments intend to implement the federal IDR process in future rulemaking.

related to items and services subject to the balance billing protections in the No Surprises Act are resolved in a timely fashion. These include timeframes for: A plan or issuer to send a notice of denial of payment or make an initial payment; the length of any open negotiation period regarding payment; and initiating the IDR process following an open negotiation period. However, those three requirements do not apply under certain circumstances with regard to post-stabilization services or to out-of-network non-emergency services (other than out-of-network air ambulance services) if the provider or facility provided notice to, and received consent from, the participant, beneficiary, or enrollee (or their authorized representative), as discussed later in this preamble.

Therefore, it is critical that a group health plan or health insurance issuer have knowledge of any notice provided and consent given under these interim final rules for items and services that it covers, and that would otherwise be subject to the surprise billing provisions in the statute and these interim final rules. As discussed later in this preamble, the interim final rules issued by HHS in this rulemaking require providers and facilities to notify plans and issuers when the notice and consent criteria have been satisfied. Absent receiving this information, a plan or issuer must assume that the individual has not waived the protections provided in these interim final rules, and must therefore calculate cost sharing, apply cost sharing to deductibles and out-of-pocket limits, and make any payments to providers and facilities before an individual has satisfied the coverage deductible, accordingly. In instances where a plan or issuer does receive this information, it may rely on the provider's or facility's representation as being true and accurate, unless and until the plan or issuer knows or reasonably should know otherwise. Thus, if a provider or facility indicates to a plan or issuer that the notice and consent described in these interim final rules was properly and timely given and received, the plan or issuer may rely on that information and, for example, apply out-of-network cost sharing for the applicable items and services, unless and until the plan or issuer knows or reasonably should know that the notice and consent was not properly and timely given and received. In cases where a plan or issuer believes that notice was not properly and timely given and received, notwithstanding a provider's or facility's assertion to the contrary, the plan or issuer should

apply the cost-sharing and other requirements set forth in these interim final rules and applicable state law by, among other actions, reprocessing any claims that were not processed consistently with those requirements. The plan or issuer may also submit a complaint against the provider or facility as set forth in these interim final rules at 45 CFR 149.450.

Sections 9816(a)(1)(iv)(I) and 9817(a)(3)(A) of the Code, sections 716(a)(1)(iv)(I) and 717(a)(3)(A) of ERISA, sections 2799A–1(a)(1)(iv)(I) and 2799A–2(a)(3)(A) of the PHS Act, and these interim final rules, require plans and issuers to send “an initial payment or notice of denial of payment” not later than 30 calendar days after a nonparticipating provider or facility submits a bill related to the items and services that fall within the scope of the new surprise billing protections for emergency services, non-emergency services performed by nonparticipating providers at participating facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services. Given that plans and issuers cannot comply with this requirement unless the plan or issuer first determines that the billed items and services are covered under the plan or coverage, these interim final rules require that the plan or issuer make such determination not later than 30 calendar days after a nonparticipating provider or facility submits a bill related to the items and services that fall within the scope of the new surprise billing protections for emergency services, non-emergency services performed by nonparticipating providers at participating facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services.

The Departments specify in these interim final rules that the 30-calendar-day period generally begins on the date the plan or issuer receives the information necessary to decide a claim for payment for such services, commonly known as a “clean claim” under many existing state laws. To the extent feasible, the Departments encourage providers and facilities to include information about whether the surprise billing protections apply to an item or service on the claim form itself. With respect to non-emergency services, HHS requires, under 45 CFR 149.420(i), nonparticipating providers (or the participating facility on behalf of the nonparticipating provider) to timely notify the plan or issuer that the item or service was furnished during a visit at a participating health care facility. In addition, in all cases, under either 45

CFR 149.410(e) or 45 CFR 149.420(i), providers and facilities must notify the plan or issuer as to whether the requirements for notice and consent have been met when transmitting the bill, either on the bill or in a separate document. The Departments seek comments with recommendations on how HIPAA standard transactions to submit claims could be modified to accommodate the submission of several types of information on the claim itself. Specifically, the Departments seek comment on how HIPAA standard transactions to submit claims could be modified to include whether the surprise billing protections apply to the items and services included on a claim, whether the item or service was furnished during a visit at a participating health care facility, and whether the requirements for notice and consent have been met. The 30-calendar-day initial payment period also does not prohibit payments outside of the 30-calendar-day timeframe for any future adjustments for errors in payment, such as in cases of duplicate bills where providers and plans or issuers reconcile overpayments. The Departments expect that plans and issuers will act reasonably and in good faith when requesting additional information, by providing specific detail to help ensure that the claimant, provider, or facility understands what is required to perfect the claim. The Departments may specify additional standards if the Departments become aware of instances of abuse and gaming where plans and issuers are unduly delaying making an initial payment or sending a notice of denial to providers on the basis that the provider has not submitted a clean claim. The Departments solicit comment on whether any additional standards are necessary to prevent abusive claims payment practices. Under these interim final rules, a notice of denial of payment means, with respect to an item or service for which benefits are subject to the surprise billing protections, a written notice from the plan or issuer to the provider or facility that payment for the item or service will not be made by the plan or coverage and which explains the reason for denial. A notice of denial of payment could be provided, for example, if the item or service is covered but is subject to a deductible greater than the recognized amount.

In the Departments' view, the statute's reference to an “initial” payment does not refer to a first installment. Rather, this initial payment should be an amount that the plan or issuer reasonably intends to be payment in full

based on the relevant facts and circumstances and as required under the terms of the plan or coverage, prior to the beginning of any open negotiations or initiation of the IDR process. In cases where the provider or facility is willing to accept the cost-sharing amount plus the initial payment (or the cost-sharing amount alone, in cases where a denial of payment is sent) as payment in full, this amount will be treated as the out-of-network rate. If plans and issuers make initial payments that providers and facilities are willing to accept (when combined with the cost-sharing amount) as payment in full, the administrative costs of determining the out-of-network amount will be significantly reduced through the avoidance of an open negotiation period and IDR process.

These interim final rules do not require plans and issuers, when making an initial payment to providers or facilities, to make any specific amount of minimum initial payment. However, several state balance billing laws set standards for minimum initial payment amounts. For example, in Washington State, issuers are required to pay an out-of-network provider or facility a commercially reasonable amount, reduced by the applicable cost-sharing amount, within 30 calendar days of receipt of a claim to which the state's balance billing protections apply. Requiring a minimum initial payment amount may help reduce the number of cases that go to arbitration in some states, and could help to reduce the number of cases that go to the federal IDR process established under the No Surprises Act.

The Departments seek comment on whether to set a minimum payment rate or methodology for a minimum initial payment in future rulemaking, and if so, what that rate or methodology should be. For example, a minimum payment rate could be a specific percentage of the Medicare rate, a specific percentage of the plan or issuer's QPA for the item or service, an amount calculated in the same way the plan or issuer typically calculates payment for the specific item or service to nonparticipating providers or facilities, an amount representing the highest amount that would result from applying two or more of these or other methodologies, or any other method. To the extent comments suggest that a percentage of a rate calculated or determined in a specific way would be appropriate, the Departments seek comment regarding an appropriate specific percentage. The Departments also seek comment on whether a minimum payment rate should be defined as a commercially reasonable

rate based on payments for the same or similar services in a similar area, without requiring any specific methodology. In addition, the Departments seek comment regarding the impact of these provisions on underserved and rural communities, and other communities facing a shortage of providers.

The Departments are aware that the timeframes for deciding post-service claims under the claims and appeals rules issued under section 2719 of the PHS Act and the timeframes for sending an initial payment or notice of denial of payment under these final rules may not always align. The Departments seek to minimize confusion about which types of disputes should be resolved through a plan or issuer's internal claims and appeals process instead of the IDR process established by the No Surprises Act.

The ERISA claims procedure regulation requires group health plans to notify a claimant of a benefit determination for post-service claims not later than 30 days after receipt of the claim. A plan can generally extend this period once for up to 15 days for matters beyond the control of the plan, including if the claimant fails to provide information necessary to decide the claim. In such cases, the plan may notify the claimant they provided insufficient information within 30 days, and the plan must give the claimant at least 45 days to provide additional information. After the information is provided, the plan has 15 days to make a determination. Claims that result in an adverse benefit determination (ABD) may be appealed within 180 days following receipt of the notice of the ABD. The requirements of the ERISA claims procedure regulation are incorporated by reference in the internal claims and appeals and external review requirements added by the Affordable Care Act to section 2719 of the PHS Act and, therefore, subject to limited exceptions, apply to all non-grandfathered group health plans and health insurance issuers offering non-grandfathered coverage in the group and individual markets.

If an initial claim submitted is a clean claim, the timeframes for making the relevant determinations would generally be aligned under these interim final rules and the ERISA claims procedure regulation. However, if a claim is submitted without sufficient information to make a benefit determination, under the ERISA claims procedure regulation, the plan would only have 15 days to make a determination once the claim is resubmitted with the additional

information. Yet, under the No Surprises Act and these interim final rules, the plan would have up to 30 calendar days to send a notice of denial of payment or an initial payment to the out-of-network provider from the time the claim is resubmitted with additional information. Consistent with the requirement that plans and issuers provide an initial payment or notice of denial of payment within 30 calendar days of a provider or facility submitting a clean claim, the Departments clarify that while the ERISA claims procedure regulation would require plans to make a benefit determination within 15 days of a claim being resubmitted with additional information, plans and issuers have 30 calendar days (which is an additional 15 days) to make an initial payment to a nonparticipating provider or facility, or send a separate notice of denial of payment.

The Departments note that there is also a significant distinction between an ABD, which may be disputed through a plan's or issuer's claims and appeals process, and a denial of payment or an initial payment that is less than the billed amount under these interim final rules, which may be disputed through the open negotiation process or through the IDR process. In general, when adjudication of a claim results in a participant, beneficiary, or enrollee being personally liable for payment to a provider or facility, this determination may be an ABD that can be disputed through a plan's or issuer's claims and appeals process. Conversely, when: (1) The adjudication of a claim results in a decision that does not affect the amount the participant, beneficiary, or enrollee owes; (2) the dispute only involves payment amounts due from the plan to the provider; and (3) the provider has no recourse against the participant, beneficiary, or enrollee, the decision is not an ABD and the payment dispute may be resolved through the open negotiation or the IDR process. This clarification is consistent with previous guidance included in FAQs related to the ERISA claims procedure regulation, which have explained that with respect to in-network benefits, the regulation does not apply to requests by health care providers for payments due to the provider, rather than due to the claimant, where the provider has no recourse against the claimant for amounts, in whole or in part, not paid by the plan.⁶⁷ The Departments

⁶⁷ See Benefit Claims Procedure Regulation FAQs, Q A-8, available at <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/benefit-claims-procedure-regulation>; see also Q C-12 (clarifying that failure to make payment in whole

Continued

acknowledge that there may be instances where a participant, beneficiary, or enrollee appeals an ABD (such as, a determination of cost-sharing amounts) through the claims and appeals process concurrently with a provider's challenge to a payment amount through the IDR process.

4. Surprise Billing Complaints Regarding Group Health Plans and Health Insurance Issuers

Section 9816(a)(2)(B)(iv) of the Code, section 716(a)(2)(B)(iv) of ERISA, and section 2799A-1(a)(2)(B)(iv) of the PHS Act direct the Departments to establish a process to receive complaints regarding violations of the application of QPA requirements by group health plans and health insurance issuers offering group or individual health coverage. The Departments are of the view that, in order to effectively enforce the No Surprises Act balance billing protections, the complaints process should extend to all of the consumer protection and balance billing requirements as described in these interim final rules that apply to group health plans and health insurance issuers offering group or individual health coverage. As such, these interim final rules establish a process by which the Departments will receive complaints regarding violations by plans and issuers of the requirements under sections 9816 and 9817 of the Code, sections 716 and 717 of ERISA, and sections 2799A-1 and 2799A-2 of the PHS Act. The Departments seek comment on whether the complaints process should be restricted to the QPA or extended as described in these interim final rules.

The No Surprises Act also adds section 2799B-4(b)(3) of the PHS Act, which directs HHS to establish a process to receive consumer complaints regarding violations by health care providers, facilities, and providers of air ambulance services regarding balance billing requirements under sections 2799B-1, 2799B-2, 2799B-3, and 2799B-5 of the PHS Act and to respond to such complaints within 60 days. As such, HHS is issuing HHS-only interim final rules to establish a process by which HHS will receive complaints regarding violations of these requirements by health care providers, facilities, and providers of air ambulance services.

For purposes of the complaint processes for plans and issuers, providers, facilities, and providers of air ambulance services, these interim final

rules define a complaint as a written or oral communication that indicates there has been a potential violation by a plan or issuer of sections 9816 or 9817 of the Code, sections 716 or 717 of ERISA, or sections 2799A-1, 2799A-2 of the PHS Act, or a potential violation by a provider, facility, or provider of air ambulance services of sections 2799B-1, 2799B-2, 2799B-3 and 2799B-5 of the PHS Act, whether or not a violation actually occurred. A complainant means any individual, or their authorized representative, who files a complaint as defined in these interim final rules.

The Departments seek to minimize the burden of filing a complaint and seek to require only the information necessary to process the complaint and conduct an investigation if deemed necessary. Therefore, these interim final rules specify that the Departments will consider a complaint to be filed on the date on which the Departments receive an oral or written statement with information about the complaint sufficient to identify the parties involved (including the plan sponsor, if the complaint involves a group health plan), and the action or inaction that is the subject of the complaint. The information may also include the timing of the alleged violation, and the state where the alleged violation occurred. The Departments seek comment on the information needed to file a complaint, and the definitions in this section.

The Departments have considered whether a complaint should be filed within a defined amount of time of the alleged violation. The Departments understand that timely action is necessary to investigate and adjudicate billing matters and therefore considered whether complainants should be required to file a complaint regarding an alleged violation of the requirements in these interim final rules by a plan, issuer, health care provider or provider of air ambulance services within 90 or 180 calendar days after learning of the alleged violation. Without a time requirement for filing a complaint, the Departments may be restricted in directing the complainant to other state or federal resolution processes with timing requirements such as the internal and external claims review process as described in section 2719 of the PHS Act, or an appropriate IDR process as defined in sections 9816 and 9817 of the Code, sections 716 and 717 of ERISA, and sections 2799A-1 and 2799A-2 of the PHS Act. However, the Departments are of the view that every complaint should be processed and investigated as appropriate to ensure that any necessary enforcement action can be taken. Therefore, these interim final rules do

not include a time period upon which a complaint must be filed. The Departments seek comment on whether a complainant should be required to file a complaint within a given time period and if so within what time period a complaint should be filed for the purpose of this section.

Section 2799B-4 of the PHS Act directs HHS to respond to complaints regarding violations of balance billing protections by health care providers, facilities, and providers of air ambulance services within 60 days of receipt. The Departments are of the view that the timing for responding to complaints regarding plans and issuers should be the same as that for providers to ensure timely resolution. Therefore, upon receiving the information necessary to file a complaint regarding a plan or issuer, the Departments will respond to complainants under section 9816(a)(2)(B)(iv) of the Code, section 716(a)(2)(B)(iv) of ERISA, and section 2799A-1(a)(2)(B)(iv) of the PHS Act no later than 60 business days after the complaint is received. Similarly, HHS will respond to a processed complaint regarding a health care provider, facility, or provider of air ambulance services under section 2799B-4 of the PHS Act no later than 60 business days after the complaint is received.

The response will be by oral or written means, and will acknowledge receipt of the complaint, notify the complainant of their rights and obligations under the complaints process, and describe the next steps of the complaint resolution process. The Departments may also request any additional information needed to process the complaint. The requested information may include an explanation of benefits, processed claims, information about the health care provider, facility, or air ambulance service involved; information about the plan or issuer covering the individual; information to support a determination regarding whether the service was an emergency service or non-emergency service; the summary plan description, policy, certificate, contract of insurance, membership booklet, outline of coverage or other evidence of coverage the plan or issuer provides to their participant, beneficiary, or enrollee; documents regarding asserted facts in the complaint that are in the possession of or otherwise attainable by the complainant; or any other information the Departments may need to make a determination of facts for an investigation.

HHS may also request additional information to process a complaint under section 2799B-4 of the PHS Act

or in part due to the imposition of cost-sharing requirements is an ABD).

regarding a health care provider, facility, or provider of air ambulance services. This information may include, but is not limited to, the bills or network status of a health care provider, health care facility, or provider of air ambulance services; information regarding the health care plan or health insurance coverage of a participant, beneficiary or enrollee; information to support a determination regarding whether the service was an emergency service or non-emergency service; documents that support the asserted facts in the complaint in the possession of, or otherwise attainable by the complainant; or any other information HHS needs to make a determination of facts for an investigation. The Departments seek comment on additional information that may be required to process a complaint.

The response may be provided directly upon receipt of the complaint, or it may be provided afterwards, though no later than 60 business days after the complaint is received. The next steps of the complaint resolution process may include referring the complainant to another appropriate state or federal resolution process, referring a complainant to the state or federal regulatory authority with enforcement jurisdiction, or initiating an investigation for enforcement action. The Departments will make reasonable efforts consistent with agency practices to notify the complainant of the outcome of such investigations or enforcement actions, including an explanation of the findings, resolution, or any corrective action taken. The Departments will also make reasonable efforts to notify the complainant if the complaint is transferred to another state or Federal regulatory authority. The Departments seek comment on whether a complainant should receive the notification of the outcome of the complaint within a given time period and if so within what time period a complainant should receive the notice for the purpose of this section.

The Departments intend to provide the public with a seamless experience for filing complaints by creating one system to intake all complaints on behalf of all complainants under section 9816(a)(2)(B)(iv) of the Code, section 716(a)(2)(B)(iv) of ERISA, and sections 2799A–1(a)(2)(B)(iv) and 2799B–4 of the PHS Act. The Departments understand that a complainant may not know which Department has enforcement jurisdiction; therefore, the Departments intend to provide one system that will direct complaints to the appropriate Department for processing, investigation, and enforcement action as

necessary. The Departments will release guidance on where the public can file complaints and welcome comments on the operations, protections, user experience, or other facets of this complaint system. The Departments also seek comment on ways to ensure consumers are aware and know how to use this system.

The Departments seek to uphold Executive Order 13985 and all civil rights protections regarding non-discrimination and accessibility, as noted in prior sections. The Departments will make all reasonable efforts to implement a robust complaint process, including but not limited to, acknowledgement of receipt of a complaint, explanations of rights and information requested, explanations of findings, and referrals to other authorities. The Departments will ensure that the complaints process is accessible to all individuals, that communication and language needs are met, and that all individuals are able to understand the options available to them and information required of them. The Departments seek comment from individuals in underserved and rural communities, minority communities, and persons otherwise adversely affected by persistent poverty or inequality on specific barriers to the complaint process and solutions to address these barriers and ensure equitable access to all aspects of the complaint processes.

C. Choice of Health Care Professionals

In the Patient Protections Final Rule, the Departments finalized regulations addressing the provisions in section 2719A of the PHS Act, regarding patient protections related to choice of health care professional and emergency services.⁶⁸ As explained earlier, the No Surprises Act amended section 2719A of the PHS Act to sunset when the new emergency services protections under the No Surprises Act take effect. The provisions of section 2719A of the PHS Act will no longer apply with respect to plan years beginning on or after January 1, 2022.⁶⁹ The No Surprises Act re-codified the patient protections related to choice of health care professional in newly added section 9822 of the Code,

section 722 of ERISA, and section 2799A–7 of the PHS Act.

To reflect these statutory amendments, these interim final rules add a sunset clause to the current patient protection provisions codified in the Patient Protections Final Rule, and re-codify the provisions related to choice of health care professional without substantive change at 26 CFR 54.9822–1T, 29 CFR 2590.722, and 45 CFR 149.310. These interim final rules make minor technical edits to the original provisions for clarity.

The Departments note that, although the substantive requirements of these regulations have not changed, the No Surprises Act extends the applicability of the patient protections for choice of health care professionals to grandfathered health plans. The patient protections under section 2719A of the PHS Act apply to only non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage. In contrast, the patient protections under the No Surprises Act apply generally to all group health plans and group and individual health insurance coverage, including grandfathered health plans.⁷⁰ Therefore, the requirements regarding patient protections for choice of health care professional under these interim final rules will newly apply to grandfathered health plans for plan years beginning on or after January 1, 2022. Until the requirements under section 9822 of the Code, section 722 of ERISA, and section 2799A–7 of the PHS Act and these interim final rules become applicable, non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage must continue to comply with the applicable requirements under section 2719A of the PHS Act and its implementing regulations.

D. Applicability

These interim final rules generally apply to group health plans and health insurance issuers offering group or individual health insurance coverage with respect to plan years (in the

⁷⁰ Section 2719A was added to the PHS Act by the Affordable Care Act. Section 1251 of the Affordable Care Act provides that certain requirements, including those in section 2719A of the PHS Act, do not apply to grandfathered health plans. The No Surprises Act does not include a comparable exception for grandfathered health plans. Furthermore, section 103(d)(2) of the No Surprises Act amends section 1251(a) of the Affordable Care Act to clarify that the new and recodified patient protections provisions, including those related choice of choice of health care professional, apply to grandfathered health plans.

⁶⁸ 80 FR 72191 (November 18, 2015).

⁶⁹ Section 2719A(e) of the PHS Act states, “The provisions of this section shall not apply with respect to a group health plan, health insurance issuers, or group or individual health insurance coverage with respect to plan years beginning on or on January 1, 2022.” The Departments interpret subsection (e) to sunset section 2719A for plan years beginning on or after January 1, 2022.

individual market, policy years) beginning on or after January 1, 2022. The term “group health plan” includes both insured and self-insured group health plans. Group health plans include private employment-based group health plans subject to ERISA, non-federal governmental plans (such as plans sponsored by states and local governments) subject to the PHS Act, and church plans subject to the Code. Individual health insurance coverage includes coverage offered in the individual market, through or outside of an Exchange, and includes student health insurance coverage as defined at 45 CFR 147.145. In addition, as discussed further in section V of the preamble, under the OPM interim final rules, FEHB carriers must comply with the Departments’ interim final rules, subject to OPM regulation and contract provisions.

The No Surprises Act amended section 1251(a) of the Affordable Care Act to specify that sections 2799A–1, 2799A–2, and 2799A–7 of the PHS Act apply to grandfathered health plans for plan years beginning on or after January 1, 2022. Therefore, these interim final rules apply to grandfathered health plans (as defined in 26 CFR 54.9815–1251, 29 CFR 2590.715–1251, and 45 CFR 147.140). In addition, these interim final rules apply to certain non-grandfathered health insurance coverage in the individual and small group markets with respect to which CMS has announced it will not take enforcement action with respect to certain specified market requirements even though the coverage is out of compliance with those requirements (sometimes referred to as grandmothers or transitional plans).⁷¹

These interim final rules do not apply to health reimbursement arrangements, or other account-based plans, as described in 26 CFR 54.9815–2711(d)(6)(i), 29 CFR 2590.715–2711(d)(6)(i), and 45 CFR 147.126(d)(6)(i), that make reimbursements subject to a maximum fixed dollar amount for a period, as the benefit design of such plans makes concepts related to surprise billing and choice of health care professionals inapplicable.

By statute, certain plans and coverage are not subject to these interim final rules. This includes a plan or coverage

consisting solely of excepted benefits,⁷² as well as short-term, limited-duration insurance. Excepted benefits are described in section 9832 of the Code, section 733 ERISA, and section 2791 of the PHS Act. Under section 2791(b)(5) of the PHS Act, short-term, limited-duration insurance is excluded from the definition of individual health insurance coverage and is, therefore, exempt from these interim final rules and the statutory provisions the regulations implement. Short-term, limited-duration insurance is defined in regulations at 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103.

These interim final rules do not apply to retiree-only plans. ERISA section 732(a) generally provides that part 7 of ERISA—and section 9831(a) of the Code generally provides that chapter 100 of the Code—does not apply to plans with less than two participants who are current employees (including retiree-only plans, which cover less than two participants who are current employees). Title XXVII of the PHS Act, as amended by the Affordable Care Act, no longer contains a parallel provision at section 2721(a) of the PHS Act. However, as explained in prior rulemaking, HHS will not enforce the requirements of title XXVII of the PHS Act with respect to non-federal governmental retiree-only plans and encourages states to adopt a similar approach with respect to health insurance coverage of retiree-only plans.⁷³ HHS intends to continue to follow this same approach, including with respect to the new market reforms established in the No Surprises Act.

These interim final rules are generally applicable to traditional indemnity plans, meaning plans that do not have networks of providers or facilities. However, the Departments recognize that indemnity plans may have unique benefit designs that cause certain provisions of these interim final rules not to be relevant. For example, the requirements regarding balance billing for non-emergency services provided by nonparticipating providers at certain participating facilities would never be triggered if a plan does not have a network of participating facilities. On the other hand, such requirements could be triggered by plans that have participating facilities but do not have participating providers, either for certain provider types or at all. In addition, requirements that are unrelated to whether a plan or coverage has a network of participating providers

or facilities, such as the requirement that emergency services be covered without the need for any prior authorization determination, even if the services are provided on an out-of-network basis, are applicable to traditional indemnity plans.

The Departments seek comment as to whether there are any other plans with unique benefit designs that should be exempt from all or some of these interim final rules.

IV. Overview of Interim Final Rules—Department of Health and Human Services

A. Preventing Surprise Medical Bills

1. In General

In addition to the new provisions applicable to group health plans and health insurance issuers, discussed in section III of this preamble, the No Surprises Act adds a new Part E of title XXVII of the PHS Act establishing requirements applicable to health care providers, facilities, and providers of air ambulance services. Specifically, the No Surprises Act adds new sections 2799B–1, 2799B–2, 2799B–3, and 2799B–5 of the PHS Act, which protect participants, beneficiaries, and enrollees in group health plans and group and individual health insurance coverage from balance bills by prohibiting nonparticipating providers, facilities, and providers of air ambulance services from billing or holding liable individuals for an amount that exceeds in-network cost sharing determined in accordance with the balance billing provisions in circumstances where the balance billing provisions apply. This includes: (1) When emergency services are provided by a nonparticipating provider or nonparticipating emergency facility; (2) when non-emergency services are provided by a nonparticipating provider at a participating health care facility; and (3) when air ambulance services are furnished by a nonparticipating provider of air ambulance services.

Under 5 U.S.C. 8902(p), as added by the No Surprises Act, sections 2799B–1, 2799B–2, 2799B–3, and 2799B–5 of the PHS Act apply to a health care provider, a facility, and a provider of air ambulance services with respect to a covered individual in a health benefits plan offered by a FEHB carrier in the same manner as they apply with respect to a participant, beneficiary, or enrollee in a group health plan or group or individual health insurance coverage offered by a health insurance issuer. These interim final rules apply to a health care provider, a facility, and a provider of air ambulance services in

⁷¹ CMS Insurance Standards Bulletin Series—INFORMATION—Extension of Limited Non-Enforcement Policy through 2022 (January 19, 2021), available at <https://www.cms.gov/files/document/extension-limited-non-enforcement-policy-through-calendar-year-2022.pdf>.

⁷² Section 9831 of the Code, section 9832 of ERISA, and section 2722 of the PHS Act.

⁷³ 75 FR 34537, 34540 (June 17, 2010).

this same manner.⁷⁴ The applicability of these interim final rules with respect to FEHB carriers is discussed in more detail in section V of this preamble.

With respect to post-stabilization services provided by nonparticipating emergency facilities or nonparticipating providers, and non-emergency services furnished by nonparticipating providers at participating health care facilities (including off-site nonparticipating providers who furnish items or services that an individual receives as part of a visit to such health care facility), the prohibitions on balance billing do not apply if certain notice is provided to the participant, beneficiary, or enrollee, and the individual acknowledges receipt of the information in the notice and consents to waive the balance billing protections with respect to the nonparticipating emergency facility or nonparticipating providers to which the notice and consent apply. Under the No Surprises Act and these interim final rules, with respect to certain types of non-emergency services furnished by nonparticipating providers in a participating health care facility, the notice and consent provisions do not apply, meaning the prohibitions on balance billing apply without exception.

Given that the statute and these interim final rules authorize HHS to impose civil money penalties on facilities and providers that violate these requirements, nonparticipating providers should take steps necessary to ensure compliance by, among other actions, determining whether a given item or service is being furnished under circumstances that would trigger the surprise billing protections. For example, nonparticipating providers furnishing non-emergency services at a facility must determine whether the facility is a participating health care facility to determine whether balance billing protections apply. Relatedly, nonparticipating providers and nonparticipating emergency facilities will need to timely communicate with plans and issuers regarding when the limitations on cost sharing in these interim final rules do not apply because the notice and consent criteria (described more fully elsewhere in this preamble) have been satisfied. These HHS interim final rules address the steps providers and facilities must take to ensure the balance billing and cost-sharing protections are applied appropriately and consistently with the statute.

⁷⁴ For purposes of these interim final rules, references to participants, beneficiaries, and enrollees should be construed to include covered individuals in a FEHB plan.

HHS also recognizes that compliance with these requirements may require nonparticipating providers and nonparticipating emergency facilities to refrain from billing an individual directly, even in cases that are not subject to these requirements. For example, the protections applicable to non-emergency services provided by a nonparticipating provider in a participating health care facility apply only with respect to services for which benefits are provided or covered by the plan or coverage. A nonparticipating provider may not have the information necessary to determine whether the services are a covered benefit under the plan or coverage. As a result, the nonparticipating provider may need to bill the plan or issuer directly for the services in order to determine whether the protections apply. Otherwise, the provider risks violating the statute and these interim final rules by billing individuals. HHS understands that nonparticipating providers and facilities frequently bill individuals directly for out-of-network services, leaving the individual to submit the bill to the plan or coverage. HHS seeks comment on the impact this change will have on nonparticipating providers and facilities, and on plans and issuers receiving bills from nonparticipating providers and facilities.

In instances where a provider or facility does balance bill a participant, beneficiary, or enrollee for services in violation of the statute and these interim final rules, the Secretary of HHS (the Secretary) may impose civil money penalties in states where HHS is directly enforcing the balance billing provisions with respect to health care providers, facilities, and providers of air ambulance services. However, the statute provides that the Secretary shall waive the penalties with respect to a health care provider, facility, or provider of air ambulance services who does not knowingly violate, and should not have reasonably known it violated, the provisions, with respect to a participant, beneficiary, or enrollee, if such provider or facility, within 30 days of the violation, withdraws the bill that was in violation of such provision and reimburses the health plan or individual, as applicable, in an amount equal to the difference between the amount billed and the amount allowed to be billed under the provision, plus interest, at an interest rate determined by the Secretary. HHS intends to address enforcement of the requirements of the No Surprises Act applicable to health care providers, facilities, and providers of air

ambulance services in future rulemaking.

2. Notice and Consent Exception to Prohibition on Balance Billing

Under the No Surprises Act and these interim final rules, the protections that limit cost sharing and prohibit balance billing do not apply to certain non-emergency services or to certain post-stabilization services provided in the context of emergency care, if the nonparticipating provider or nonparticipating emergency facility furnishing those items or services provides the participant, beneficiary, or enrollee, with notice, the individual acknowledges receipt of the information in the notice, and the individual consents to waive the balance billing protections with respect to the nonparticipating emergency facility or nonparticipating providers named in the notice.

Non-emergency services furnished by a nonparticipating provider at a participating health care facility are exempt from cost sharing protections and balance billing protections when the notice and consent requirements are met. In contrast, the notice and consent exception does not apply to emergency services, other than post-stabilization services, under certain circumstances, or air ambulance services. A nonparticipating provider or nonparticipating emergency facility may obtain notice and consent from the individual in order to balance bill for post-stabilization services only in the case where a participant, beneficiary, or enrollee has received emergency services and that individual's condition has stabilized, and then only if certain additional conditions are met. Such conditions are described later in this preamble and codified at 45 CFR 149.410(b).

If an individual receives a notice, but does not provide (or revokes) consent to waive their balance billing protections, those protections remain in place. A provider or facility may, subject to other state or federal laws, refuse to treat the individual if the individual does not consent.⁷⁵ However, the cost-sharing and balance billing protections applicable to plans, issuers, providers and facilities would apply with respect to any items or services furnished by the provider or facility subsequent to the

⁷⁵ HHS is aware that some providers and facilities charge fees for cancelled appointments. HHS is of the view that an individual cannot provide consent freely if a provider or facility will require the individual to pay a fee if the appointment is cancelled because the individual refuses or revokes consent.

provision of the notice, and absent consent.

The requirements related to the notice and consent exception are set forth in section 2799B–2 of the PHS Act, as added by the No Surprises Act, and implemented at 45 CFR 149.410 and 45 CFR 149.420 of the HHS interim final rules, describing the requirements for post-stabilization services and non-emergency services, respectively. These interim final rules outline the requirements related to the content, method, and timing of the notice and consent communications; requirements related to language access; exceptions to the applicability of the notice and consent process; requirements for the retention of notice and consent documents; and requirements to notify the plan or issuer regarding consent provided by the participant, beneficiary, or enrollee.

i. Standards for Notice

The No Surprises Act and these interim final rules allow an individual to waive balance billing protections only after receiving a written notice that includes detailed information designed to ensure that individuals knowingly accept out-of-pocket charges (including charges associated with balance bills) for care received from a nonparticipating provider or nonparticipating emergency facility. In HHS's view, the option to consent to waive balance billing protections may be valuable to individuals in certain instances where they knowingly and purposefully seek care from a nonparticipating provider. For example, an individual with a complex health condition may want to be treated by a specialist who is not in their plan's network. If that specialist will not treat the individual unless the specialist can bill the individual directly for the care (and balance bill the individual), that individual may want to waive the balance billing protections. HHS seeks comment on striking the appropriate balance between allowing a specialist to refuse to treat an individual unless the specialist can balance bill the individual, while ensuring that the individual is not being pressured into waiving the balance billing protections. In HHS's view, it is important that these consumer protections do not present a barrier to obtaining out-of-network care, when an individual knowingly seeks out such care. However, it is equally important that individuals are not unknowingly subject to balance billing. Therefore, the No Surprises Act and these interim final rules allow an individual to waive balance billing protections in limited circumstances

only, and only if the nonparticipating providers or nonparticipating emergency facility have provided the participant, beneficiary, or enrollee with appropriate notice explaining the applicable consumer protections and the implications of providing consent.

Section 2799B–2(d)(1)(A) of the PHS Act requires providers and facilities to use a written notice specified by HHS in guidance. Therefore, these interim final rules require providers and facilities to provide the notice using the standard notice document provided by HHS in guidance. The standard notice document will contain the elements required by the statute in a manner that is intended to be easy to read and comprehend. The notice must be provided in accordance with guidance issued by HHS. HHS is of the view that requiring use of the standard notice will help to ensure that the notice includes the content that is required to be included in the notice under the No Surprises Act and these interim final rules. Providers and facilities will need to tailor the document in each case to include information specific to the individual (for example, by identifying the provider or facility, as applicable, and adding the good faith estimated amount).

HHS is concerned that individuals may be less likely to review the notice carefully if it is embedded within other information or provided with additional consent forms. Therefore, these interim final rules require that the notice be provided with the consent document, and together these documents be given physically separate from, and not attached to or incorporated into any other documents. Providers and facilities must provide the notice within the required timeframe. The notice must be written and provided on paper, or, as practicable, electronically, as selected by the individual. The notice must meet applicable language access requirements, as described in this HHS interim final rule. A participating health care facility may provide the notice on behalf of the nonparticipating provider.⁷⁶

Authorized Representatives

The notice may be provided to the individual's authorized representative

⁷⁶ However, if a facility that has agreed to provide the notice on behalf of the nonparticipating provider fails to provide the notice and obtain consent, or provides notice and obtains consent in a manner that does not satisfy the regulatory requirements in these interim final rules, the notice and consent criteria would not be considered to be met. Therefore, the cost-sharing and balance billing protections would continue to apply to the items and services furnished by the nonparticipating provider.

instead of the individual, and consent may be provided by the authorized representative on behalf of the individual. These interim final rules specify that for purposes of 45 CFR 149.410 and 149.420, an authorized representative is an individual authorized under state law to provide consent on behalf of the participant, beneficiary, or enrollee, provided that the individual is not a provider affiliated with the facility or an employee of the facility, unless such provider or employee is a family member of the participant, beneficiary, or enrollee. Although treating providers may be authorized under state law to provide consent to treatment, HHS is of the view that providers should generally not be permitted to receive notice or provide consent regarding treatment by a nonparticipating provider or facility because of the strong likelihood of an inherent financial or professional conflict of interest. These same concerns extend to employees of the facility at which the items or services are furnished. HHS is also of the view that these concerns are not warranted for providers or facility employees that are family members of the individual, because of their presumed interest in the well-being of the individual, or providers that are unaffiliated with the provider or facility furnishing the care. HHS is of the view that these limitations provide important consumer protections to ensure that an individual's authorized representative is acting in the individual's best interest rather than the interests of the provider or facility. HHS seeks comment on whether and how the term "family member" should be defined. HHS is sensitive to concerns that some individuals may not have a familial relation formally recognized under applicable state law, or other documented legal partnership with individuals whom they consider family. Therefore, when interpreting this requirement, HHS will construe the term "family member" broadly to include such individuals prior to the issuance of additional guidance.

Timing of Notice

In order to ensure that a participant, beneficiary, enrollee, or authorized representative has an opportunity to properly review and consent to a notice to receive items or services furnished by a nonparticipating provider or nonparticipating emergency facility and waive balance billing protections, the provider or facility must provide such a notice in the timeframe specified in the statute and this interim final rule. As specified in section 2799B–2(d) of the PHS Act, if an individual schedules an

appointment for such items or services at least 72 hours before the date of the appointment, the provider or facility must provide the notice to the individual, or their authorized representative, no later than 72 hours before the date of the appointment; and if an individual schedules an appointment for such items or services within 72 hours of the date of the appointment, the provider or facility must provide the notice to the individual, or their authorized representative, on the day that the appointment is made. In addition, these interim final rules specify that in the situation where an individual is provided the notice on the same day that the items or services are furnished, providers and facilities are required to provide the notice no later than 3 hours prior to furnishing items or services to which the notice and consent requirements apply.

This 3-hour requirement is intended to address situations where an individual might be asked to provide consent immediately before a provider furnishes the item or service, which may prevent their consent from being truly voluntary. Stakeholders have recommended that notice and consent procedures be unavailable when an individual visits a participating facility and receives care from a nonparticipating provider from whom the individual did not seek out services (for example, if a specialist furnishes an unexpected consultation on the recommendation of the attending physician). Stakeholders expressed concern that such providers might provide the notice at the time they appear for the consultation, and the individual might feel compelled to consent to receive care. HHS is of the view that the requirement that the notice be provided no later than 3 hours prior to furnishing items or services helps to ensure individuals can voluntarily provide informed consent, while not removing the informed consent option entirely in instances where the appointment is made the same day as the date the services are scheduled. HHS seeks comment on whether such a time limit is a reasonable approach, as well as whether the 3 hours' time requirement should be shorter or longer, in order to best ensure that consent is freely given while also facilitating timely access to care. For example, HHS is interested in understanding if there are situations where this time requirement may unduly delay access to urgently necessary care, including in the post-

stabilization care context.⁷⁷

Alternatively, HHS is interested in understanding if more time may be necessary for an individual to read, understand, and consider their options, including considering whether they can resolve prior authorization or other care management limitations, before voluntarily consenting to treatment. HHS is also interested in whether these timing requirements present barriers to providers' and facilities' ability to comply with the requirement that the notice and consent documents be provided to the individual in paper or, as practicable, electronic form, as selected by the individual.

Content of Notice

As stated previously, a provider or facility must provide the written notice using the form specified by HHS in guidance, customized to include the information specified in 45 CFR 149.420(d) (and 45 CFR 149.410(b)(2), for post-stabilization services, as applicable).

The notice must state that the health care provider furnishing the items or services is a nonparticipating provider, or that the health care facility furnishing the items or services is a nonparticipating emergency facility, as applicable, with respect to the health plan or coverage. The provider or facility will need to customize the form to identify the provider or facility by name. This will help ensure individuals understand for which specific providers or facilities they would be waiving their balance billing protections.

The notice must include the good faith estimated amount that such nonparticipating provider or nonparticipating emergency facility may charge the individual for the items and services involved, including any item or service that the nonparticipating provider reasonably expects to provide in conjunction with such items and services. In the case of a nonparticipating emergency facility, the notice must include the good faith estimate for such items or services that would reasonably be expected to be provided by the nonparticipating emergency facility or by nonparticipating providers as part of the visit at such facility. HHS is including the requirement regarding disclosing

items and services reasonably expected to be provided in order to ensure that the participant, beneficiary, or enrollee has an accurate understanding of the cost of care. As discussed in section IV.A.2.iv of this preamble, individuals cannot waive the balance billing protections for items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished for which the nonparticipating provider or nonparticipating facility satisfied the notice and consent criteria.

Nonparticipating providers who are providing this notice are required to provide a good faith estimate for only the items or services that they would be furnishing and are not required to provide a good faith estimate for items or services furnished by other providers at the facility. However, if a nonparticipating provider has not satisfied the notice and consent criteria, balance billing and cost-sharing protections will apply to the individual with respect to items and services furnished by that nonparticipating provider, even if a different nonparticipating provider has satisfied the notice and consent criteria with respect to the same visit. If they choose, multiple nonparticipating providers that are furnishing related items and services for an individual may provide a single notice to the individual, provided that: (1) Each provider's name is specifically listed on the notice document; (2) each provider includes in the notice a good faith estimate for the items and services they are furnishing, and the notice specifies which provider is providing which items and services within the good faith estimate; and (3) the individual has the option to consent to waive balance billing protections with respect to each provider separately.

HHS is of the view that an individual cannot consent to waive balance billing and cost-sharing protections unless they have been informed of their potential liability with respect to both the facility and provider charges related to receiving post-stabilization services at a nonparticipating emergency facility. Therefore, nonparticipating emergency facilities must include in the written notice the good faith estimated amount that the participant, beneficiary, or enrollee may be charged for items or services furnished by the nonparticipating emergency facility or by nonparticipating providers with respect to the visit at such facility (including any item or service that is reasonably expected to be furnished by the nonparticipating emergency facility or nonparticipating providers in conjunction with such items or

⁷⁷ A provider or facility is never required to provide notice and seek consent from a participant, beneficiary, or enrollee. To the extent a provider is concerned that the 3 hours' prior requirement will result in a delay in care that is detrimental to the individual, the provider or facility can furnish the items or services, subject to the balance billing protections, rather than providing notice and seeking consent to waive the protections.

services). HHS seeks comment regarding potential challenges nonparticipating emergency facilities may have in coordinating the development of a good faith estimate on behalf of both the facility and providers. To the extent that the nonparticipating facility omits from the good faith estimate information about items and services provided by a nonparticipating provider, the notice and consent criteria will be not be considered met for items and services furnished by that provider, and the requirements in 45 CFR 149.410(a) (and the corresponding requirements on plans and issuers) would apply.

HHS is aware that nonparticipating providers and nonparticipating emergency facilities generally are unable to calculate what an individual's final out-of-pocket costs (inclusive of balance bills) will be for items and services partially or wholly covered by the individual's plan or coverage. Therefore, the good faith estimated amount should reflect the amount the provider or facility expects to charge for furnishing such items or services, even if the provider or facility intends to bill the plan or coverage directly. In calculating this good faith estimated amount, the provider or facility is expected to apply the same process and considerations used to calculate the good faith estimate that is required under section 2799B-6(2) of the PHS Act. HHS seeks comment regarding the method by which this good faith estimated amount should be calculated, and anticipates addressing this requirement in future rulemaking. The notice must make clear that the provision of the good faith estimate in the notice, or the individual's consent to be treated, does not constitute a contract with respect to the charges estimated for such items and services, or a contract that binds the participant, beneficiary, or enrollee to be treated by that provider or facility. HHS seeks comment regarding whether the provider or the facility should be required to include information about what may be covered by the individual's plan or coverage and an estimate of the individual's out-of-pocket costs.

The notice must provide information about whether prior authorization or other care management limitations may be required in advance of receiving such items or services at the facility or from the provider. HHS recognizes that there may be challenges for nonparticipating providers or facilities to identify what prior authorization and other care management limitations may apply with respect to a plan or coverage in which they do not participate. Therefore, providers and facilities may provide

general information in order to satisfy this requirement, but to the extent possible, HHS encourages them to contact the issuer or plan about any such limitations so that they can include specific information in the notice. HHS interprets this statutory provision to require information on prior authorization or care management requirements to extend to care furnished by both providers and facilities, in order for participants, beneficiaries, and enrollees to understand all requirements associated with their care before they consent to treatment and balance billing. Requiring that the notice include specificity regarding prior authorization or care management requirements could improve the usefulness of the information to individuals compared to general information about what requirements may apply, but may make providing notices overly burdensome for providers and facilities. HHS seeks comment on whether providers and facilities should instead be required to include in the notice specific information about any prior authorization and care management requirements that apply to any items and services covered under the notice. HHS also seeks comment on barriers or other burdens facing nonparticipating providers or facilities in obtaining this information from a plan or issuer.

The notice must clearly state that the individual is not required to consent to receive such items or services from such nonparticipating provider or nonparticipating emergency facility. The notice must state that the individual may instead seek care from an available participating provider or at a participating emergency facility, with respect to the plan or coverage, as applicable, and that in such cases, in-network cost-sharing amounts will apply.

In cases where post-stabilization services are being furnished by a nonparticipating provider at a participating emergency facility, the notice must include a list of any participating providers at the participating emergency facility who are able to furnish the items or services involved. The notice must inform the individual that they may be referred, at their option, to such a participating provider. HHS seeks comment regarding the format and content of the referral list to be included in the notice, including any challenges that providers may have in providing this information, and any further requirements that should be applied to providers when furnishing this information to the individual.

ii. Standards for Consent

In order to meet the notice and consent requirements of the No Surprises Act and these interim final rules, the nonparticipating provider, participating health care facility on behalf of the nonparticipating provider, or nonparticipating emergency facility must obtain from the participant, beneficiary, or enrollee the individual's acknowledgment that they consent to be treated and balance billed by the nonparticipating emergency facility or nonparticipating provider under circumstances where the individual elects to receive such items or services. The consent must be provided voluntarily, meaning that the individual has consented freely, without undue influence, fraud, or duress. An incomplete consent document will be treated as a lack of consent and balance billing protections will still apply.

As with the notice document, providers and facilities must use the standard consent document specified by HHS in guidance, and the consent document must be provided in accordance with such guidance. The consent document, specified in guidance, contains the information (or fillable fields for the information) required to be included in the consent form under these interim final rules, and described further in this section of the preamble. Providers and facilities will need to tailor the document to include information specific to the individual. In addition, as discussed previously, these interim final rules require that the consent be accompanied by the notice document, and that these documents be given together at the same time, physically separate from and not attached to or incorporated into any other documents. The consent document must be signed (including by electronic signature) by the individual, or the individual's authorized representative.

The nonparticipating provider, participating health care facility on behalf of the nonparticipating provider, or nonparticipating emergency facility must provide the individual with a copy of the signed notice and consent in-person, or through mail or email, as selected by the individual.

The notice and consent documents must meet applicable language access requirements, as described in these interim final rules. The signed consent document must acknowledge that the individual has been provided with the written notice as described in these interim final rules, in the form selected by the individual. The signed consent document must also acknowledge that

the individual has been informed that the payment made by the individual might not accrue toward meeting any limitation that the plan or coverage places on cost sharing, including an explanation that the payment might not apply to an in-network deductible or out-of-pocket maximum under the plan or coverage.

The consent document must state that, by signing the consent document, the individual agrees to be treated by the nonparticipating provider or nonparticipating emergency facility and understands that the individual may be balance billed and subject to cost-sharing requirements that apply to services furnished by nonparticipating providers or nonparticipating emergency facilities. In the case of a nonparticipating provider seeking consent, by signing the consent document, the individual agrees to waive balance billing and cost-sharing protections for only the items or services furnished by the provider or providers specifically named in the notice. In HHS's view, an individual cannot provide informed consent to waive balance billing protections with respect to an unnamed provider, as the individual would not be on notice that the individual may be balance billed for items or services furnished by that provider. In addition, the individual may choose to consent to waive balance billing protections with respect to items or services furnished by none, some, or all of the nonparticipating providers listed in the notice.

The signed consent document must include the date on which the individual received the written notice and the date on which the individual signed such consent to be furnished the items or services covered in the notice. In order to ensure that consent is provided prior to when the item or service is received, HHS also requires that the signed consent document include the time at which the individual signed the consent.

The signed consent provided by the individual constitutes the individual's consent to the receipt of the information contained in the notice document, and includes an acknowledgement that they may be balance billed for the receipt of the items or services. The consent does not constitute a contractual agreement with regard to any estimated charge or amount included in the notice or consent document, or a contract that binds the participant, beneficiary, or enrollee to be treated by that provider or facility. Consent obtained by the provider or facility under this notice and consent process in no way substitutes for or modifies requirements

for informed medical consent otherwise required of the provider or facility, under state law or codes of medical ethics.

The participant, beneficiary, or enrollee may revoke consent by notifying the provider or facility in writing prior to the furnishing of the items or services. If an individual revokes consent, the balance billing protections apply to applicable items or services provided after the revocation as if consent was never provided. HHS is of the view that the option to revoke consent is a critical safeguard to ensure that balance billing protections are waived only when individuals knowingly, purposefully, and freely provide informed consent. HHS seeks comment on whether additional rulemaking or guidance is needed on how an individual can revoke consent.

iii. Language Access

A nonparticipating provider or nonparticipating emergency facility providing a participant, beneficiary, or enrollee, or such individual's authorized representative, with a notice under section 2799B-2(d) of the PHS Act must make the notice available in any of the 15 most common languages in the geographic region in which the applicable facility is located. HHS is of the view that individuals cannot provide meaningful consent if they cannot understand the information provided in the written notice and consent documents. These interim final rules, therefore, also require that the notice and consent document be made available in any of the 15 most common languages in the geographic region in which the applicable facility is located. Providers and facilities will need to translate the standard notice and consent documents specified by HHS in guidance into the applicable 15 languages.

A provider or facility meets this requirement if it provides the notice and consent documents in the 15 most common languages in its state. However, HHS recognizes that in some cases, particularly in larger states or metropolitan areas, these 15 languages may not adequately represent the languages spoken by the population served by the provider or facility.⁷⁸ Therefore, the provider or facility may

alternatively choose to provide the notice and consent documents in the 15 most common languages in its geographic region, which reasonably reflects the geographic region served by the applicable facility. For example, a facility that serves the greater Los Angeles area may choose to provide the notice and consent documents in the 15 most common languages within that geographic region, instead of the 15 most common languages in the state of California.

HHS considered different standards to apply in defining such geographic regions, and is seeking comment regarding the appropriate standard. HHS's objective is to implement a standard that ensures that the language accessibility requirement is responsive to the needs of the individuals served by the provider or facility, while mitigating inconsistencies in the way that such geographic regions are determined. HHS is interested in comments regarding the use of metropolitan statistical areas (MSAs),⁷⁹ hospital service areas (HSAs),⁸⁰ hospital referral regions (HRRs),⁸¹ and public use microdata areas (PUMAs),⁸² applied based on where the applicable facility is located, as well as other standards that may be well-suited for this purpose. HHS also seeks comment on what language access standards would be appropriate in circumstances where the applicable facility serves populations in multiple states.

As noted earlier in this section, HHS is of the view that individuals cannot provide meaningful consent if they cannot understand the information provided in the written notice and consent document. These interim final rules, therefore, add a language access requirement to address circumstances in which the individual cannot understand any of the 15 languages in which the notice and consent document are available. If the individual's preferred language is not among the 15 most common languages in which the documents are made available by the nonparticipating provider or nonparticipating emergency facility, or the individual cannot understand the language in which the notice and consent documents are provided, as self-reported by the individual, the

⁷⁹ <https://www.census.gov/programs-surveys/metro-micro/about.html>.

⁸⁰ <https://www.dartmouthatlas.org/faq/>.

⁸¹ <https://www.dartmouthatlas.org/faq/>.

⁸² [https://www.census.gov/programs-surveys/geography/guidance/geo-areas/pumas.html#:~:text=Public%20Use%20Microdata%20Areas%20\(PUMAs\)%20are%20non%20overlapping%2C,and%20the%20U.S.%20Virgin%20Islands.](https://www.census.gov/programs-surveys/geography/guidance/geo-areas/pumas.html#:~:text=Public%20Use%20Microdata%20Areas%20(PUMAs)%20are%20non%20overlapping%2C,and%20the%20U.S.%20Virgin%20Islands.)

⁷⁸ See, e.g., "Understanding Communication and Language Needs of Medicare Beneficiaries" (2017), <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf> ("The common languages in a given region, city, or town may vary greatly from those spoken in the state or in the U.S. as a whole.").

notice and consent requirements described in these interim final rules are not met unless the provider or facility furnishes the individual with a qualified interpreter.

The provider or facility should provide the notice and consent documents, or the qualified interpretive services, as applicable, in the individual's self-reported, preferred language. Individuals should be asked what language they prefer to communicate in regarding health care information, for written or verbal communication, as applicable. An individual's preference might not be the same for written and verbal communication, and an individual's preference might not correlate with the individual's native language.

In interpreting the statutory requirements regarding language access in the notice and consent process, HHS recognizes communication, language, and literacy barriers are associated with decreased quality of care, poorer health outcomes, and increased utilization.⁸³ Alternatively, the use of appropriate language services and at appropriate literacy levels in health care settings is associated with increased quality of care, improved patient safety outcomes, and lower utilization of costly medical procedures.⁸⁴ HHS is of the view that it is imperative that health care providers

and facilities take these efforts to provide the required notice and consent information in a manner understandable to the participant, beneficiary, or enrollee, to help achieve the goal of the statute and ensure that individuals are aware their rights and the options available to them.

Providers and facilities are also required to comply with other state and federal laws regarding language access, to the extent applicable. HHS reminds health care providers and facilities that recipients of federal financial assistance must comply with federal civil rights laws that prohibit discrimination. These laws include section 1557 of the Affordable Care Act,⁸⁵ title VI of the Civil Rights Act of 1964,⁸⁶ section 504 of the Rehabilitation Act of 1973,⁸⁷ and the Americans with Disabilities Act of 1990.⁸⁸ Section 1557 and title VI require covered entities to take reasonable steps to ensure meaningful access to individuals with limited English proficiency, which may include provision of language assistance services such as written translation of written content in paper or electronic form into languages other than English. Section 1557 and section 504 require covered entities to take appropriate steps to ensure effective communication with individuals with disabilities, including provision of appropriate auxiliary aids and services at no cost to the individual. Auxiliary aids and services may include interpreters, large print materials, accessible information and communication technology, open and closed captioning, and other aids or services for persons who are blind or have low vision, or who are deaf or hard of hearing. Information provided through information and communication technology also must be accessible to individuals with disabilities, unless certain exceptions apply. Consistent with Executive Order 13985 and civil rights protections cited in these regulations, HHS particularly seeks comments from minority and underserved communities including those with limited English proficiency and those with disabilities who prefer information in alternate and accessible formats, and stakeholders who serve such communities, on whether the provisions and protections related to communication, language, and literacy sufficiently address barriers that exist to ensuring all individuals can read, understand, and consider their options related to notice and consent. HHS also

seeks comment on what additional or alternate policies HHS may consider to help address and remove such barriers.

HHS understands that the technical nature of these protections may inherently pose barriers to individuals or their authorized representatives as they consider their options. Numerous studies have indicated that consumer comprehension of common health insurance concepts is varied and that many are not able to accurately answer questions about their health plan's benefit design or health care costs.⁸⁹ Individuals may also face intersecting and overlapping barriers (commonly referred to as the Social Determinants of Health) as they interact with the health care system, in addition to numerous technical forms and documents as part of receiving care. HHS solicits comment on how to best strike the balance between consumer friendliness and usability of such documents, while ensuring that they are consistent with these interim final rules and the statutory intent. HHS specifically seeks comment from those with experience in supporting individuals with low health literacy, including providers, patient advocates, and navigators, as well as those with experience in user design, in order to ensure that documents conveying these protections and opportunities to convey notice and consent are understandable and accurate.

iv. Exceptions to the Availability of Notice and Consent

The notice and consent exception is not applicable with respect to some non-emergency items or services.⁹⁰ Instead, the prohibition on balance billing and the in-network cost-sharing requirements, as described in these interim final rules, always apply with respect to those items or services. In addition, the exception for notice and consent is not applicable with respect to emergency services, except for post-stabilization services, under certain conditions.

First, as specified in section 2799B–2(b) of the PHS Act, with respect to non-

⁸³ Batencourt, J.R., et al., Improving Patient Safety Systems for Patients with Limited English Proficiency: A Guide for Hospitals, Agency for Healthcare Research and Quality, Publication No. 12–0041, September 2012; Proctor, K. et al., The Limited English Proficient Population: Describing Medicare, Medicaid, and Dual Beneficiaries, *Health Equity* Vol. 2.1, 2018; Green, A.R. and Nze, C. Language-Based Inequity in Health Care: Who is the “Poor Historian”?, *American Medical Association Journal of Ethics*, Vol. 19, Number 3: 263–271, March 2017; Shamsi, H. et al., Implications of Language Barriers for Healthcare: A Systematic Review, *Oman Medical Journal*, Vol. 53, No. 2:e122, 2020; de Moissac, D., Bowen, S., Impact of Language Barriers on Quality of Care and Patient Safety for Official Language Minority Francophones in Canada, *Journal of Patient Experience*, Vol. 6(1) 24–32, 2019; Napoles, A.N., et al., Inaccurate Language Interpretation and its Clinical Significance in the Medical Encounters of Spanish-speaking Latinos, *Med Care*. 2015 November; 53(11): 940–947; Divi, C., et al., Language Proficiency and Adverse Events in U.S. Hospitals: a Pilot Study, *Int'l Journal for Quality in Health Care*, vol. 19, no.2; Ali, P.A. and Watson, R., Language Barriers and their Impact of Provision of Care to Patients with Limited English Proficiency: Nurses Perspective, *J. Clin. Nurs.*, 2018 Mar;27(5–6); Flores G. Language barriers to health care in the United States. *N Engl J Med* 2006; 355:229–231. Ku L, and Flores G. Pay now or pay later: Providing interpreter services in health care. *Health Affairs*. 2005;24(2): 435–444; Hampers L.C., et al. Language barriers and resource utilization in a pediatric emergency department. *Pediatrics*. 1999; 103(6): 1253–1256; Dewalt D.A., et al. Literacy and health outcomes: A systematic review of the literature. *J. Gen Intern Med*. 2004;19(12):1228–1239. doi:10.1111/j.1525–1497.2004.40153.x.

⁸⁴ *Id.*

⁸⁵ 42 U.S.C. 18116.

⁸⁶ 42 U.S.C. 2000d *et seq.*

⁸⁷ 269 U.S.C. 794.

⁸⁸ 42 U.S.C. 12101 *et seq.*

⁸⁹ <https://www.policygenius.com/blog/health-insurance-literacy-survey-2019/>; <https://www.cmu.edu/dietrich/sds/docs/loewenstein/ConsumerMisUnderstandHealthIns.pdf>.

⁹⁰ 45 CFR 149.420(b) applies in cases of non-emergency services furnished by a nonparticipating provider at a participating facility and not in cases of emergency services. Additionally, 45 CFR 149.410(c) specifies that the notice and consent exception for post-stabilization services does not apply to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time a post-stabilization service is furnished for which the nonparticipating provider or nonparticipating emergency facility already satisfied the notice and consent criteria.

emergency services, the notice and consent exception does not apply to ancillary services, which include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by a nonparticipating provider, only if there is no participating provider who can furnish such item or service at such facility.

Additionally, as specified in section 2799B–2(c) of the PHS Act, the notice and consent exception does not apply to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished for which a nonparticipating provider satisfied the notice and consent criteria. For example, even if an individual has consented to waive balance billing and in-network cost-sharing protections with respect to items and services provided by certain nonparticipating providers related to a knee surgery, that individual has not consented, nor are providers permitted to seek consent under the statute and these interim final rules, to waive those protections with respect to unforeseen, urgent medical needs that arise during the knee surgery. Because individuals lack the requisite information to provide informed consent to waive balance billing and cost-sharing protections with respect to unforeseen, urgent medical needs, HHS has determined that the rationale for the statutory exception for notice and consent to not extend to unforeseen, urgent medical needs with respect to non-emergency services also applies to unforeseen, urgent post-stabilization services. Therefore, these interim final rules provide that any notice provided and consent obtained with regard to the furnishing of certain items or services does not extend to additional items or services furnished in response to unforeseen, urgent medical needs either in the context of a nonparticipating provider in a participating facility, or of post-stabilization services.

The statute authorizes HHS to expand the definition of ancillary services to include items and services provided by other types of providers. HHS seeks comment on other ancillary services that should be considered to be made ineligible for the notice and consent exception. In particular, HHS is interested in comments on whether there are other ancillary services for which individuals are likely to have

little control over the particular provider who furnishes items or services. HHS is of the view that it is with respect to these types of providers that notice and consent procedures are least appropriate. HHS is also interested in comments regarding the types of ancillary services for which surprise bills are most common, and whether they should be added to the definition of ancillary services that are not subject to the notice and consent exception. Finally, HHS seeks comment on what criteria HHS should use in determining whether other ancillary services should be added to the definition.

Furthermore, the statute authorizes HHS to specify a list of advanced diagnostic laboratory tests that would not be considered ancillary services under this definition. Any such advanced diagnostic laboratory tests would still be subject to the surprise billing protections described in these interim final rules, but the notice and consent exemption process would also be available for these tests. HHS seeks comment on what criteria HHS should consider in determining whether an advanced diagnostic laboratory test should be excepted from the definition of ancillary services, and on any specific advanced diagnostic laboratory tests that should be considered to be made eligible for the notice and consent exception.

v. Retention of Certain Documents

Under Section 2799B–2(e) of the PHS Act and these interim final rules, nonparticipating emergency facilities, participating health care facilities, and nonparticipating providers are required to retain written notice and consent documents for at least a 7-year period after the date on which the item or service in question was furnished. Specifically, when a nonparticipating emergency facility obtains a signed consent from a participant, beneficiary, or enrollee, or such individual's authorized representative, for an item or service furnished to the individual by the facility or any nonparticipating provider at such facility, the facility must retain the written notice and consent for the 7-year period. Similarly, when a participating health care facility obtains a signed consent from a participant, beneficiary, or enrollee, or such individual's authorized representative, for an item or service furnished to the individual by a nonparticipating provider at such facility, the facility must retain the written notice and consent for a 7-year period. If a nonparticipating provider obtains a signed consent from a participant, beneficiary, or enrollee, or

such individual's authorized representative, where the facility does not otherwise obtain the consent on behalf of the provider, the provider may either coordinate with the facility so that the facility retains the written notice and consent for a 7-year period, or the provider must retain the written notice and consent for a 7-year period. HHS interprets the retention requirement to apply to providers as well as facilities, in order to ensure that all notice and consent documents are appropriately retained, regardless of how they are obtained.

vi. Requirements To Notify the Plan or Issuer

For each item or service furnished by a nonparticipating provider or nonparticipating emergency facility, the provider (or participating facility on behalf of the nonparticipating provider) or nonparticipating emergency facility, as applicable, must timely notify the plan or issuer as to whether balance billing and in-network cost sharing protections apply to the item or service, and provide to the plan or issuer a signed copy of any signed written notice and consent documents. With respect to non-emergency services described in 45 CFR 149.410(a), the nonparticipating provider (or the participating facility on behalf of the provider) must timely notify the plan or issuer that the item or service was furnished during a visit at a participating health care facility. With respect to post-stabilization services, the nonparticipating provider or nonparticipating emergency facility must notify the plan or issuer as to whether all the conditions described in 45 CFR 149.410(b) are met with respect to each of the items and services for which the bill is submitted. With respect to non-emergency services only, in instances where the nonparticipating provider bills the participant, beneficiary, or enrollee directly (where permitted under these interim final rules), the provider (or participating health care facility on behalf of the provider) may satisfy the requirement to timely notify the plan or issuer by including the notification with the bill to the individual.

In interpreting the statutory requirements, HHS recognizes that it is critical that a group health plan or health insurance issuer have knowledge of whether the balance billing and in-network cost-sharing requirements apply, including whether an item or service is furnished during a visit at a participating health care facility and if any notice was provided and consent given what items and services were consented to, where such items and

services would otherwise be subject to the balance billing protections. This information is crucial for the plan or issuer to be able to appropriately assign cost sharing and adjudicate the claim in compliance with the No Surprises Act. These interim final rules require the provider or facility to notify the plan or issuer so that the plan or issuer is aware when the balance billing and in-network cost sharing protections apply and can process the claim appropriately.⁹¹

HHS seeks comment on whether additional rulemaking would be helpful regarding the process and timing for such notification, including the definition of ‘timely,’ and what processes for conveying the notification would be most efficient, including existing processes that could be leveraged to convey the information. HHS is particularly interested in comments regarding the requirement that providers or facilities provide to the plan or issuer a copy of the signed written notice and consent document, including comments on barriers and burdens associated with such requirement, and recommendations on how best to ensure plans and issuers have information regarding the notice and consent documents without imposing undue burden on providers and facilities.

3. Provider and Facility Disclosure Requirements Regarding Patient Protections Against Balance Billing

Section 2799B–3 of the PHS Act, added by the No Surprises Act, requires providers and facilities to provide disclosures regarding patient protections against balance billing. Among other things, the statute requires health care providers and facilities (including an emergency department of a hospital or independent freestanding emergency department) to make publicly available, post on a public website of the provider or facility (if applicable), and provide to participants, beneficiaries, and enrollees a one-page notice about the balance billing requirements and prohibitions that apply to the provider or facility under sections 2799B–1 and 2799B–2 of the

PHS Act. The notice must include information about any applicable state requirements, and about how to contact appropriate state and federal agencies if the individual believes the provider or facility has violated the balance billing rules. These interim final rules codify the statutory requirements and information that these disclosures must include. In addition, as stated previously, under section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A–5(c) of the PHS Act, plans and issuers must provide information in plain language on the prohibition against balance billing and information on contacting appropriate state and federal agencies in the case that an individual believes that such a provider or facility has violated the prohibition against balance billing. These disclosure requirements are applicable for plan years beginning on or after January 1, 2022. To reduce burden and facilitate compliance with these disclosure requirements, the Departments are concurrently issuing a model disclosure notice that health care providers, facilities, group health plans, and health insurance issuers may, but are not required to, use to satisfy the disclosure requirements regarding the balance billing protections. The Departments will consider use of the model notice in accordance with the accompanying instructions to be good faith compliance with the disclosure requirements of section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A–5(c) of the PHS Act, if all other applicable requirements are met. The Departments may address these requirements in more detail in future guidance or rulemaking. Until such guidance or rulemaking implementing the requirements under section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A–5(c) of the PHS Act becomes effective and applicable, plans and issuers should exercise good-faith compliance with those statutory provisions.

These disclosures are critical to helping raise awareness and enhance the public’s understanding of state and federal balance billing protections. The purpose of these disclosures is to empower individuals to better understand the balance billing protections afforded under applicable state and federal law. In addition, these disclosures are important in ensuring individuals are able to identify violations of these interim final rules and related state law requirements and, if necessary, file complaints against providers and facilities. These disclosures further the efforts to help

achieve the goals of the No Surprises Act and ensure that individuals are aware of their rights and the options available to them. These interim final rules codify the provider and facility disclosure requirements at 45 CFR 149.430. These requirements apply to health care providers and health care facilities (including independent freestanding emergency departments). These interim final rules outline requirements regarding the content of the one-page disclosure, methods for disclosure, timing of disclosure to individuals, exceptions to the requirements, and a special rule to prevent unnecessary duplication with respect to providers. These disclosure requirements do not apply to providers of air ambulance services, as section 2799B–3 of the PHS Act requires providers and facilities to disclose information regarding the requirements and prohibitions applicable to the provider or facility under sections 2799B–1 of the PHS Act (relating to balance billing for emergency services) and 2799B–2 of the PHS Act (relating to balance billing for non-emergency services furnished by nonparticipating providers at certain participating facilities), but not under section 2799B–5 of the PHS Act (relating to balance billing for air ambulance services). Although this provision does not apply to providers of air ambulance services, as the definition of health care providers in 45 CFR 149.30 excludes providers of air ambulance services, HHS encourages providers of air ambulance services to make available clear and understandable information about the requirements and prohibitions on balance billing for air ambulance services.

i. Content of Disclosure

The statute and these interim final rules require that the disclosure must include a clear and understandable statement that explains the requirements and prohibitions applicable to the provider or facility under sections 2799B–1 and 2799B–2 of the PHS Act and their implementing regulations, relating to prohibitions on balance billing in cases of emergency services and non-emergency services performed by a nonparticipating provider at certain participating facilities as described earlier in this preamble.

In addition, the disclosure must include clear and understandable language that explains any applicable state law requirements regarding the amounts such provider or facility may charge a participant, beneficiary, or enrollee after receiving payment, if any,

⁹¹ The Departments note that whether a provider or facility provides such a notification to the plan or issuer and whether a plan or issuer processes a claim as if notice and consent were obtained based on a provider’s notification is not determinative of whether the balance billing protections apply. A participant, beneficiary, or enrollee who is balance billed or whose cost-sharing responsibility is calculated at out-of-network rates would still be able to contend that they did not receive sufficient notice or did not provide consent, and challenge the provider or facility’s right to balance bill them, as well as and the plan or issuer’s handling of the claim.

from a plan or coverage (with which the provider or facility does not have a contractual relationship) and any applicable cost-sharing payment from such participant, beneficiary, or enrollee.

HHS recognizes that there may be some state laws that are more protective of consumers than sections 2799B–1 and 2799B–2 of the PHS Act and their implementing regulations. For example, a state law might prohibit an individual from providing consent to be balance billed under more circumstances than those in which balance billing are prohibited under those sections and their implementing regulations. If the more protective state law causes certain provisions of sections 2799B–1 and 2799B–2 of the PHS Act and their implementing regulations to be inapplicable to the provider or facility, the provider or facility is not required to include language containing information on those inapplicable provisions in the disclosures regarding the federal requirements and prohibitions, to the extent permitted under state law. However, the provider or facility would continue to be required to include information in the disclosures about any provisions in sections 2799B–1 and 2799B–2 of the PHS Act and their implementing regulations that remain applicable to the provider or facility.

Last, the statute and these interim final rules require that the disclosure must include clear and understandable language providing contact information for the appropriate state and federal agencies that an individual may contact if the individual believes the provider or facility has violated a requirement described in the notice. If only one federal or state agency has oversight with respect to providers or facilities in the state, the disclosure may include contact information for only that agency.

In an effort to reduce the burden on health care providers and facilities, HHS has developed a model notice that health care providers and facilities may adopt, but are not required to use. HHS would consider a provider or facility that uses the HHS-developed model notice to be compliant with these federal disclosure rules with respect to the information regarding sections 2799B–1 and 2799B–2 of the PHS Act and their implementing regulations. HHS encourages states to develop model language to assist health care providers and facilities in fulfilling the disclosure requirements related to applicable state law requirements and contact information. If a state develops model language that is consistent with section

2799B–3 of the PHS Act, HHS will consider a provider or facility that makes appropriate use of the state-developed model language to be compliant with the federal requirement to include information about state law protections.

To ensure clear and understandable language for the required information, HHS encourages health care providers and facilities to utilize plain language in the disclosure statements and to consider user testing in the development of such notices.⁹² Providers and facilities must comply with applicable state or federal language access standards in providing the disclosures.⁹³ Communication and language barriers are associated with decreased quality of care and poorer health outcomes.⁹⁴ Studies have shown the benefits associated with the use of language services in clinics and hospitals include (1) increased quality of care, (2) improved patient safety outcomes, and (3) lower utilization of costly medical procedures. The presence of a language barrier is associated with higher rates of costly resource utilizations for diagnostic testing, increased emergency department visits, decreased use of preventive services, higher rates of hospitalization, and higher rates of adverse health outcomes.⁹⁵ HHS believes it is imperative that health care providers and facilities provide the required disclosure information in a clear and understandable manner to help achieve the goal of the No Surprises Act and ensure that individuals are aware of their rights related to protections against balance billing.

In addition, HHS reminds health care providers and facilities that these notices must comply with applicable federal civil rights laws, including that

providers and facilities must take reasonable steps to provide meaningful access for individuals with limited English proficiency and appropriate steps to ensure effective communication with individuals with disabilities, including accessibility of information and communication technology.

HHS seeks comment on the content of the required disclosures. Consistent with Executive Order 13985 and civil rights protections cited in these interim final rules, HHS particularly seeks comments from minority and underserved communities, including from those with limited English proficiency, those who prefer information in alternate and accessible formats, those who are otherwise adversely affected by persistent poverty and inequality, as well as from stakeholders who serve these communities, on what additional barriers may exist so as to ensure individuals can read, understand, and consider disclosure information and on what policies HHS may consider for addressing and removing these barriers.

ii. Methods of Disclosure

The statute and these interim final rules require that each health care provider and facility must make the required disclosure publicly available, and (if applicable) post it on a public website of such provider or facility. In addition, providers and facilities must provide a one-page notice to individuals who are participants, beneficiaries, or enrollees of a group health plan or individual health insurance coverage offered by a health insurance issuer.

To satisfy the requirement to post the disclosure on a public website, the disclosure or a link to such disclosure must be searchable on the provider's or facility's public website. HHS is of the view that the required disclosure information would not be publicly available unless displayed in a manner that is easily accessible, without barriers, and that ensures that the information is accessible to the general public, including that it is findable through public search engines. For example, HHS is of the view that a public website must be accessible free of charge, without having to establish a user account, password, or other credentials, accept any terms or conditions, and without having to submit any personal identifying information such as a name or email address. HHS seeks comment on whether additional regulatory standards are needed regarding what constitutes disclosure on a provider's or facility's public website to ensure the information is accessible to the public.

⁹² See <https://methods.18f.gov/> for information on user testing.

⁹³ See section IV.2.iii of this preamble for discussion of select federal access standards.

⁹⁴ <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan-508.pdf>.

⁹⁵ See Dewalt DA, Berkman ND, Sheridan S, Lohr KN, Pignone MP. Literacy and health outcomes: a systematic review of the literature. *J Gen Intern Med.* 2004;19(12):1228–1239. doi:10.1111/j.1525-1497.2004.40153.x; Scott TL, Gazmararian JA, Williams MV, Baker DW. Health literacy and preventive health care use among Medicare enrollees in a managed care organization. *Med Care.* 2002;40:395–404; Baker DW, Parker RM, Williams MV, Clark WS. Health literacy and the risk of hospital admission. *J Gen Intern Med.* 1998;13:791–8; Neira L. The importance of addressing language barriers in the US health system. *Duke Center for Personalized Health Care* (July 17, 2018), available at: <https://dukepersonalizedhealth.org/2018/07/the-importance-of-addressing-language-barriers-in-the-us-health-system/>.

These interim final rules provide that a health care provider or health care facility that does not have its own website is not required to make a disclosure on a public website. HHS anticipates that most facilities subject to the requirements in sections 2799B–1 and 2799B–2 of the PHS Act would generally have a website, but recognizes that providers who furnish services at such facilities may not have their own website.

To satisfy the required disclosure to the public, providers and facilities must display the required disclosure information on a sign posted prominently at the location of the health care provider or health care facility. HHS would consider a sign to be posted prominently, if the sign were posted in a central location, such as where individuals schedule care, check-in for appointments, or pay bills. Such locations would allow individuals to be aware of the protections available before or at the time of service or payment. HHS is of the view that ensuring the individual is aware of the surprise billing protections is integral to implementation of these requirements. HHS recognizes that some providers may not have publicly accessible locations and has concluded that requiring a sign to be posted prominently at a non-publicly accessible location would not further the purpose of providing a disclosure. Therefore, providers without a publicly accessible location are not required to make the disclosure under 45 CFR 149.430(c)(2).

Lastly, the statute and these interim final rules require that health care providers and facilities must provide the required disclosure information in a one-page notice to individuals who are participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer. The notice must be provided in-person or through mail or email, as selected by the participant, beneficiary, or enrollee. As outlined in the statute, the required disclosure to individuals must be limited to one page. HHS interprets the statute such that the disclosure notice may be one double-sided page. These interim final rules specify that the one-page disclosure must not include print smaller than 12-point font. These specifications are important to ensure that the one-page document is both designed in a form and presented in a manner that is readable by the individual or their representative and that it contains sufficient content to meet the requirements of these interim final rules.

HHS seeks comment on these disclosure methods, including whether additional methods of providing information should be required or permitted. In particular, HHS is interested in comments regarding whether posting of the disclosure information could be in a location other than a sign posted prominently at the location of the provider or facility. In addition, HHS seeks comment on ways to ensure that the required disclosure information posted on a public website is accessible to individuals.

iii. Timing of Disclosure to Individuals

These interim final rules generally require a health care provider or health care facility to provide the notice to participants, beneficiaries, or enrollees no later than the date and time on which the provider or facility requests payment from the individual (including requests for copayment made at the time of a visit to the provider or facility). In cases where the facility or provider does not request payment from the individual, the notice must be provided no later than the date on which the provider or facility submits a claim for payment to the plan or issuer.

HHS is of the view that the notice will be most effective in helping individuals understand their rights and protections under federal and state balance billing laws and protecting individuals from being improperly billed, if individuals receive the notice in accordance with this timing requirement. The requirement will ensure the disclosures are meaningful and that individuals are aware of their rights before or at the time of payment, which is likely to help individuals to avoid paying bills that are prohibited under state or federal balance billing rules. However, these interim final rules offer providers and facilities flexibility regarding when the disclosure must be provided to individuals. Providers and facilities may provide the required disclosures to individuals earlier. For example, they could provide the notice when an individual schedules an appointment, or when other standard notice disclosures (such as the Notice of Privacy Practices for Protected Health Information⁹⁶) are shared with individuals.

In developing these interim final rules, HHS considered allowing providers or facilities to provide the disclosure annually or only at the time a patient schedules a service, but wanted to ensure the timing of the disclosure was relevant to when the

individual may experience a violation of the surprise billing protections. HHS encourages providers and facilities to provide individuals with the notice at a time that will maximize the notice's effectiveness.

HHS seeks comment on this timing requirement, and whether another timing requirement would be more appropriate.

iv. Exceptions

Although section 2799B–3 of the PHS Act could be interpreted to apply broadly to all health care providers and facilities, these interim final rules include two exceptions to the general requirement to provide disclosures regarding balance billing protections. First, health care providers are not required to make the disclosures required under this section if they do not furnish items or services at a health care facility, or in connection with visits at health care facilities. Second, health care providers are required to provide the required disclosure only to individuals to whom they furnish items or services, and then only if such items or services are furnished at a health care facility, or in connection with a visit at a health care facility. HHS further notes that, under section 2799B–3 of the PHS Act, disclosure is required only to individuals who are participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer. However, as specified in 5 U.S.C. 8902(p), section 2799B–3 of the PHS Act applies to a health care provider and facility with respect to a covered individual in a FEHB plan, as well. The disclosure requirement is not required with respect to other individuals seeking care from a provider or facility.

While the statute does not explicitly provide for these exceptions, HHS is of the view that these exceptions serve two important purposes. First, they seek to avoid unnecessary confusion among individuals who otherwise might receive the disclosure under circumstances in which the balance billing protections would never apply. For instance, providing the disclosure of balance billing protections in a primary care provider's office could lead individuals to incorrectly assume balance billing protections exist where they do not. Second, by ensuring that the disclosures are targeted narrowly to relevant individuals, the exceptions aim to implement the statutory requirement without creating additional undue burden on providers and facilities.

HHS is of the view that these exceptions are consistent with balance

⁹⁶ For requirements regarding when health care providers are required to provide the Notice of Privacy Practices, see 45 CFR 164.520(c).

billing requirements elsewhere in these interim final rules, related to emergency services or non-emergency services furnished by a nonparticipating provider at a participating facility. Furthermore, HHS is of the view that these exceptions do not lessen the positive impact of the disclosure requirement, as health care providers and facilities are still required to make the disclosures where balance billing is most likely to occur, which will help to ensure individuals are aware of their rights relating to consumer protections against balance billing.

HHS seeks comment on these exceptions and whether there are other scenarios that should be considered.

v. Special Rule To Prevent Unnecessary Duplication With Respect to Providers

HHS realizes there may be some instances where an individual may receive two disclosure notices—one from a provider furnishing items or services at a health care facility, and the other from the health care facility itself. These interim final rules include a special rule to streamline the provision of the required disclosure to the public and one-page notice to individuals and avoid unnecessary duplication of the disclosures with respect to providers furnishing care at a health care facility. This special rule does not apply with respect to the requirement that each health care provider and facility post the required disclosure on a public website of such provider or facility. While section 2799B–3 of the PHS Act does not explicitly provide for a special rule to prevent unnecessary duplication with respect to providers, HHS is of the view that this special rule serves an important purpose in implementing these requirements while reducing unnecessary burden and effort for providers. Furthermore, HHS is of the view that this special rule will also help reduce potential consumer confusion by allowing individuals to receive only one disclosure notice when receiving services from a provider furnishing items or services at a health care facility, both of which are subject to the disclosure requirement.

The special rule provides that to the extent a provider furnishes an item or service covered under the plan or coverage at a health care facility (including an emergency department of a hospital or independent freestanding emergency department), the provider satisfies the disclosure requirements if the facility agrees to provide the information, in the required form and manner, pursuant to a written agreement. In such instance, the disclosure must include information

about the balance billing requirements and prohibitions applicable to both the facility *and* the provider. If a provider and facility have a written agreement under which the facility agrees to provide the information required under these interim final rules, and the facility fails to provide full or timely disclosure information, then the facility, but not the provider, would violate the provider disclosure requirements regarding balance billing protections. HHS is of the view that this will remove unnecessary burden and effort for the providers. HHS clarifies that a “written agreement” may be an existing contract between the provider and facility to furnish care at the facility, if amended to provide for this special rule. Alternatively, a provider and facility may enter into a new written agreement specifically outlining the disclosure requirements regarding balance billing protections.

Providers that enter into these arrangements with facilities are encouraged to monitor the facility’s adherence to these requirements. In addition, if a provider has knowledge that the required disclosure information is not being provided in a manner specified in these interim final rules, HHS encourages the provider to work with the facility to correct the noncompliance as soon as practicable or notify the applicable state authority or HHS, in states where HHS is enforcing this requirement.⁹⁷ HHS may provide additional guidance if HHS becomes aware of situations where participants, beneficiaries, and enrollees are not being provided the required disclosure information in accordance with these interim final rules.

HHS recognizes that providers and facilities frequently bill separately for items and services furnished by the provider and the facility, and considered whether to make the special rule inapplicable in those instances. However, HHS concluded that applying the special rule is appropriate in these situations, since the disclosures are not required to be included with the bill itself. Although these interim final rules provide some flexibility around the timing of the notice, HHS anticipates that the disclosure to the individual would generally be provided at the point of care. Thus, requiring the

⁹⁷ Pursuant to section 2799B–4 of the PHS Act, states have authority to enforce the requirements of Part E of title XXVII of the PHS Act against a provider or health care facility (including a provider of air ambulance services), and HHS must enforce if a state has failed to substantially enforce the requirements. HHS intends to issue rulemaking in the future to implement section 2799B–4 of the PHS Act.

provider and facility to separately provide notices whenever they bill separately could result in the individual receiving multiple notices for the same visit. Duplicative paperwork could overwhelm or confuse the receiving individual, which could detract from the primary purpose of clarifying and making known the protections that may apply to the individual. In addition, HHS is of the view that requiring a provider to separately post a disclosure within a facility is of limited additional benefit and may present compliance challenges for providers who lack designated space within a facility. Therefore, the special rule applies regardless of whether the provider and facility bill jointly or separately.

Furthermore, since the special rule does not apply with respect to the requirement that each health care provider and facility make the required disclosure available on the public website of the provider or facility, HHS is of the view that this special rule works to achieve the goals of preventing unnecessary duplication for providers and facilities, while encouraging safeguards to ensure that individuals receive the required disclosure information and are aware of their rights. HHS is of the view that this special rule does not lessen the positive impact of the disclosure requirement. This special rule will continue to help to ensure individuals are aware of their rights relating to patient protections against surprise billing.

HHS seeks comment on this special rule and whether there are other circumstances that may warrant a special rule to prevent unnecessary duplication. In addition, HHS seeks comment on whether providers should be required, rather than encouraged, to monitor and report whether a facility is not complying with the requirement outlined in these interim final rules.

4. Surprise Billing Complaints Regarding Health Care Providers, Facilities, and Providers of Air Ambulance Services

The No Surprises Act adds section 2799B–4(b)(3) of the PHS Act, which directs HHS to establish a process to receive consumer complaints regarding violations by health care providers, facilities, and providers of air ambulance services of balance billing requirements under sections 2799B–1, 2799B–2, 2799B–3, and 2799B–5 of the PHS Act and to respond to such complaints within 60 days. Therefore, the interim final rules establish an HHS-only complaints process for health care providers, facilities and providers of air ambulance services that parallels the

process that the Departments are establishing through these interim final rules for plans and issuers. A more fulsome discussion of the complaints process for providers can be found in section III.B.4 of this preamble. HHS seeks comment on the complaints process for health care providers, facilities, and providers of air ambulance services described in these interim final rules.

5. Catastrophic Plans

As discussed earlier in this preamble, where the surprise billing protections apply, and the out-of-network rate exceeds the amount upon which cost sharing is based (which for emergency services provide by a nonparticipating emergency facility and for non-emergency services provided by a nonparticipating provider at a participating health care facility is the recognized amount, and for services provided by a nonparticipating provider of air ambulance services is the lesser of the billed amount or the QPA), a group health plan or health insurance issuer offering group or individual health insurance coverage must pay the provider or facility the difference between the out-of-network rate and the cost-sharing amount, even in cases where an individual has not satisfied their deductible (in which case the cost-sharing amount is the recognized amount, or the lesser of the billed amount or the QPA, as applicable). Catastrophic plans generally cannot provide benefits for any plan year until the annual limitation on cost sharing in section 1302(c)(1) of ACA is reached, other than coverage of preventive services under section 2713 of the PHS Act and at least three primary care visits. A catastrophic plan cannot comply with the new balance billing protections, specifically the obligation to make a payment to a provider or facility prior to the enrollee meeting the annual limitation on cost sharing, while satisfying the definition of a catastrophic plan at section 1302(e) of ACA. Because the No Surprises Act does not contain language eliminating catastrophic plans or exempting catastrophic plans from the law's requirements, HHS interprets the statute as permitting catastrophic plans to make payments required by sections 2799A–1 or 2799A–2 of the PHS Act without losing their status as catastrophic plans. HHS is, therefore, amending 45 CFR 156.155 in these interim final rules to specify that a catastrophic plan must provide benefits as required under sections 2799A–1 and 2799A–2 of the PHS Act and their implementing regulations, or any applicable state law

providing similar surprise billing protections to individuals. Additionally, a health plan will not fail to be treated as a catastrophic plan because the plan provides benefits prior to the annual limitation on cost sharing in section 1302(c)(1) of the ACA, as required under sections 2799A–1 and 2799A–2 of the PHS Act or any applicable state law providing similar protections to individuals.

V. Overview of Interim Final Rules—Office of Personnel Management

A. Conforming Changes for FEHB Program

The OPM interim final rules, through new 5 CFR 890.114 in subpart A, protect FEHB Program covered individuals from surprise medical bills for emergency services, air ambulance services furnished by nonparticipating providers, and non-emergency services furnished by nonparticipating providers at participating health care facilities in certain circumstances in the same manner as the Departments' rules protect participants, beneficiaries, or enrollees. The Departments' interim final rules generally apply with respect to FEHB carriers' compliance with the No Surprises Act, except to the extent that differences are necessitated for clarification or appropriate application in the context of the FEHB Program. In considering application of the Departments' interim rules with respect to the FEHB Program, it is important to recognize that all FEHB carriers offer fully insured health benefits plans in consideration of premium payments pursuant to contract terms, and no health benefits plan is self-insured by OPM or the Federal government. OPM seeks comment on this approach and whether there should be any additional considerations in the application of these interim final rules in the context of the FEHB Program.

B. Preemption and OPM Enforcement

FEHB contract terms preempt state law with respect to coverage or benefits (including payments with respect to benefits) pursuant to 5 U.S.C. 8902(m)(1). Such preemption renders specified state law inapplicable for the purposes of determining recognized amounts and out-of-network rates under 26 CFR part 54, 29 CFR part 2590, and 45 CFR part 149. However, pursuant to bilateral negotiation of FEHB contract terms, OPM and the carrier may agree to apply state law to determine the total amount payable, rendering the state law amount, method, or process for determining the total amount payable an effective term of the Federally-regulated,

Federally-enforced contract. Accordingly, in this instance, FEHB contract terms will govern the methodology for determining recognized amounts and out-of-network rates. In the absence of a FEHB contract term incorporating a state law amount, method, or process for determining the total amount payable (including an amount determined pursuant to an All-Payer Model Agreement under section 1115A of the Social Security Act), the lesser of the billed amount or the QPA will serve as the recognized amount under the FEHB plan. Likewise, in the absence of a FEHB contract term incorporating an applicable state IDR process, the federal IDR process will govern the determination of out-of-network rates in cases of failed open negotiations.

Example A: A community-rated FEHB plan covers a specific non-emergency service that is provided to a covered individual in State A by a nonparticipating provider in a participating health care facility. Both the provider and the facility are licensed in State A. State A has a law that prohibits balance billing for non-emergency services provided to individuals by nonparticipating providers in a participating health care facility, and provides for a method for determining the cost-sharing amount and total amount payable. The law applies to health insurance issuers and providers licensed in State A and applies to the type of service provided. OPM and the FEHB carrier, through the annual contract negotiation cycle, have elected to utilize State A's law, and the FEHB health benefits plan contains a term expressly incorporating the State A law prohibiting balance billing. In this Example, the FEHB contract terms apply the state law to determine the recognized amount and the out-of-network rate.

Example B: Same facts as Example A, except that the FEHB contract terms do not incorporate or expressly refer to the balance billing law of State A. In this Example, State A's law prohibiting balance billing would be preempted by the terms of the FEHB contract. The lesser of the billed amount or QPA would apply to determine the recognized amount. The out-of-network rate would be determined through open negotiation between the nonparticipating provider and the FEHB carrier, or in the case of failed negotiations, an amount determined under the federal IDR process.

Enforcement of these interim final rules with respect to FEHB carriers will generally be governed by OPM authorities set forth herein and 5 U.S.C.

8901 *et seq.*, 5 CFR part 890, 48 CFR chapter 16, or the carrier's FEHB contract. Any differences in terminology or other clarification will be set forth in the applicable FEHB contract.

C. Definitions

The No Surprises Act and these interim final rules include defined terms that are specific to the law's requirements and implementation. Definitions of key terms with respect to OPM's enforcement of 5 U.S.C. 8902(p) generally align with the Departments' regulations, with certain exceptions. For compliance with these provisions, the terms "group health plan or plan," "health insurance issuer or issuer," and "participant, beneficiary, or enrollee" are respectively replaced with the terms "health benefits plan," "carrier," and "enrollee or covered individual."

D. Complaints

Complaints related to the provisions under Part D of title XXVII of the PHS Act with respect to carriers and FEHB plans will generally be resolved in accordance with the Departments' interim final rules. OPM will coordinate with the Departments to ensure that complaints appropriate for OPM resolution under the FEHB Program statute, regulations or contractual authorities are referred to OPM.

E. Jurisdiction of Courts

Under 5 U.S.C. 8912, the district courts of the United States have original jurisdiction, concurrent with the United States Court of Federal Claims, of a civil action or claim against the United States founded on FEHBA. Pursuant to new paragraph (e) in 5 CFR 890.107, in the event of litigation under these interim final rules, a suit for equitable relief founded on 5 U.S.C. chapter 89 that is based on 5 U.S.C. 8902(p) and is governed by 5 CFR part 890 must be brought against OPM by December 31 of the 3rd year after the year in which disputed services were rendered. OPM seeks comment on amendments to its regulation on court review.

F. Applicability

OPM seeks comment on the appropriate manner of conforming compliance with sections 9816, 9817, and 9822 of the Code; sections 716, 717, and 722 of ERISA; and sections 2799A–1, 2799A–2, and 2799A–7 of the PHS Act for application to FEHB carriers, including the appropriateness and usability of the definitions and any additional changes to the Departments' regulatory provisions that must be conformed for appropriate implementation in the FEHB Program.

For purposes of 5 U.S.C. 8902(p), the HHS interim final rules apply to health care providers, facilities, and providers of air ambulance services with respect to covered individuals in a FEHB plan in the same manner as they apply with respect to participants, beneficiaries, and enrollees in a group health plan or group or individual health insurance coverage offered by a health insurance issuer. OPM seeks comment on the appropriate manner of conforming compliance with 5 U.S.C. 8902(p) and sections 2799B–1, 2799B–2, 2799B–3, and 2799B–5 of the PHS Act.

Consistent with the Departments' approach discussed in section III.D. of this preamble, OPM will not apply these interim final rules to health benefits plans that are retiree-only plans.

VI. Waiver of Proposed Rulemaking

Section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act authorize the Secretaries of the Treasury, Labor, and HHS (collectively, the Secretaries), respectively, to promulgate any interim final rules that they determine are necessary or appropriate to carry out the provisions of chapter 100 of the Code, part 7 of subtitle B of title I of ERISA, and title XXVII of the PHS Act.

In addition, under section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 551 *et seq.*) a general notice of proposed rulemaking is not required when an agency finds good cause that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued. The Secretaries and OPM Director have determined that it would be impracticable and contrary to the public interest to delay putting the provisions in these interim final rules in place until after a full public notice and comment process has been completed.

The No Surprises Act was enacted on December 27, 2020, as title I of Division BB of the Consolidated Appropriations Act, 2021. The cost-sharing and balance billing requirements on plans, issuers, health care providers, facilities, and providers of air ambulance services in the No Surprises Act apply for plan years (in the individual market, policy years) beginning on or after January 1, 2022. Although this effective date may have allowed for the regulations, if promulgated with the full notice and comment rulemaking process, to be applicable in time for the applicability date of the provisions in the No Surprises Act, this timeframe would not provide sufficient time for the regulated entities to implement the requirements. These interim final rules require plans

and issuers to make significant changes to how they pay for items and services that are subject to the cost-sharing and balance billing protections, including implementing claims processing procedures to ensure that claims for items and services subject to these protections are processed in accordance with the requirements in these interim final rules. Group health plans and health insurance issuers offering group or individual health insurance coverage will have to account for these changes in establishing their premium or contribution rates, and in making other changes to the designs of plan or policy benefits. In some cases, issuers will need time to secure approval for these changes in advance of the plan or policy year in question. The Departments and OPM anticipate the plans and issuers will have already taken into consideration the statutory provisions in the No Surprises Act as they developed plan designs for 2022, and preliminary rates. Issuing these rules as interim final rules, rather than as a notice of proposed rulemaking, may allow plans and issuers to account for the finalized regulations as they finalize rates and plan offerings.

The interim final rules place new requirements on facilities, health care providers, and providers of air ambulance services regarding when they are permitted to balance bill for items and services. Such requirements include new requirements related to how providers and facilities must bill for items and services furnished on an out-of-network basis, requirements related to providing notice and obtaining consent regarding balance billing protections in certain circumstances, and requirements to disclose information on balance billing publicly, on a public website and to participants, beneficiaries, and enrollees. Health care providers and facilities require time to implement these new requirements to ensure compliance by January 1, 2022.

These interim final rules contain critical protections for participants, beneficiaries, and enrollees against balance billing. For individuals who receive balance bills, the costs can be astronomical and devastating.⁹⁸ In addition, the recipients of such bills are not the only ones who feel their impact. As discussed elsewhere in this preamble, providers have previously been able to leverage the ability to

⁹⁸ See, Greaney, T.L., Surprise Billing: A Window into the U.S. Health Care System, ABA Civil Rights and Social Justice Section, Human Rights Magazine (Sept. 8, 2020); Cooper, Z. et al., Surprise! Out-Of-Network Billing For Emergency Care in the United States, NBER Working Paper 23623, 20173623 (July 2017, Revised January 2018).

balance bill to negotiate higher in-network rates. This leads to higher premiums, higher cost sharing for consumers, and increased health expenditures.⁹⁹ One study estimated that policies to address surprise billing on a federal level could decrease health insurance premiums by one to five percent.¹⁰⁰ Additionally, consumers may delay receiving needed medical care, including for emergency medical conditions, over concern about surprise medical bills. It is therefore in the public interest that individuals receive the protections under the No Surprises Act on the date on which those protections go into effect. Accordingly, in order to allow plans, health insurance issuers, facilities, health care providers, and providers of air ambulance services sufficient time to implement these new requirements, these rules must be published and available to the public well in advance of the effective date of the requirements in the No Surprises Act. Allowing time for a full notice and comment process prior to the requirements taking effect would not provide sufficient time for these entities to comply with the requirements for plan years (in the individual market, policy years) beginning on or after January 1, 2022, which would risk subjecting the public to prohibited balance bills and excess cost sharing. Additionally, plans and issuers need certainty regarding the standards of these requirements in order to begin implementation, which these interim final rules seek to provide.

Section 2723 of the PHS Act authorizes states to enforce the requirements in Part D of title XXVII of the PHS Act with respect to issuers. Section 2799B–4 of the PHS Act authorizes states to enforce the requirements in Part E of title XXVII of the PHS Act with respect to providers and health care facilities (including a provider of air ambulance services). Under both sections, HHS is required to enforce such requirements if a state fails to substantially enforce them. In order to ensure effective oversight of these new requirements as soon as they go

into effect, states require time to assess the requirements contained in these interim final regulations, and notify HHS if they have not enacted legislation to enforce such requirements or they otherwise will not be enforcing such requirements. States that opt to enforce the requirements may require time to update their regulations or statutes and develop processes for enforcing the new requirements. Delaying the rules to allow for notice and comment procedures would not provide sufficient time for states to assess the new requirements and notify HHS of their ability to enforce.

In addition, the law requires the Secretaries to issue rulemaking by July 1, 2021, regarding the QPA methodology (including defining the geographic regions for purposes of the methodology); information plans or issuers must share with nonparticipating providers or facilities, as applicable, regarding the plan or issuer's determination of the QPA; and a process to receive complaints related to the QPA. Allowing time for a full notice and comment process prior to July 1, 2021, would not have provided sufficient time for the Departments to develop and publish these rules by the statutory deadline.

For the foregoing reasons, the Departments and OPM have determined that it is impracticable and contrary to the public interest to engage in full notice and comment rulemaking before putting these interim final rules into effect, and that it is in the public interest to promulgate interim final rules.

VII. Economic Impact and Paperwork Burden

A. Summary

These interim final rules implement provisions of the No Surprises Act, which Congress enacted as part of the CAA, that protect participants, beneficiaries, and enrollees in group health plans and group and individual health insurance coverage from surprise medical bills when they receive emergency services, non-emergency services from nonparticipating providers at certain participating facilities, and air ambulance services, under certain circumstances.

The Departments and OPM¹⁰¹ have examined the effects of these interim final rules as required by Executive Order 13563 (76 FR 3821, January 21, 2011, Improving Regulation and Regulatory Review); Executive Order 12866 (58 FR 51735, October 4, 1993,

Regulatory Planning and Review); the Regulatory Flexibility Act (September 19, 1980, Pub. L. 96–354); section 1102(b) of the Social Security Act (42 U.S.C. 1102(b)); section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995, Pub. L. 104–4); Executive Order 13132 (64 FR 43255, August 10, 1999, Federalism); and the Congressional Review Act (5 U.S.C. 804(2)).

B. Executive Orders 12866 and 13563

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 is supplemental to and reaffirms the principles, structures, and definitions governing regulatory review as established in Executive Order 12866.

Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a rule: (1) Having an annual effect on the economy of \$100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis must be prepared for major rules with economically significant effects (for example, \$100 million or more in any one year), and a “significant” regulatory action is subject to review by OMB. The Departments anticipate that this regulatory action is likely to have economic impacts of \$100 million or more in at least 1 year, and thus meets the definition of an “economically significant rule” under Executive Order 12866. Therefore, the Departments have provided an assessment of the potential costs, benefits, and transfers associated with these interim final rules. In accordance with the provisions of Executive Order 12866, these interim final rules were reviewed by OMB.

⁹⁹ See Cooper, Z. et al., Surprise! Out-Of-Network Billing For Emergency Care in the United States, NBER Working Paper 23623, 20173623 (July 2017, Revised January 2018); Duffy, E. et al., “Policies to Address Surprise Billing Can Affect Health Insurance Premiums,” *The American Journal of Managed Care* 26.9 (2020): 401–404; and Brown E.C.F., et al., The Unfinished Business of Air Ambulance Bills, *Health Affairs Blog*, March 26, 2021. DOI: 10.1377/hblog20210323.911379, available at <https://www.healthaffairs.org/doi/10.1377/hblog20210323.911379/full/>.

¹⁰⁰ Trish E. et al., Policies to Address Surprise Billing Can Effect Health Insurance Premiums, *Am J Manag Care*. 2020;26(9):401–404. <https://doi.org/10.37765/ajmc.2020.88491>.

¹⁰¹ All references to the Departments in the Economic Impact section of the preamble include OPM. The analysis includes FEHB plans.

1. Need for Regulatory Action

A surprise medical bill is an unexpected bill from a health care provider or facility that occurs when a participant, beneficiary, or enrollee receives medical services from a provider (including a provider of air ambulance services) or facility that, generally unbeknownst to the participant, beneficiary, or enrollee, is a nonparticipating provider or facility with respect to the individual's coverage. Surprise bills usually occur in situations when a patient is unable to choose a provider (including a provider of air ambulance services) or emergency facility and ensure that they receive care from only providers or emergency facilities that are participating for their coverage. A recent survey revealed that two-thirds of adults worry about being able to afford unexpected medical bills for themselves and their families, and 41 percent of adults with health insurance received a surprise medical bill in the previous 2 years.¹⁰² Surprise bills can cause significant financial hardship and cause individuals to forgo care. A project carried out by Vox, a news and opinion website, which collected emergency department medical bills reported instances of accident victims receiving care at out-of-network hospitals and receiving bills of over \$20,000.¹⁰³ These challenges may be more keenly experienced by minority and underserved communities, which are more likely to experience poor communication, underlying mistrust of the medical system, and lower levels of patient engagement than other

populations.¹⁰⁴ Communities experiencing poverty and other social risk factors are particularly impacted as surprise medical bills can negatively affect individuals' abilities to eliminate debt and create wealth, and ultimately can affect a family for generations.¹⁰⁵ Effective, culturally, and linguistically tailored communication at appropriate literacy levels, along with policies that address the social risk factors and other barriers underserved communities face to accessing, trusting, and understanding health care costs and coverage can reduce disparities and promote health equity.¹⁰⁶

¹⁰⁴ Butler S., Sherriff N. How poor communication exacerbates health inequities and what to do about it. Brookings Institution: Report (February 22, 2021). <https://www.brookings.edu/research/how-poor-communication-exacerbates-health-inequities-and-what-to-do-about-it/>; Hamel, L., Lopes, L., Muñana, C., Artiga, S., Brodie, M. Race, Health, and COVID-19: The Views and Experiences of Black Americans. Kaiser Family Foundation (October 2020). <https://files.kff.org/attachment/Report-Race-Health-and-COVID-19-The-Views-and-Experiences-of-Black-Americans.pdf>; and Shen M.J., Peterson E.B., Costas-Muñiz R. *et al.* The Effects of Race and Racial Concordance on Patient-Physician Communication: A Systematic Review of the Literature. *J. Racial and Ethnic Health Disparities* 5, 117–140 (2018). <https://doi.org/10.1007/s40615-017-0350-4>.

¹⁰⁵ Taylor, J., Racism, inequality, and health care for African Americans. The Century Foundation: Report (December 19, 2019). <https://tcf.org/content/report/racism-inequality-health-care-african-americans/>; and Chavis, B., Op-Ed: Big insurance must help end surprise medical billing. *blackpressUSA* (February 24, 2020). <https://blackpressusa.com/op-ed-big-insurance-must-help-end-surprise-medical-billing/>.

¹⁰⁶ Pérez-Stable E.J., El-Toukhy S., Communicating with diverse patients: How patient and clinician factors affect disparities. *Patient Educ Couns.* 2018;101(12):2186–2194. doi:10.1016/j.pec.2018.08.021; McNally, M., Confronting disparities in access to healthcare for underserved populations. *MedCity News* (February 22, 2021). <https://medcitynews.com/2021/02/confronting-disparities-in-access-to-healthcare-for-underserved-populations-in-2021/>.

¹⁰² Pollitz K., *et al.*, US Statistics on Surprise Medical Billing. *JAMA.* 2020;323(6):498. doi:10.1001/jama.2020.0065.

¹⁰³ Kliff S., Surprise medical bills, the high cost of emergency department care, and the effects on patients [published online August 12, 2019]. *JAMA Intern Med.* doi:10.1001/jamainternmed.2019.3448.

The No Surprises Act provides federal protections against surprise billing and limits out-of-network cost sharing under many of the circumstances in which surprise medical bills arise most frequently. These interim final rules implement provisions of the No Surprises Act that protect individuals from surprise medical bills for emergency services, air ambulance services furnished by nonparticipating providers, and non-emergency services furnished by nonparticipating providers at participating facilities in certain circumstances.

2. Summary of Impacts

The provisions in these interim final rules will ensure that participants, beneficiaries, and enrollees with health coverage are protected from surprise medical bills. Individuals with health coverage will gain peace of mind, experience a reduction in out-of-pocket expenses, be able to meet their deductible and out-of-pocket maximum limits sooner, and may experience increased access to care. Plans, issuers, health care providers, facilities, and providers of air ambulance services will incur costs to comply with the requirements in these interim final rules. In accordance with OMB Circular A–4, Table 1 depicts an accounting statement summarizing the Departments' assessment of the benefits, costs, and transfers associated with this regulatory action. The Departments are unable to quantify all benefits, costs, and transfers of these interim final rules but have sought, where possible, to describe these non-quantified impacts. The effects in Table 1 reflect non-quantified impacts and estimated direct monetary costs resulting from the provisions of these interim final rules.

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TABLE 1: Accounting Statement

Benefits:				
Non-Quantified:				
• Elimination of surprise medical bills for individuals from out-of-network medical care and air ambulance services. • Reduction in financial anxiety, including anxiety associated with medical debt, for individuals with health coverage, due to a reduction in surprise bills. • Increased access to care for individuals with health coverage that may have otherwise forgone or neglected needed treatment due to high out-of-pocket expenses, and better health outcomes as a result. Potential improved health outcomes for individuals with grandfathered health coverage due to the ability to choose their own primary care physicians, the ability to choose a pediatrician as the primary care physician for children, and the ability to receive obstetrical and gynecological care without a referral.				
Costs:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized (\$/year)	\$ 2,252.23 million	2021	7 percent	2021— 2025
	\$ 2,177.12 million	2021	3 percent	2021— 2025
Quantitative:				
• Costs to issuers and third-party administrators (TPAs) to comply with the requirements related to the recognized amount and QPA, estimated to be one-time costs of approximately \$4,958 million to make the necessary information technology system changes in 2021 and ongoing operational costs of \$2,047 million in 2022 and \$724 million annually from 2023 onwards. • Costs to issuers and TPAs to revise standard operating procedures and provide training to staff, estimated to be one-time costs of approximately \$12.1 million in 2021. • Costs to health care facilities and emergency facilities to revise standard operating procedures and provide training to staff, estimated to be one-time costs of \$117.2 million in 2021. • Costs to providers of air ambulance services to revise standard operating procedures and provide training to staff, estimated to be one-time costs of \$517,086 in 2021.				

- Costs to issuers and TPAs to share information related to QPA, estimated to be approximately \$55.4 million annually starting in 2022.
- Costs to self-insured plans opting in to state law to include disclosure in plan documents, estimated to be one-time costs of approximately \$50,708 in 2022.
- Costs to grandfathered health plans to provide the notice of right to designate a primary care provider, estimated to be \$4.5 million in 2022.
- Costs to nonparticipating providers and nonparticipating emergency facilities to comply with requirements related to notice and consent, recordkeeping, and notice to plans and issuers, estimated to be one-time costs of approximately \$22.6 million in 2021 and ongoing costs of \$117.2 million annually starting in 2022.
- Costs to individuals to read and understand the notice from nonparticipating providers and nonparticipating emergency facilities, estimated to be approximately \$99.1 million annually, starting in 2022.
- Costs to health care providers and facilities to provide disclosures on patient protections against balance billing, estimated to be one-time costs of approximately \$6.8 million in 2021 and \$2.5 million annually starting in 2022.
- Costs to states to develop state-specific language for patient disclosures to be provided by health care providers and facilities, estimated to be one-time costs of approximately \$10,732 in 2021.
- Costs to health care facilities to enter into agreements for the facilities to provide the disclosure on patient protection on behalf of the providers, estimated to be one-time costs of approximately \$6.4 million in 2021.
- Costs to plans and issuers to provide disclosure on patient protections to participants, beneficiaries and enrollees, estimated to be approximately \$699,245 in 2021 and approximately \$23.4 million annually starting in 2022.
- Costs to individuals and providers to submit complaints related to surprise bills, estimated to be approximately \$97,452 annually starting in 2022.
- Costs to the federal government to build a system to receive complaints and expand existing systems, estimated to be one-time costs of approximately \$19 million in 2021; and ongoing costs to process complaints, estimated to be approximately \$1.6 million in 2021, \$9.9 million in 2022, \$10.1 million in 2023 and \$10.3 million in 2024 and subsequent years.

Transfers:

Non-Quantified:

- Increase in health care expenditures if health care utilization increases.

Non-Quantified:

- Transfer from plans and issuers to participants, beneficiaries, and enrollees because plans and issuers will now pay additional amounts for some services provided by nonparticipating providers and facilities and participants, beneficiaries, and enrollees will experience a reduction in out-of-pocket expenditures.
- Potential transfer from providers, including air ambulance providers, and facilities to the participant, beneficiary or enrollee if the out-of-network rate collected is lower than what would have been collected had the provider or facility balance billed the participant, beneficiary or enrollee.

More detailed analysis forthcoming in future rulemaking:

- Potential reduction in negotiated rates for certain health care services and air ambulance services, leading to reductions in cost sharing for individuals with health coverage.
- Potential change in premiums depending on the impact on provider payments.
- Potential transfer from individuals to the federal government in the form of reduced premium tax credits if premiums decrease as a result of these interim final rules.
- Potential transfer from the federal government to individuals in the form of increased premium tax credits if premiums increase as a result of these interim final rules.

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a. Prevalence of Surprise Billing

There is extensive research on the incidence of out-of-network providers and facilities billing patients for items and services furnished at in-network

and out-of-network health care facilities. Most of these studies analyze claims data to identify cases that may potentially result in a surprise medical bill. The studies reveal that surprise billing is a significant issue for consumers across the country and

across all types of coverage. For example, an analysis of claims data from large group health plans revealed that while rates varied by state, 18 percent of emergency department visits, on average, resulted in individuals receiving a surprise medical bill in

2017. The out-of-network charges came either from facilities or providers, or both, though the majority of the charges were from individual providers, rather than facilities.¹⁰⁷ In addition, in 2017, 16 percent of inpatient stays at in-network facilities resulted in out-of-network charges, though the rate of out-of-network billing varied by state and also between rural and urban areas. Another study revealed that admissions at in-network hospitals for surgery and mental health/substance use disorders are more likely to include out-of-network charges, and women with large-employer coverage who have had a mastectomy at an in-network facility were also more likely (21 percent) to be billed for out-of-network charges.¹⁰⁸ An analysis of commercial claims data for in-network hospital admissions in 2016 found that out-of-network claims occurred in 14.5 percent of admissions, with wide variation between states.¹⁰⁹

A study using 2007–2014 claims data for group health plans indicated that in 2014, 20 percent of hospital inpatient admissions that originated in the emergency department, 14 percent of outpatient emergency department visits, and 9 percent of elective inpatient admissions were likely to result in surprise medical bills. In approximately 40 percent of inpatient admissions and more than half of outpatient cases with surprise bills, issuers paid the claims at an in-network level, so the patients were potentially billed for the remaining amount.¹¹⁰ Another study using claims data from a large issuer for the period 2010–2016 found that over 39 percent of emergency department visits to in-network hospitals resulted in an out-of-network bill, and that the incidence increased from 32.3 percent in 2010 to 42.8 percent in 2016. The average potential amount of the surprise medical bill also increased from \$220 in 2010 to \$628 in 2016. During the same time period, 37 percent of inpatient

admissions to in-network hospitals resulted in at least one out-of-network bill, increasing from 26.3 percent in 2010 to 42 percent in 2016 and the average potential amount of the surprise medical bill increased from \$804 to \$2,040.¹¹¹

For elective surgeries, analysis of claims data from a large issuer revealed that between 2012 and 2017, an out-of-network bill occurred in over 20 percent of cases, when the primary surgeon and facility were in-network, resulting in potential balance bills ranging from \$1,255 to \$3,449. Occurrences of out-of-network bills were associated with significantly higher total charges and out-of-pocket costs for patients, compared to cases without out-of-network bills.¹¹²

Researchers have also tried to estimate the amounts of surprise bills patients receive. A study using 2015 claims data from a large issuer for services provided at in-network hospitals concluded that average potential balance bills from anesthesiologists, pathologists, radiologists, and assistant surgeons were \$1,171, \$177, \$115, and \$7,420, respectively.¹¹³ Another study analyzing 2014–2017 data related to ambulatory surgical centers from three large issuers revealed that in 10 percent of cases, patients treated at in-network facilities received care from out-of-network providers, and patients may have received surprise bills in 8 percent of cases. On average, the amount of the surprise medical bill was \$1,141, and the amount increased by 81 percent over the period, from \$819 in 2014 to \$1,483 in 2017.¹¹⁴

Surprise billing is often associated with certain physician specialties, especially those whose services are not actively “shoppable” by consumers. Researchers analyzing claims data from a large issuer for the period 2010–2016 found that for emergency department visits, out-of-network bills arose frequently within the context of medical transport encounters (resulting in out-

of-network bills in 85.6 percent of incidents involving ambulances) and the following physician specialties: Emergency medicine (32.6 percent), anesthesiology (22.8 percent), internal medicine (23.8 percent), cardiology (20.9 percent), family practice (20.1 percent), radiology (18.1 percent), general surgery (13.3 percent), and pediatrics (8.4 percent). For inpatient admissions at in-network hospitals, in addition to medical transport (81.6 percent of cases involving ambulances), the study found that out-of-network bills arose most commonly with the following physician specialties: emergency medicine (42.6 percent of total inpatient admissions with at least 1 claim submitted by the given specialty), internal medicine (25.3 percent), radiology (22.6 percent), pathology (22.2 percent), cardiology (19.6 percent), anesthesiology (19.3 percent), family practice (18.2 percent), and obstetrics and gynecology (0.8 percent).¹¹⁵ While emergency medicine physicians make up only approximately 5 percent of the total number of active physicians,¹¹⁶ these studies show that emergency medical physicians have the highest percentage of out-of-network claims. Analysis of claims data for elective surgeries from a large issuer revealed that between 2012 and 2017, out-of-network claims were commonly associated with anesthesiologists (in 37 percent of cases), surgical assistants (37 percent), pathologists (22 percent), radiologists (7 percent), and medical consultants (3 percent).¹¹⁷ Another study analyzing commercial claims data for in-network inpatient admissions in 2016 found that some specialties with large shares of out-of-network bills were anesthesiology (16.5 percent), primary care (12.6 percent), and emergency medicine (11 percent) and that the specialties that most often billed as out-of-network at in-network facilities were independent labs (22.1 percent), followed by emergency medicine (12

¹⁰⁷ Pollitz K., et al., An examination of surprise medical bills and proposals to protect consumers from them, Peterson-KFF Health System Tracker, February 10, 2020, <https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them-3/>.

¹⁰⁸ Pollitz, K. et al., Surprise Bills Vary by Diagnosis and Type of Admission, Peterson-KFF Health System tracker, December 9, 2019, <https://www.healthsystemtracker.org/brief/surprise-bills-vary-by-diagnosis-and-type-of-admission/>.

¹⁰⁹ Kennedy K. et al., Surprise out-of-network medical bills during in-network hospital admissions varied by state and medical specialty, 2016, Health Care Cost Institute, March 28, 2019, <https://healthcostinstitute.org/out-of-network-billing/oon-physician-bills-at-in-network-hospitals>.

¹¹⁰ Garmon C. and Chatock B., One In Five Inpatient Emergency Department Cases May Lead to Surprise Bills, Health Affairs 36, No. 1 (2017): 177–181.

¹¹¹ Sun E.C., Mello M.M., Moshfegh J., Baker L.C. Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-Network Hospitals. JAMA Intern Med. 2019;179(11):1543–1550. doi:10.1001/jamainternmed.2019.3451.

¹¹² Chhabra K.R. et al., Out-of-Network Bills for Privately Insured Patients Undergoing Elective Surgery With In-Network Primary Surgeons and Facilities, 2020;323(6):538–547. doi:10.1001/jama.2019.21463.

¹¹³ Cooper Z. et al., Out-of-Network Billing And Negotiated Payments for Hospital-Based Physicians, Health Affairs 39, No. 1, 2020. doi: 10.1377/hlthaff.2019.00507.

¹¹⁴ Duffy E. et al., Prevalence And Characteristics Of Surprise Out-of-Network Bills from Professionals in Ambulatory Surgery Centers, Health Affairs 39, No. 5, 2020. doi:10.1377/hlthaff.2019.01138.

¹¹⁵ Sun E. et al., Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-Network Hospitals. JAMA Intern Med. 2019;179(11):1543–1550.

¹¹⁶ American Association of Medical Colleges. “Active Physicians by Age and Specialty.” Physician Specialty Data Report. (December 2019). <https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-age-and-specialty-2019>. The American Association of Medical Colleges estimated that among the 935,136 active physicians in the U.S. in 2019, 45,134 were emergency physicians (4.8%).

¹¹⁷ Chhabra K.R. et al., Out-of-Network Bills for Privately Insured Patients Undergoing Elective Surgery With In-Network Primary Surgeons and Facilities, 2020;323(6):538–547. doi:10.1001/jama.2019.21463.

percent).¹¹⁸ Another study analyzing 2014–2017 data related to ambulatory surgical centers from three large issuers revealed that out-of-network bills often came from anesthesiologists (44 percent of bills), certified registered nurse anesthetists (25 percent), independent laboratories (10 percent) and pathologists (3 percent).¹¹⁹

As discussed earlier in this preamble, multiple studies have shown that a large percentage of out-of-network bills come from independent laboratories. An analysis of 2008–2016 claims data for individuals with group health insurance coverage found that there was an increase in the share of out-of-network laboratory spending, and that utilization and prices for out-of-network laboratory tests increased relative to in-network tests during that time period. The number of out-of-network laboratory tests increased by 18.9 percent each year, while the number of in-network laboratory tests increased by 2.3 percent per year. The study authors speculated that large suppliers of laboratory services have sufficient market power to set high out-of-network prices and utilization by clinicians may be influenced by financial incentives.¹²⁰

Providers who choose to remain out-of-network usually do so because it does not affect their patient volume. The ability to balance bill is often used as leverage by such providers to obtain higher in-network payments when they join plans' or issuers' networks. Higher in-network payments lead to higher premiums,¹²¹ higher cost sharing for consumers, and increased health care expenditures overall. For example, hospitals often outsource the staffing of their emergency departments to outside firms. A study on out-of-network billing in emergency departments looked at the behavior of the two largest emergency department staffing firms in the United States.¹²² The study found that one firm exits networks when it enters into a

contract with a hospital, and bills as an out-of-network provider. The other firm temporarily exits networks and later rejoins after negotiating higher in-network payments.

Utilizations of air ambulance services also frequently result in surprise bills. A study by the Government Accountability Office (GAO) analyzed private health insurance claims from 2012 and 2017 to describe the extent to which air ambulance transports are out-of-network.¹²³ This study analyzed claims data from approximately 24,100 transports in 2012 and another 33,800 transports in 2017 from all 50 states and the District of Columbia. The study found that in 2012, 75 percent of transports were out-of-network and in 2017, 69 percent were out-of-network. The GAO also reported that the median price charged by providers of air ambulance services had increased from a rate of \$22,100 for rotary-wing and \$24,900 for fixed-wing in 2012 to approximately \$36,400 for rotary-wing and \$40,600 for a fixed-wing transport in 2017. The changes in price between 2012 and 2017 indicate a consistent rate of increase as a previously published report by the GAO also noted that between 2010 and 2014, the median prices charged by providers of air ambulance services for rotary-wing transports approximately doubled.¹²⁴ Another study found that for one of the largest providers of air ambulance services (with a market share of approximately 24 percent) the average charge increased from \$17,262.23 in 2009 to approximately \$50,199.24 by 2016.¹²⁵

As the costs associated with air ambulance transports continue to increase, the GAO reported that providers of air ambulance services report entering into more network contracts.¹²⁶ However, additional analyses find that many providers of air

ambulance services, particularly those not affiliated with a hospital, do not participate in insurer networks and have little incentive to do so, further noting that network participation remains low and provider avoidance of insurance network participation combined with aggressive collection practices has been described as a business strategy of some providers of air ambulance services.¹²⁷

A study using 2014–2017 data from three large issuers to evaluate the share of air ambulance claims that are out-of-network and the prevalence and magnitude of potential surprise balance bills, found that 77 percent of air ambulance transports were out-of-network and approximately 40 percent of air ambulance transports resulted in potential balance bills. The bills averaged approximately \$19,851 in addition to the standard out-of-network cost sharing, which averaged \$561. The study also found that with out-of-network rotary-wing claims, issuers paid the providers' full billed charges approximately 48 percent of the time, at an average of \$35,733 and that for in-network providers, billed charges were paid in full only 7 percent of the time. They noted that self-insured plans paid out-of-network claims in full 50 percent of the time, whereas fully insured plans paid claims in full 38 percent of the time.¹²⁸

A study using claims data from a large issuer to evaluate the potential impact of out-of-network emergency medical transport services from 2013 to 2017 identified a total of 1,498,600 ambulance encounters of which 29,972 (2 percent) were air ambulance encounters, and of these 26,375 (88 percent) were rotary-wing and 3,597 (12 percent) were fixed-wing. The study further noted that the prevalence of potential surprise medical billing was an estimated 73 percent for rotary-wing (18,463) and 70 percent (2,518) for fixed-wing transports.¹²⁹ The study determined that the potential surprise

¹¹⁸ Kennedy K. et al., *Surprise out-of-network medical bills during in-network hospital admissions varied by state and medical specialty*, 2016, Health Care Cost Institute, March 28, 2019, <https://healthcostinstitute.org/out-of-network-billing/oon-physician-bills-at-in-network-hospitals>.

¹¹⁹ Duffy E. et al., *Prevalence And Characteristics Of Surprise Out-of-Network Bills from Professionals in Ambulatory Surgery Centers*, Health Affairs 39, No. 5, 2020. doi:10.1377/hlthaff.2019.01138.

¹²⁰ Song, Z. et al., *JAMA, Out-of-Network Laboratory Test Spending, Utilization, and Prices in the US*, JAMA. 2021;325(16):1674–1676. doi:10.1001/jama.2021.0720.

¹²¹ Duffy, E. et al., *"Policies to Address Surprise Billing Can Affect Health Insurance Premiums."* The American Journal of Managed Care 26.9 (2020): 401–404.

¹²² Cooper, Z. et al., *Surprise! Out-Of-Network Billing For Emergency Care in the United States*, NBER Working Paper 23623, 2017, available at <https://www.nber.org/papers/w23623>.

¹²³ GAO (2019) Report to Congressional Committees. *Air Ambulance*. Available Data Show Privately-Insured Patients Are at Financial Risk (GAO–19–292) available at: <https://www.gao.gov/assets/700/697684.pdf>. The data analyzed included claims from over 50 payers in each year (including both fully- and self-insured plans) and accounted for 110.1 million covered lives in 2012 and 145.0 million covered lives in 2017.

¹²⁴ GAO (2017) Report to the Committee on Transportation and Infrastructure, House of Representatives. *Air Ambulance*. Data Collection and Transparency Needed to Enhance DOT Oversight. (GAO–17–637) available at: <https://www.gao.gov/assets/gao-17-637.pdf>.

¹²⁵ Consumer Union. *Up in the Air: Inadequate Regulation for Emergency Air Ambulance Transportation*. Health Policy Report, March 2017.

¹²⁶ GAO (2019) Report to Congressional Committees. *Air Ambulance*. Available Data Show Privately-Insured Patients Are at Financial Risk (GAO–19–292) available at: <https://www.gao.gov/assets/700/697684.pdf>.

¹²⁷ Missouri Department of Insurance, Financial Institutions & Professional Registration. *Policy Brief: Health Coverage for Air Ambulance Transportation*. January 2019; and New Mexico Office of the Superintendent of Insurance. *Air Ambulance Memorial Study Report*. January 2017. Available at: <https://www.nmlegis.gov/handouts/ERDT%20083117%20Item%208%20NM%20Superintendent%20of%20Insurance%20Air%20Ambulance%20Memorial%20Study%20Report.pdf>.

¹²⁸ Brown, E.C.F. et al., *Out-of-Network Air Ambulance Bills: Prevalence, Magnitude, and Policy Solutions*. The Milbank Quarterly, Vol. 98, No. 3, 2020 (pp. 747–774).

¹²⁹ Chhabra, H.R., McGuire, K., Scott, J.W., Nuliyalu, U., and Ryan, A. *Most Patients Undergoing Ground And Air Ambulance Transportation Receive Sizable Out-Of-Network Bills*. Health Affairs 39, NO. 5 (2020): 777–782.

billing amount for the study period totaled approximately \$456 million for air ambulance services, with a yearly average of \$91 million and a median potential surprise medical bill of approximately \$27,513.¹³⁰

A number of studies have reviewed state investigations or consumer complaints to obtain information on the amount of balance billing, and costs, associated with air ambulance transports. One study reviewed state investigations and found that in North Dakota, of 20 complaints against one provider of air ambulance services that charged a total of \$884,244 (an average of \$44,212 per flight), 33 percent of the charges were covered by insurance. In an additional nine states, the study found that 55 complaints resulted in a combined \$3.8 million in charges, or an average of \$77,000 per trip; and in Montana, the study found the average out-of-network rate, of the 19 bills analyzed, was \$53,397.¹³¹ The GAO further analyzed 60 consumer complaints related to air ambulance services from Maryland and North Dakota and found that from 24 complaints in Maryland the balance billed amounts ranged from \$12,300 to \$52,000 and from 36 complaints in North Dakota the balance bills ranged from \$600 to \$66,000.¹³²

b. Impact of Surprise Medical Bills

A study of out-of-network billing in emergency departments considered how some providers use the ability to bill out-of-network to increase payments. The study found that charges from out-of-network physicians in emergency departments were 637 percent of Medicare payments, which is 2.4 times higher than in-network payment rates, on average, for identical services. The study also found that emergency department physicians were paid in-network rates of 266 percent of Medicare payments, a higher percentage

of Medicare payment than most other specialists.¹³³

Another study using 2017 claims data from 3 large issuers looked at expenditures on ancillary and emergency services that are most often associated with surprise bills: emergency medicine professionals, radiologists, anesthesiologists, pathologists, emergency outpatient facilities, and emergency ground ambulance services.¹³⁴ The study concluded that a 15 percent reduction in average payments for these services would lower premiums by 1.4 percent to 1.6 percent; while a reduction in average payments to 150 percent of Medicare rates would likely lower premiums by 4.5 percent to 5.1 percent. The authors estimated that for all consumers with commercial insurance coverage, 1.6 percent and 5.1 percent reductions in premiums would result in total annual savings of \$12 billion and \$38 billion, respectively.

A study using 2015 claims data from a large issuer for services provided at in-network hospitals considered the impact of policies that would prevent anesthesiologists, pathologists, radiologists, and assistant surgeons from balance billing and would reduce their in-network payments to 164 percent of Medicare payments. The study concluded that such a reduction in payment would result in savings equal to 13.4 percent of spending on physicians and 3.4 percent of spending for people with employer-sponsored coverage, approximately \$40 billion annually.¹³⁵

Surprise bills result in higher out-of-pocket expenses and cause financial anxiety and medical debt for consumers.¹³⁶ As discussed earlier in this preamble, the impact is most keenly felt by those communities experiencing poverty and other social risk factors. Potential surprise bills can vary in size, and are often large, as concluded by the studies discussed previously. A Federal Reserve report found that about 37 percent of adults in the U.S. in 2019 would not be able to pay an unexpected

expense of \$400 using cash or its equivalent.¹³⁷ In a 2016 survey, among the respondents with health coverage who reported having difficulty paying medical bills, 75 percent reported that copayments, deductibles or coinsurance were more than they could afford and 32 percent had received out-of-network bills that insurance either did not cover or only partially covered.¹³⁸ Of those who had difficulty paying out-of-network bills, 69 percent said that it was a surprise bill and they had not been aware that the provider was out-of-network for their plan. Respondents also reported that bills from emergency room visits and hospitalizations often made up the largest share of the amount they owed. In the survey, respondents reported making sacrifices such as reducing expenditures on food, clothing, and basic household items, using up savings, working additional jobs or hours, borrowing, changing living arrangements, and reducing or delaying vacations or major household purchases. Survey respondents also reported being contacted by collection agencies. Survey results indicated that 37 percent of individuals with household incomes less than \$50,000 (compared to 14 percent with incomes of \$100,000 or more), and 47 percent of individuals with a disability (compared to 22 percent of individuals without one) had difficulties paying medical bills, demonstrating a disproportionate impact on these populations.

In addition, out-of-network cost sharing and surprise bills usually do not count towards an individual's deductible or maximum out-of-pocket expenditure limit. Therefore, individuals with surprise bills may have difficulty reaching those limits, even though they may have high health care expenses. This can result in reduced access to care, since high medical expenses can cause individuals to delay or forgo medical care. In a 2017 survey, 64 percent of respondents reported that they had delayed care in the last year because of high medical expenses and 44 percent stated that they would forgo care if their out-of-pocket expenses

¹³⁰ This study found that potential surprise bills in the study period increased from \$41 million in 2013 to \$143 million in 2017. The study further found that the median potential surprise bill from air transportation nearly doubled from \$14,356 to \$27,513, or an increase of 15 percent annually, on average, after adjustment for inflation and that the prevalence ranged from 25 percent (Minnesota) to 93 percent (Massachusetts) with the size of potential surprise bills varying widely.

¹³¹ Consumer Union. Up in the Air: Inadequate Regulation for Emergency Air Ambulance Transportation. Health Policy Report, March 2017.

¹³² GAO (2019) Report to Congressional Committees. Air Ambulance. Available Data Show Privately-Insured Patients Are at Financial Risk (GAO-19-292) available at: <https://www.gao.gov/assets/700/697684.pdf>.

¹³³ Cooper, Z. et al., Surprise! Out-Of-Network Billing For Emergency Care in the United States, NBER Working Paper 23623, 2017, available at <https://www.nber.org/papers/w23623>.

¹³⁴ Duffy, E. et al., "Policies to Address Surprise Billing Can Affect Health Insurance Premiums." The American Journal of Managed Care 26.9 (2020): 401–404.

¹³⁵ Cooper Z. et al., Out-of-Network Billing And Negotiated Payments for Hospital-Based Physicians, Health Affairs 39, No. 1, 2020. doi: 10.1377/hlthaff.2019.00507.

¹³⁶ Garmon C. and Chatock B. One In Five Inpatient Emergency Department Cases May Lead to Surprise Bills, Health Affairs 36, No. 1 (2017): 177–181.

¹³⁷ Board of Governors of the Federal Reserve System, Report on the Economic Well-Being of U.S. Households in 2019—May 2020, <https://www.federalreserve.gov/publications/2020-economic-well-being-of-us-households-in-2019-dealing-with-unexpected-expenses.htm>.

¹³⁸ Hamel, Liz et al., The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey, The Henry J. Kaiser Family Foundation, 2016, <https://www.kff.org/wp-content/uploads/2016/01/8806-the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey.pdf>.

would be more than \$500.¹³⁹ Another study reported that 7 percent of adults with health insurance delayed or went without care in 2019 because of cost reasons and adults who are in worse health are twice as likely to delay or forgo care because of cost reasons.¹⁴⁰ This study also reported that while 10.5 percent of all adults reported delaying or forgoing medical care due to costs, 15.1 percent of Hispanic adults and 13 percent of Non-Hispanic Black adults and 17.7 percent of adults with income below 200 percent of the federal poverty level reported the same, showing the disparate effect of high cost of care on these communities. Another survey concluded that 65 million adults had a health issue but did not seek treatment because of cost reasons in 2018.¹⁴¹

In addition to causing financial hardship, surprise medical bills may also cause consumers to change providers in the future. Analysis of a large national sample of claims for obstetrics patients who had two deliveries covered by insurance found that 11 percent of patients received a surprise medical bill for their first delivery and were 13 percent more likely to switch hospitals for the second delivery compared to patients who did not.¹⁴²

Individuals living in rural areas experience socioeconomic and health related disparities.¹⁴³ Rural areas have fewer primary care and mental health providers and higher rates of preventable hospitalizations. Currently, there are 1,805 rural hospitals in the United States,¹⁴⁴ with 137 rural hospitals having closed since 2010.¹⁴⁵ Individuals who live in rural or geographically remote areas often must rely on air ambulance services for

transfer to facilities with equipment and expertise to treat serious medical conditions. Often these transports are costly due to lack of options for in-network providers available to provide lifesaving services.¹⁴⁶ It is estimated that a quarter of Americans, approximately 85 million people, are unable to access health care in less than an hour of travel time without an air ambulance, and air ambulances may be the only viable means of transporting patients to the health care center they need.¹⁴⁷ One air ambulance provider estimates that 90 percent of their transports originate from rural areas, as defined by CMS.¹⁴⁸ The GAO found that about 60 percent of rotary-wing bases added between 2012 and 2017 were located in rural areas, and about half of fixed-wing bases added between 2012 and 2017 were rural.¹⁴⁹ As a result of the growing reliance on air ambulance services, rural populations are disproportionately affected by high costs of air ambulance services.

c. Existing State Laws Regarding Balance Billing

As of February 5, 2021, 33 states have enacted legislation that provides some protection for consumers with regard to balance bills.¹⁵⁰ Laws vary by state; there are differences in the types of networks, plans, facilities, and providers that are subject to regulations, and in payment standards. While most of these states prohibit balance billing for emergency services, many of them also prohibit balance billing for certain non-emergency care furnished at in-network hospitals. It is possible that states may enact new legislation or modify existing legislation in response to the passage of the No Surprises Act and these implementing regulations.

Even within a state that has enacted such protections, those protections typically apply only to individuals enrolled in group or individual health

insurance coverage, as ERISA generally preempts state laws that regulate self-insured group health plans sponsored by private employers. (Some state laws allow ERISA-covered plans to opt in to the consumer protections and process for setting payment under the state law.) In addition, states are limited in their ability to address surprise bills that involve out-of-state providers.

The air ambulance industry currently functions and operates within the health care system unlike any other entity or service, only somewhat due to the unique nature of the service. There are limited avenues for states and the U.S. Department of Transportation (DOT) to regulate their operations. States and the DOT have limited authority under the ADA to regulate the prices, routes, or services of an air carrier, including an air ambulance operator, in air transportation.¹⁵¹ The intent of the ADA was to allow the prices of air transportation services to be controlled by market forces.¹⁵² The ADA defines an “air carrier” as “a citizen of the United States undertaking by any means, directly or indirectly, to provide air transportation;” defining “air transportation” to include interstate air transportation.¹⁵³ The ADA effectively limits the ability of states to regulate the prices, routes, or services of air carriers that provide transportation services,¹⁵⁴ explicitly stating that states “may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation.”¹⁵⁵ The Departments are not aware of any state laws regulating or limiting surprise billing or other price control measures with regard to air ambulance providers or the air ambulance industry.

State laws appear to have succeeded in providing some protection to consumers from balance billing. A study analyzing the impact of New York State’s law concluded that the law resulted in a 34 percent reduction in surprise billing in the state and lowered in-network emergency department physician payments by 9 percent.¹⁵⁶ In

¹³⁹ Heath, Sara, 64% of Patients Avoid Care Due to High Patient Healthcare Costs, Patient Engagement HIT, 2018, <https://patientengagementhit.com/news/64-of-patients-avoid-care-due-to-of-high-patient-healthcare-costs>.

¹⁴⁰ Amin, K. et al., How Does Cost Affect Access to Care?, Peterson-KFF Health System Tracker, January 5, 2021, <https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care/#item-start>.

¹⁴¹ Gallup and West Health, The U.S. Healthcare Cost Crisis, 2019, <https://news.gallup.com/poll/248081/westhealth-gallup-us-healthcare-cost-crisis.aspx>.

¹⁴² Chartock, B. et al., Consumers’ Responses to Surprise Medical Bills in Elective Situations, Health Affairs 38, No. 3 (2019): 425–430.

¹⁴³ North Carolina Rural Health Research Program, Rural Health Snapshot (2017), May 2017, https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2017/05/Snapshot2017.pdf.

¹⁴⁴ American Hospital Association, Fast Facts on U.S. Hospitals, 2021, <https://www.aha.org/statistics/fast-facts-us-hospitals>.

¹⁴⁵ Cecil G. Sheps Center for Health Services Research, UNC, Rural Hospital Closures, <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>.

¹⁴⁶ Haer, A., Senate Bill 1264: The Texan Template for the National Fight Against Balance Billing, Texas Law Review, 99(4), 813–838 (2021).

¹⁴⁷ Hinsdale, J.G. Report of the Council on Medical Services: Air Ambulance Regulations and Payments. American Medical Association. (2018), available at: <https://www.ama-assn.org/system/files/2018-12/i18-cms-report2.pdf>.

¹⁴⁸ Air Evac Lifeteam, <https://lifeteam.net/history-and-mission/#:-:text=Approximately%2090%20percent%20of%20Air,are%20based%20in%20rural%20areas>.

¹⁴⁹ GAO (2019) Report to Congressional Committees, Air Ambulance, Available Data Show Privately-Insured Patients Are at Financial Risk (GAO–19–292), available at: <https://www.gao.gov/assets/700/697684.pdf>.

¹⁵⁰ The Commonwealth Fund, State Balance-billing Protections, https://www.commonwealthfund.org/sites/default/files/2021-03/Hoadley_state_balance_billing_protections_table_02052021.pdf.

¹⁵¹ See <https://www.transportation.gov/individuals/aviation-consumer-protection/air-ambulance-service>.

¹⁵² Missouri Department of Insurance, Financial Institutions & Professional Registration, *Policy Brief: Health Coverage for Air Ambulance Transportation*, January 2019.

¹⁵³ 49 U.S.C. 40102.

¹⁵⁴ 49 U.S.C. 41713.

¹⁵⁵ 49 U.S.C. 41713(b).

¹⁵⁶ Cooper, Z. et al., Surprise! Out-Of-Network Billing For Emergency Care in the United States, NBER Working Paper 23623, 2017, available at <https://www.nber.org/papers/w23623>.

addition, between the implementation of the law in March 2015 and the end of 2018, the law saved individuals in the state over \$400 million with respect to emergency services.¹⁵⁷ These savings were partly due to a reduction in costs associated with emergency services and a greater incentive to participate in provider networks. In New Jersey, issuers experienced a reduction in costs associated with emergency and inadvertent out-of-network claims since the state law took effect.¹⁵⁸ The total spending on involuntary out-of-network services were reduced by 56 percent for issuers in the individual market and by 38 percent for the issuers in the small group market. A report on California law concluded that patients were being protected from surprise medical bills in the state and that issuers had broader networks such that 80 percent to 100 percent of their hospitals and health care facilities had no nonparticipating providers practicing there.¹⁵⁹ A study on the impact of California's surprise billing law analyzed claims data for provider specialties most affected by the law (anesthesiology, diagnostic radiology, pathology, assistant surgeons, and neonatal-perinatal medicine) for the pre-implementation period from January 2014 to June 2017 and the post-implementation period from July 2017 to December 2018.¹⁶⁰ The study concluded that the share of services delivered out-of-network by the affected specialties at inpatient hospitals and ambulatory surgical centers decreased by 17 percent, ranging from a 15 percent reduction for pathology to a 31 percent decline for neonatal-perinatal medicine.

d. Benefits

Provisions in these interim final rules will protect participants, beneficiaries, or enrollees with health coverage from

receiving surprise bills for emergency services, air ambulance services furnished by nonparticipating providers, and non-emergency services furnished by nonparticipating providers at participating facilities in certain circumstances. Providers will no longer be able to balance bill an individual for emergency services. A provider will only be able to balance bill an individual for certain post-stabilization services, and for services performed by nonparticipating providers at certain participating facilities, if the provider or facility provides notice to the participant, beneficiary, or enrollee, and obtains the individual's consent to receive care on an out-of-network basis and be balance billed. Further, provisions ensuring all relevant civil rights protections are upheld and communication with consumers is accessible, in a language that is understandable, and at an appropriate literacy level, help to effectively confer these protections to minority and underserved communities.

These interim final rules also specify that for emergency services furnished by a nonparticipating provider or emergency facility, and for non-emergency services furnished by nonparticipating providers in a participating health care facility, cost sharing is generally calculated as if the total amount that would have been charged for the services by a participating emergency facility or participating provider were equal to the recognized amount for such services, as defined by the statute and in these interim final rules, while for nonparticipating providers of air ambulance services, cost sharing is generally calculated as if the total amount that would have been charged for the services by a participating provider of air ambulance services were equal to the lesser of the billed amount or QPA, as defined by the statute and in these interim final rules.

In addition, these interim final rules require that these cost-sharing amounts be counted toward any in-network deductible or in-network out-of-pocket maximums applied under the plan or coverage in the same manner as if such cost-sharing payments were made with respect to services furnished by a participating provider, participating facility, or participating provider of air ambulance services.

Consider, for example, one case included in the project by Vox,¹⁶¹ where

a victim of a violent attack was taken to an emergency facility. When the individual was able, he checked to make sure that the hospital was in-network for his plan. He was not aware, however, that the surgeon who performed emergency jaw surgery was nonparticipating for his plan and the individual received a surprise bill of \$7,924. Two other cases in the same study included an individual involved in a bike crash and another individual hit by a public bus. Both individuals were treated at the same emergency facility, which was out-of-network for both their plans and received surprise bills of \$20,243 and \$27,660, respectively. In another case, the parents of an infant who needed an inter-facility air ambulance transport for urgent surgery received a surprise medical bill of approximately \$64,000 from the air ambulance provider.¹⁶² Another case reported in the media¹⁶³ involved an expectant mother choosing an in-network hospital and a participating obstetrician for the birth of her baby. However, a nonparticipating pediatrician was called in due to a potential risk of post-delivery complications for the baby. The mother later received a surprise bill of \$636 from the pediatrician because her plan had denied the claim. In each of these situations, plans and issuers either denied the claim or paid the nonparticipating provider, nonparticipating facility, or nonparticipating provider of air ambulance services an amount that the plan or issuer considered reasonable for the services provided, and the nonparticipating provider or nonparticipating facility sent a balance bill to the individual. Under the No Surprises Act and these interim final rules, individuals in similar situations will only be responsible for in-network cost-sharing amounts and deductibles. Nonparticipating providers and nonparticipating facilities will not be able to balance bill such individuals, but instead will need to agree to an amount of payment with plans and issuers or enter into the independent dispute resolution process to determine an appropriate payment amount, if

¹⁵⁷ New York State Department of Financial Services. New York's Surprise Out-of-Network Protection Law: Report on the Independent Dispute Resolution Process. September 2019.

¹⁵⁸ State of New Jersey Department of Banking and Insurance. The Out-of-network Consumer Protection, Transparency, Cost Containment, and Accountability Act (Pub. L. 2018, c. 32) Data Reporting. As of January 31, 2021. https://www.state.nj.us/dobi/division_insurance/oonarbitration/data/210131report.html.

¹⁵⁹ Health Access California. Patients Protected, Providers Paid: Data From Three Years of California's Compromise to Stop Surprise Medical Bills. September 2019. <https://health-access.org/wp-content/uploads/2019/09/ha-factsheet-AB72report-final.pdf>.

¹⁶⁰ Adler, L. et al. California Saw Reduction In Out-Of-Network Care From Affected Specialties After 2017 Surprise Billing Law. U.S.C.-Brookings Schaeffer Initiative for Health Policy, September 26, 2019. <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/09/26/california-saw-reduction-in-out-of-network-care-from-affected-specialties-after-2017-surprise-billing-law/>.

¹⁶¹ Kliff S. Surprise medical bills, the high cost of emergency department care, and the effects on patients [published online August 12, 2019]. JAMA Intern Med. doi:10.1001/jamainternmed.2019.3448.

¹⁶² Wingerter, Megan. \$64K Air Ambulance Tab Shows Limits of Surprise Billing Law. Claims Journal. January 4, 2021. <https://www.claimsjournal.com/news/national/2021/01/04/301271.htm>.

¹⁶³ Herman, Bob. Billing squeeze: Hospitals in middle as insurers and doctors battle over out-of-network charges. Modern Healthcare, August 29, 2015. <https://www.modernhealthcare.com/article/20150829/MAGAZINE/308299987/billing-squeeze-hospitals-in-middle-as-insurers-and-doctors-battle-over-out-of-network-charges>.

agreement on a payment amount cannot be reached.

Therefore, individuals with health coverage, including members of minority and underserved communities, are likely to see a significant reduction in balance billing, reducing one source of anxiety, financial stress, and medical debt. They will also experience a reduction in out-of-pocket expenditures, because they will only be liable for their in-network cost-sharing amounts when receiving care from nonparticipating providers, emergency facilities, and providers of air ambulance services, which will now count towards their deductible and maximum out-of-pocket limits, allowing individuals to reach those limits sooner. As discussed previously in this preamble, a significant number of individuals forgo or delay care due to the cost of care. A reduction in out-of-pocket expenses is likely to improve access to care and allow individuals to obtain needed treatment that they may otherwise have neglected or foregone due to concerns about the cost of care.

These interim final rules also establish a complaints process for receiving and resolving complaints related to these new surprise billing protections. The Departments are of the view that this will result in increased compliance with balance billing requirements and ensure that all individuals, including members of minority and underserved communities, are able to benefit from the protections provided by the No Surprises Act and these interim final rules. The Departments also seek comment from members of minority and underserved communities to help identify barriers to individuals exercising their rights under the No Surprises Act, as well as policies to address and remove such barriers.

The No Surprises Act extends the applicability of the patient protections for choice of health care professionals to grandfathered health plans. Participants, beneficiaries, and enrollees in grandfathered plans will now be able to designate any participating primary care provider who is available to accept the participant, beneficiary, or enrollee. If patients are able to choose physicians they trust and with whom they have a good relationship, they are likely to have better health outcomes.¹⁶⁴ Similarly, allowing physicians specializing in pediatrics to become primary care physicians for children will also improve health outcomes for

children. The American Academy of Pediatrics (AAP) strongly supports the idea that the choice of primary care clinicians for children should include pediatricians.¹⁶⁵ In addition, a female participant, beneficiary, or enrollee in a grandfathered plan who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology will not need an authorization or referral by the plan, issuer, or any person (including a primary care provider), which will allow them to obtain care without any delay.

The potential financial savings to consumers as a result of the protections in these interim final rules are significant. As of January 1, 2022, individuals across the country will no longer receive surprise medical bills for out-of-network emergency services, non-emergency services provided by nonparticipating providers at certain participating health care facilities, or air ambulance services. The Departments understand that some of these savings will result instead in cost transfers from participants, beneficiaries, and enrollees to group health plans or issuers, as discussed later in this preamble, or may ultimately be paid for by individuals in the form of increased health insurance premiums, which will be discussed in future rulemaking. However, the Departments anticipate that there are potentially additional cost savings for individuals, but are unaware of comprehensive national data that quantifies the potential financial benefits to individuals of the surprise billing protections included in these rules and invite stakeholders to share relevant data that would help the Departments quantify this potential consumer financial benefit.

e. Costs

Plans, issuers, health care providers, facilities, and providers of air ambulance services will incur significant costs to comply with the requirements of these interim final rules.

These interim final rules specify that for emergency services furnished by a nonparticipating provider or emergency facility, and for non-emergency services furnished by nonparticipating providers in a participating health care facility, cost sharing is generally calculated as if the total amount that would have been

charged for the services by a participating emergency facility or participating provider were equal to the recognized amount for such services, as defined by the No Surprises Act and these interim final rules. For nonparticipating providers of air ambulance services, cost sharing is generally calculated as if the total amount that would have been charged for the services by a participating provider of air ambulance services were equal to the lesser of the billed amount or the QPA, as defined by the statute and in these interim final rules. In addition, these interim final rules require that such cost sharing must also be counted toward any in-network deductible or in-network out-of-pocket maximums applied under the plan or coverage in the same manner as if such cost sharing payments were made with respect to services furnished by a participating provider, a participating facility, or a participating provider of air ambulance services.

Under these interim final rules, cost-sharing for emergency services furnished by a nonparticipating provider or emergency facility, and for non-emergency services furnished by nonparticipating providers in a participating health care facility, must be calculated based on the “recognized amount,” which is: (1) An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act, (2) if there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law, or (3) if there is no such applicable All-Payer Model Agreement or specified state law, the lesser of the billed amount for the services or the QPA, which generally is the median of the contracted rates of the plan or issuer for the item or service furnished in the applicable geographic region. For air ambulance services, subject to these interim final rules, plans and issuers generally must use the QPA to calculate cost sharing.

Plans and issuers will incur significant costs to calculate the recognized amount and applicable cost-sharing amount. The Departments assume that for self-insured group health plans, the costs will be incurred by third party administrators (TPAs). The Departments estimate a total 1,758 entities—1,553 issuers¹⁶⁶ and 205

¹⁶⁴ Olaisen, R., et al., “Assessing the Longitudinal Impact of Physician-Patient Relationship on Functional Health.” *The 18 Annals of Family Medicine* 5 (2020). <https://www.annfammed.org/content/18/5/422>.

¹⁶⁵ See AAP Policy Statement, “Guiding Principles for Managed Care Arrangements for the Health Care of Newborns, Infants, Children, Adolescents, and Young Adults”. <https://pediatrics.aappublications.org/content/pediatrics/132/5/e1452.full.pdf>.

¹⁶⁶ Based on data from MLR annual report for the 2019 MLR reporting year, available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr>.

TPAs¹⁶⁷—will be required to comply with these interim final rules with regard to calculating the QPA and to calculate an individual's cost sharing liability. The Departments anticipate that issuers and TPAs will need to make changes to their information technology (IT) systems to include the capability to calculate the QPA for all out-of-network claims subject to the surprise billing protections, or the amount determined by state law or All-Payer Model Agreement, if applicable, and provide the required information related to the QPA to nonparticipating providers and nonparticipating emergency facilities. In addition, system changes will be necessary to accept and process out-of-

network claims, calculate the appropriate cost-sharing amounts and include them in deductible and out-of-pocket maximum limits. The one-time cost to make system changes to include these new functionalities may be slightly lower for plans (or TPAs) and issuers already subject to state balance billing laws. The Departments estimate that each plan (or TPA) or issuer will incur one-time costs of approximately \$2.8 million, on average, to make the necessary system changes to automate the process. The total costs for all plans (or TPAs) and issuers will be approximately \$4,958 million. The Departments assume that these one-time costs will be incurred in 2021. In

addition, each issuer or TPA will incur ongoing costs related to system maintenance, processing out-of-network claims and to acquire external data necessary to calculate the QPA when there is insufficient information to calculate median contracted rates starting in 2022. The Departments estimate each issuer or TPA will incur, on average, ongoing costs of \$1.2 million in 2022 and approximately \$411,840 annually starting in 2023. The total annual costs for all issuers and TPAs will be \$2,047 million in 2022 and \$724 million annually starting in 2023. See Tables 2 and 3 for more details. The Departments seek comment on these estimates.

TABLE 2—ONE-TIME IT COSTS RELATED COSTS FOR PLANS AND ISSUERS IN 2021

Occupation:	Hourly wage rate	2021	
		Time (hours)	Estimated labor cost
IT Costs			
Project Manager/Team Lead	\$110.00	2,080	\$228,800
Scrum Master	110.00	3,640	400,400
Senior Business Analysis	134.00	1,560	209,040
UX Researcher/Service Designer	129.00	2,080	268,320
Technical Architect/Sr. Developer	207.00	2,080	430,560
DevOps Engineer/Security Engineer	143.00	1,560	223,080
Application Developer	111.00	9,360	1,038,960
Total IT Costs for Each Issuer or TPA .....	.....	22,360	2,799,160
Total IT Costs for all Issuers and TPAs .....	.....	39,308,880	4,920,923,280
Management Costs			
Chief Executives	190.24	80	15,219
Lawyers	143.18	40	5,727
Total .....	.....	120	20,946
Total Management Costs for all plans and issuers .....	.....	210,960	36,823,771
Total Costs for all Issuers and TPAs .....	.....	39,519,840	4,957,747,051

Note: All wage rates except those related to management costs use the Contract Awarded Labor Category (CALC) tool.¹⁶⁸ Wage rates for management costs are derived using data from the Bureau of Labor Statistics to derive average labor costs (including a 100 percent increase for fringe benefits and overhead).¹⁶⁹

TABLE 3—ONGOING ANNUAL OPERATIONAL COSTS FOR ISSUERS AND TPAs STARTING IN 2022

Occupation:	Hourly wage rate	2022		2023 onwards	
		Time (hours)	Estimated labor cost	Time (hours)	Estimated labor cost
Project Manager/Team Lead	\$110.00	1,040	\$114,400	520	\$57,200
Scrum Master	110.00	1,300	143,000	520	57,200
Senior Business Analysis	134.00	780	104,520	0	0
UX Researcher/Service Designer	129.00	780	100,620	0	0
Technical Architect/Sr. Developer	207.00	1,040	215,280	520	107,640
DevOps Engineer/Security Engineer	143.00	780	111,540	520	74,360
Application Developer	111.00	3,380	375,180	1,040	115,440
Total for Each Plan or Issuer .....	.....	9,100	1,164,540	3,120	411,840

¹⁶⁷ Non-issuer TPAs based on data derived from the 2016 Benefit Year reinsurance program contributions.

¹⁶⁸ The CALC tool (<https://calc.gsa.gov/>) was built to assist acquisition professionals with market

research and price analysis for labor categories on multiple U.S. General Services Administration (GSA) & Veterans Administration (VA) contracts. Wages obtained from the CALC database are fully burdened to account for fringe benefits and overhead costs.

¹⁶⁹ See May 2020 Bureau of Labor Statistics, Occupational Employment Statistics, National Occupational Employment and Wage Estimates, available at https://www.bls.gov/oes/current/oes_nat.htm.

TABLE 3—ONGOING ANNUAL OPERATIONAL COSTS FOR ISSUERS AND TPAS STARTING IN 2022—Continued

Occupation:	Hourly wage rate	2022		2023 onwards	
		Time (hours)	Estimated labor cost	Time (hours)	Estimated labor cost
Total Costs for all Issuers and TPAs		15,997,800	2,047,261,320	5,484,960	724,014,720

Issuers and TPAs will also need to revise their standard operating procedures to include processes related to out-of-network claims, recognized amount and QPA, and provide training to their billing personnel and customer service representatives. The Departments assume that, for each issuer or TPA, a business operations specialist will need 40 hours (at an hourly labor cost of \$81.06) and a senior manager (at an hourly labor cost of \$114.24) will need 16 hours to revise the standard operating procedures, with a total cost of approximately \$5,070. In addition, the Departments assume that, on average, 10 staff at each issuer and TPA will receive 4 hours of training at a cost of \$1,824. For all 1,758 issuers and TPAs, the total cost of revising standard operating procedures and training will be \$12.1 million. The Departments assume that these one-time costs will be incurred in 2021 and that new staff will be trained as a part of the usual on-boarding process at minimal additional cost and burden.

Health care and emergency facilities will also incur costs to revise their standard operating procedures and provide training to their staff regarding notice and consent requirements, patient disclosures, and out-of-network billing. The Departments estimate that there are 16,992 emergency and health care facilities (6,090 hospitals,¹⁷⁰ 270 independent freestanding emergency departments,¹⁷¹ 9,280 ambulatory surgical centers,¹⁷² and 1,352 critical access hospitals) that will incur this cost. The Departments assume that for hospital-affiliated freestanding emergency departments, the disclosure will be developed by the parent hospitals. The Departments estimate that, on average, for each health care facility, a business operations specialist

will need 40 hours and a senior manager will need 16 hours to revise the standard operating procedures, with a total cost of approximately \$5,070. In addition, on average, 10 staff at each hospital will receive 4 hours of training at a cost of approximately \$1,824. This estimate is an average of the costs and burden to be incurred by each health care facility and the Departments recognize that the costs and burden may vary depending on the size of each health care facility. The total one-time cost for 16,992 health care facilities is estimated to be approximately \$117.2 million, to be incurred in 2021, with the expectation that new staff will be trained as a part of the usual on-boarding process at minimal additional cost and burden.

Providers of air ambulance services will also incur costs to revise their standard operating procedures and provide training to their staff regarding out-of-network billing. The Departments assume that for each air ambulance provider, a business operations specialist will need 40 hours and a senior manager will need 16 hours to revise the standard operating procedures, with a total cost of approximately \$5,070. In addition, on average, 10 staff for each provider will receive 4 hours of training at a cost of approximately \$1,824. The total on-time cost for each provider of air ambulance services will be approximately \$6,894 in 2021. The total one-time cost for 75 providers of air ambulance services¹⁷³ is estimated to be approximately \$517,086, to be incurred in 2021, with the expectation that new staff will be trained as a part of the usual on-boarding process at minimal additional cost and burden.

The Departments estimate that grandfathered plans and issuers will incur a total cost of approximately \$4,516,225 in 2022 to provide the notice of right to designate a primary care provider to participants, beneficiaries, and enrollees. Self-insured plans opting in to state law will incur one-time costs of \$50,708 in 2022 to include a disclosure in plan documents. TPAs and

issuers will also incur costs of approximately \$55.4 million annually to share information related to QPAs with nonparticipating providers, nonparticipating emergency facilities, and nonparticipating providers of air ambulance services. Additionally, issuers and TPAs will incur costs to make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits the disclosure regarding patient protections against balance billing. The Departments estimate a one-time cost, incurred in 2021, for all issuers and TPAs to be \$699,245 and ongoing annual costs, to begin in 2022, of approximately \$23.4 million. These costs are discussed in detail in the Paperwork Reduction Act section of this preamble.

Nonparticipating providers and nonparticipating emergency facilities may balance bill a participant, beneficiary, or enrollee if certain notice and consent requirements have been met. Providers and facilities will incur costs to prepare the notice, provide notice and receive consent from patients, retain records, and provide notice to plans and issuers. HHS estimates that the one-time cost to prepare the notice and consent documents will be approximately \$22.6 million in 2021. The ongoing annual cost to provide the notice and obtain consent, retain records and provide notice to plans and issuers is estimated to be approximately \$117.2 million starting in 2022. In addition, individuals receiving the notice and consent, where applicable, will incur costs of approximately \$99.1 million annually, starting in 2022, to read and understand the notice. These costs are discussed in detail in the Paperwork Reduction Act section of this preamble.

Health care providers and facilities will also incur costs to make publicly available, post on a public website of the provider or facility, and provide to participants, beneficiaries, and enrollees a one-page notice disclosure on patient protections against surprise billing and for providers and facilities to enter into agreements for the facilities to provide the disclosure on behalf of the providers. HHS estimates the one-time total cost, to be incurred in 2021, to be

¹⁷⁰ American Hospital Association, Fast Facts on U.S. Hospitals, 2021. Available at <https://www.aha.org/statistics/fast-facts-us-hospitals>.

¹⁷¹ Emergency Medicine Network, 2018 National Emergency Department Inventory—USA. Available at <https://www.emnet-usa.org/research/studies/medi/medi2018/>.

¹⁷² Moriarty, A., Definitive Healthcare, How Many Ambulatory Surgery Centers are in the US? Blog. April 10, 2019. Available at: <https://blog.definitivehc.com/how-many-ascs-are-in-the-us#:~:text=Currently%2C%20there%20are%20more%20than,Healthcare's%20platform%20on%20surgery%20centers>.

¹⁷³ Federal Aviation Administration, Fact Sheet—FAA Initiatives to Improve Air Ambulance Safety, 2014, https://www.faa.gov/news/fact_sheets/news_story.cfm?newsId=15794.

approximately \$13.1 million and the ongoing annual cost, to begin in 2022, to be approximately \$2.5 million. HHS encourages states to develop language to assist facilities in fulfilling this disclosure requirement as it applies to disclosing state protections against balance billing. HHS estimates that the 33 states that currently have legislation to provide some protection to consumers for surprise billing will incur one-time costs of approximately \$10,732 in 2021 to develop the model language. These costs are discussed in detail in the Paperwork Reduction Act section of this preamble.

The No Surprises Act directs the Departments to establish a process to receive complaints regarding violations of the application of the QPA by group health plans and health insurance issuers offering group or individual health coverage. Individuals and entities that submit a complaint related to surprise billing will also incur costs to do so. As discussed in the Paperwork Reduction Act section of the preamble, the Departments estimate related costs to be approximately \$97,452 annually starting in 2022. In addition, the federal government will incur a one-time cost of approximately \$16 million in 2021 to build the IT system to receive and process complaints, an additional \$3 million to update existing systems in 2021, and ongoing annual costs of approximately \$1.6 million in 2021, \$9.9 million in 2022, \$10.1 million in 2023 and \$10.3 million in 2024 and subsequent years to process the complaints received and for system maintenance.

As discussed previously, individuals with protections against surprise billing are likely to experience a reduction in out-of-pocket expenses. This may increase their use of health care, which could lead to an increase in health care expenditures overall.

The Departments seek comment on these estimates and also on any additional costs incurred by plans, issuers, providers, and facilities.

f. Transfers

The provisions in these interim final rules will result in lower out-of-pocket spending by individuals. In situations where surprise bills currently occur, participants, beneficiaries, and enrollees will be responsible for only an approximation of the cost-sharing amounts they would have paid had the services been provided by a participating emergency facility, participating provider, or participating provider of air ambulance services. Plans and issuers will now be required to pay for some expenses for items and

services provided by nonparticipating facilities, providers, and providers of air ambulance services that they previously did not pay for. Thus, expenditures will shift from certain individuals to plans and issuers. In addition, it is possible the out-of-network rates collected by some providers, including air ambulance providers, and facilities will be lower than they would have been if the providers and facilities were able to balance bill the individuals. Such situations will result in transfers from providers and facilities to individuals. If there is a decrease in payments to some participating providers, as has happened for in-network emergency department physician payments in the state of New York,¹⁷⁴ there will be a transfer from those providers to plans, issuers, participants, beneficiaries, and enrollees.

As discussed previously in this preamble, these interim final rules are the first of several rules implementing the No Surprises Act and the transparency provisions of title II of Division BB of the CAA. Later this year, the Departments intend to issue additional regulations including regulations regarding the federal IDR process. The impact of the provisions of the No Surprises Act on premiums will depend on provisions not included in these interim final rules, and more detailed analysis will therefore be included in future rulemaking.¹⁷⁵

C. Regulatory Alternatives

In developing the interim final rules, the Departments considered various alternative approaches.

Determining the Cost-sharing Amount. The No Surprises Act generally requires that cost sharing for items and services subject to the surprise billing protections be based on the recognized amount. In instances where this requirement applies, the Departments considered whether it should apply where the billed charge is less than the recognized amount. In these instances, assuming the plan or issuer would not pay more than the billed charge, calculating cost sharing based on the QPA (which is one way in which the recognized amount might be

determined) would require a participant, beneficiary, or enrollee to pay a higher percentage in cost sharing than if such items or services had been furnished by a participating provider. However, sections 9816(a)(1)(C)(ii) and 9816(b)(1)(A) of the Code, sections 716(a)(1)(C)(ii) and 716(b)(1)(A) of ERISA, and sections 2799A–1(a)(1)(C)(ii) and 2799A–1(b)(1)(A) of the PHS Act expressly prohibit plans and issuers from applying a cost-sharing requirement that is greater than the requirement that would apply if services were provided by a participating provider or a participating emergency facility. Therefore, under these interim final rules, in circumstances where an All-Payer Model Agreement or specified state law does not apply to determine the recognized amount, cost sharing must be based on the lesser of the QPA or the amount billed by the provider for the item or service.

Methodology for Calculating the QPA.

The No Surprises Act generally requires the QPA to be calculated based on the median of the contracted rates of the plan or issuer. The Departments considered whether plans and issuers should take into account the number of claims paid at the contracted rate under each contract in calculating the QPA. Doing so, however, would not result in a pure median of the contracted rates, which the Departments are of the view would most clearly follow the language of the No Surprises Act. In addition, the Departments are of the view that this approach would likely put upward pressure on the QPA, by giving greater weight to contracts of larger provider groups and facilities, which are more likely to have negotiated higher rates than small provider groups and facilities. This approach could lead to higher out-of-pocket costs for individuals.

The Departments also considered requiring plans and issuers to calculate separate median contracted rates for facilities based on the characteristics of facilities, such as by distinguishing teaching hospitals from non-teaching hospitals, rather than distinguishing only on the basis of whether the facility is an emergency department of a hospital or an independent freestanding emergency department. The Departments decided against this approach, as doing so would result in a higher median contracted rate for facilities with higher operating costs and is not clearly contemplated in the definition of QPA under the No Surprises Act. The Departments are of the view that the different operating costs among facilities with different characteristics should not have such a

¹⁷⁴ Cooper, Z. et al., Surprise! Out-Of-Network Billing For Emergency Care in the United States, NBER Working Paper 23623, 2017, available at <https://www.nber.org/papers/w23623>.

¹⁷⁵ These interim final rules and the forthcoming regulations are interrelated, and in cases such as this, attribution of impacts is challenging. Inclusion of more detailed analysis in later rulemaking, rather than these interim final rules—about, for example, changes in premiums incentivized by the suite of surprise billing policies—should not be interpreted as indicating certainty that such impacts will not occur as a result of these interim final rules.

dramatic impact on median contracted rates. However, the Departments recognize that payment amounts for facility charges may vary depending on whether an emergency facility is connected with a hospital. Therefore, the interim final rules allow separate median contracted rates to be calculated for emergency services based on whether the facility is an emergency department of a hospital or an independent freestanding emergency department.

With respect to calculating a separate QPA for each item and service for each geographic region, the Departments considered whether to define each geographic region as the applicable rating area as defined for purposes of the individual and small group market rating rules under PHS Act 2701 section and 45 CFR 147.102, while allowing states the flexibility to establish alternative geographic regions. However, some states define rating area by county, resulting in large numbers of rating areas in a state, some of which might include few, if any, facilities and providers. Therefore, adopting rating area as the standard for geographic region could lead to a large number of geographic regions for which a plan or issuer would have to calculate separate median contracted rates, a large number of geographic regions without sufficient information, as well as a large number of geographic regions in which the median contracted rate is influenced by outliers. Therefore, the interim final rules do not adopt this approach to defining geographic regions.

With respect to the statutory requirement for plans and issuers to calculate separate QPAs for each insurance market, including for self-insured group health plans, the Departments considered whether the market for self-insured group health plans should be limited to only self-insured group health plans offered by the same plan sponsor. However, this could lead to greater instances of a self-insured plan lacking sufficient information, so the interim final rules instead define the self-insured market as all self-insured group health plans offered by the same plan sponsor, or at the option of the plan sponsor, all self-insured group health plans administered by the same entity that is responsible for determining the QPA on behalf of the plan (including a third-party administrator contracted by the plan).

Participant, Beneficiary, and Enrollee Responsibility to Pay Recognized Amount Only. In instances where a participant, beneficiary, or enrollee has not satisfied their deductible, the

Departments considered whether the plan or issuer should not be required to pay any portion of the out-of-network rate to the nonparticipating provider or facility. However, these interim final rules require that when the out-of-network rate exceeds the recognized amount (the amount upon which cost sharing is based), a plan or issuer must pay the provider or facility the difference between the out-of-network rate and the cost-sharing amount (the latter of which in this case would equal the recognized amount), even in instances where an individual has not satisfied their deductible. This approach is consistent with the purpose of the No Surprises Act to protect participants, beneficiaries, or enrollees from surprise balance bills that exceed in-network cost-sharing requirements. This approach is also consistent with section 102 of the No Surprises Act, which amends section 223 of the Code to specify that these payments will not prevent a plan from qualifying as a high-deductible health plan or make an individual ineligible to contribute to a health savings account.

Definition of Health Care Facility. The No Surprises Act defines a health care facility as each of the following with respect to non-emergency services: (1) A hospital (as defined in 1861(e) of the Social Security Act); (2) a hospital outpatient department; (3) a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); (4) an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act; or (5) any other facility, specified by the Departments, that provides items or services for which coverage is provided under the plan or coverage, respectively. The Departments considered whether to expand the definition of health care facility in this rulemaking, but concluded that the facilities at which balance billing are currently most frequent are included in the current definition. The Departments anticipate continuing to monitor the prevalence of surprise billing at various facilities and may expand the definition in future rulemaking. In particular, as discussed earlier in this preamble, the Departments considered including urgent care centers in the definition of health care facility. However, given the variation across states in how urgent care centers are licensed, including the scope of services that the centers are permitted to provide, the Departments decided to instead seek comment regarding whether the definition of health care facility should be extended to urgent care centers, including those

that are not licensed as facilities under state law.

With respect to the definition of participating health care facility and participating emergency facility, the Departments considered excluding facilities that had only single case agreements in place with a plan or issuer. However, the Departments are persuaded that doing so could harm participants, beneficiaries or enrollees. When individuals are provided with care, generally non-emergency items or services, under a single case agreement, they should not have to worry about potential surprise bills. Excluding facilities with single case agreements from the definitions of participating facilities and participating emergency facilities would be inconsistent with the Departments' intent to protect individuals from surprise medical bills.

Applicability of State Law. In determining how state laws around balance billing would intersect with the No Surprises Act, the Departments considered alternatives to the approach taken under these interim final rules, which seek to supplement, rather than supplant state balance billing laws. Specifically, the Departments considered whether to allow states to be more protective of consumers than the No Surprises Act with respect to whether individuals are permitted to waive balance billing protections upon notice and consent, and concluded that it is in the public interest to interpret the No Surprises Act as creating a floor regarding individuals' ability to waive balance billing protections. The Departments also considered whether state provisions allowing ERISA-covered plans to opt in to the state requirements should be considered specified state laws for purposes of setting the recognized amount and out-of-network rate regarding ERISA-covered plans that have opted into the state programs. The Departments have concluded such deference to state law is consistent with the overarching structure of the No Surprises Act. The Departments also considered allowing providers, facilities and providers of air ambulance services to opt in to state laws (as allowed under state laws), but decided to instead seek comments on this approach, as discussed earlier in this preamble.

Notice and Consent Exception to Prohibition on Balance Billing. Under the No Surprises Act and these interim final rules, the protections that limit cost sharing and prohibit balance billing do not apply to certain non-emergency services or to certain post-stabilization services provided in the context of emergency care, if the nonparticipating

provider or nonparticipating emergency facility furnishing those items or services provides the participant, beneficiary, or enrollee, with certain notice, the individual acknowledges receipt of the information in the notice, and the individual consents to be treated by the nonparticipating emergency facility or nonparticipating provider. These interim final rules establish the conditions under which notice and consent may be provided for certain non-emergency and post-stabilization services. The Departments considered a number of additional conditions under which the notice and consent exception would not be permitted, such as if the individual were experiencing pain, or under the influence of alcohol or drugs, including the use or administration of prescribed medications. The Departments are of the view that these factors are critical considerations for whether an individual is able to provide informed consent, and concluded that these are factors that a provider would be expected to assess when determining if the individual is capable of understanding the information provided in the notice and the implications of consenting. The HHS interim final rules therefore establish requirements related to the notice and consent exception. HHS considered a number of alternatives in developing these interim final rules. HHS considered different standards to apply in defining geographic regions for purposes of language access requirements. The HHS interim final rules require providers and facilities to provide the notice and consent documents in the 15 most common language in the state, or in a geographic region, which reasonably reflects the geographic region served by the applicable facility. HHS also considered the use of MSAs,¹⁷⁶ hospital service areas (HSAs),¹⁷⁷ hospital referral regions (HRRs),¹⁷⁸ and public use microdata areas (PUMAs),¹⁷⁹ applied based on where the applicable facility is located. These geographic regions might better reflect a facility's service area than a state. However, HHS is of the view that allowing providers and facilities to use the state as the geographic region would reduce burden, and concluded that the standard in the

HHS interim final rules provides sufficient flexibility for providers and facilities to determine how best to serve their population. HHS considered requiring that a provider or facility that uses a region other than a state must use a geographic region smaller than a state, but determined this approach would not adequately address the needs to facilities that serve populations that cross state borders. HHS also considered alternatives regarding the inapplicability of the notice and consent exception to ancillary services. HHS considered expanding the definition of ancillary services to include other services for which surprise billing frequently occurs. In particular, stakeholders raised concerns about providers who deliver services to individuals during inpatient stays, but who the individual has little involvement in selecting. These included, for example, providers furnishing mental health services, cardiology services, and rehabilitative services. The Departments are concerned about surprise bills that arise in these situations, but prefer to further consider the recommendation. Individuals may have strong preferences to select these types of providers for out-of-network care, and it is therefore not clear whether they would be appropriate to include among the types of specialties for which notice and consent to be balance billed is prohibited.

Applicability date. The Departments considered delaying the applicability date of these interim final rules in response to stakeholder feedback regarding the challenges of coming into compliance with these interim final rules by January 1, 2022. The Departments recognize the challenges that providers (including providers of air ambulance services), facilities, plans, and issuers will face in making the necessary changes to comply with these new requirements. However, delaying the applicability date would have significant ramifications for participants, beneficiaries, and enrollees and would continue to leave them vulnerable to surprise bills. Therefore, the Departments concluded that it is in the public interest to require these interim final rules to be applicable in accordance with the applicability dates in the No Surprises Act.

Provider Disclosure Requirements Regarding Patient Protections against Balance Billing. Section 2799B–3 of the PHS Act, as added by the No Surprises Act, requires providers and facilities to provide disclosures regarding patient protections against balance billing. These interim final rules include

provisions to limit this disclosure requirement to certain providers and facilities, and with respect to certain individuals. These interim final rules also include a special rule to limit unnecessary duplication, so that a facility's disclosure may satisfy the disclosure requirement on behalf of providers in certain circumstances. HHS considered applying the disclosure requirement more broadly. However, HHS determined that a broader application of the disclosure requirements would increase the administrative costs associated with the requirement, without commensurate benefits to individuals. Rather, HHS was concerned that requiring the disclosure be made by facilities and providers in circumstances where the protections against balance billing would not apply could create consumer confusion about their rights under the No Surprises Act. Additionally, HHS determined that requiring providers to provide a disclosure when furnishing services at a facility that was also required to provide a disclosure was unnecessary and could be overwhelming to consumers. If providers furnishing services at a facility were required to provide a disclosure as well, at the very least, the cost of printing and materials for the notices would have doubled, for an additional \$2.5 million in costs. If, in addition, providers had to develop the notices they provided, there would have been additional costs. If all providers were required to provide a notice, regardless of whether the services are furnished at a provider's office or a health care facility, then in addition to the 39,690,940 individuals treated in the emergency facilities,¹⁸⁰ 526,685,200 individuals visiting a provider's office or a health care facility would have been provided a disclosure, for a total of 566,376,140 disclosures.¹⁸¹ The cost to print the disclosures would have been approximately \$28.3 million, approximately \$25.8 million more than it is estimated to be under the provisions in these interim final rules.

¹⁷⁶ <https://www.census.gov/programs-surveys/metro-micro/about.html>.

¹⁷⁷ <https://www.dartmouthatlas.org/faq/>.

¹⁷⁸ <https://www.dartmouthatlas.org/faq/>.

¹⁷⁹ [https://www.census.gov/programs-surveys/geography/guidance/geo-areas/pumas.html#:~:text=Public%20Use%20Microdata%20Areas%20\(PUMAs\)%20are%20non%20overlapping%2C.and%20the%20U.S.%20Virgin%20Islands.](https://www.census.gov/programs-surveys/geography/guidance/geo-areas/pumas.html#:~:text=Public%20Use%20Microdata%20Areas%20(PUMAs)%20are%20non%20overlapping%2C.and%20the%20U.S.%20Virgin%20Islands.)

¹⁸⁰ Agency for Healthcare Research and Quality, HCUP Fast Stats—Trends in Emergency Department Visits. <https://www.hcup-us.ahrq.gov/faststats/NationalTrendsEDServlet?measure1=01&characteristic1=14&measure2=&characteristic2=11&expansionInfoState=hide&dataTablesState=hide&definitionsState=hide&exportState=hide#export>.

¹⁸¹ Estimates based on data on postoperative office visits. Centers for Disease Control, National Ambulatory Medical Care Survey: 2016 National Summary Tables. Available at <https://www.cdc.gov/nchs/fastats/physician-visits.htm>.

*D. Paperwork Reduction Act—
Department of Health and Human
Services*

Under the Paperwork Reduction Act of 1995 (PRA), HHS is required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to OMB for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that HHS solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.

- The accuracy of HHS' estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

HHS is soliciting public comment on each of the required issues under section 3506(c)(2)(A) of the PRA for the following information collection requirements (ICRs).

1. Wage Estimates

To derive wage estimates, the Departments generally used data from the Bureau of Labor Statistics to derive average labor costs (including a 100

percent increase for fringe benefits and overhead) for estimating the burden associated with the ICRs.¹⁸² Table 4 presents the mean hourly wage, the cost of fringe benefits and overhead, and the adjusted hourly wage.

As indicated, employee hourly wage estimates have been adjusted by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly across employers, and because methods of estimating these costs vary widely across studies. Nonetheless, there is no practical alternative, and the Departments are of the view that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

TABLE 4—WAGE RATES

Occupation title	Occupational code	Mean hourly wage (\$/hour)	Fringe benefits and overhead (\$/hour)	Adjusted hourly wage (\$/hour)
Secretaries and Administrative Assistants, Except Legal, Medical, and Executive	43–6014	\$19.43	\$19.43	\$38.86
Lawyer	23–1011	71.59	71.59	143.18
All Occupations	00–0000	27.07	27.07	54.14
Computer Programmers	15–1251	45.98	45.98	91.96
Medical Secretaries and Administrative Assistants	43–6013	18.75	18.75	37.50
Human Resources Specialists	13–1071	33.38	33.38	66.76
Business Operations Specialist	13–1198	38.57	38.57	77.14
General and Operations Manager	11–1021	59.15	59.15	118.30
Compensation and Benefits Manager	11–3111	65.94	65.94	131.88
Computer and Information Systems Managers	11–3021	77.76	77.76	155.52

2. ICRs Regarding Information To Be Shared About QPA (45 CFR 149.140(d))

These interim final rules require plans and issuers to provide certain information regarding the QPA to nonparticipating providers, or nonparticipating emergency facilities in cases in which the recognized amount with respect to an item or service furnished by the provider or facility is the QPA (and in all cases subject to these rules for nonparticipating providers of air ambulance services). Specifically, plans and issuers must provide the following information to providers (including air ambulance providers) and facilities, when making an initial payment or notice of denial of payment: (1) The QPA for each item or service involved; (2) a statement certifying that the plan or issuer has determined that the QPA applies for the purposes of the recognized amount (or, in the case of air ambulance services, for calculating the participant's, beneficiary's, or enrollee's cost sharing), and each QPA was determined in compliance with the methodology

established in these interim final rules; (3) a statement that if the provider or facility, as applicable, wishes to initiate a 30-day open negotiation period for purposes of determining the amount of total payment, the provider or facility may contact the appropriate person or office to initiate open negotiation, and that if the 30-day negotiation period does not result in a determination, generally, the provider or facility may initiate the independent dispute resolution process within 4 days after the end of the open negotiation period; and (4) contact information, including a telephone number and email address, for the appropriate person or office to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service. Additionally, upon request of the provider or facility, the plan or issuer must provide, in a timely manner, the following information: (1) Whether the QPA for items and services involved included contracted rates that were not on a fee-for-service basis for those specific items and services and whether

the QPA for those items and services was determined using underlying fee schedule rates or a derived amount; (2) if a related service code was used to determine the QPA for a new service code, information to identify the related service code; (3) if the plan or issuer used an eligible database to determine the QPA, information to identify which database was used; and (4) if applicable, upon request, a statement that the plan's or issuer's contracted rates include risk-sharing, bonus, or other incentive-based or retrospective payments or payment adjustments for covered items and services that were excluded for purposes of calculating the QPA.

The Departments assume that TPAs will provide this information on behalf of self-insured plans. In addition, the Departments assume that issuers and TPAs will automate the process of preparing and providing this information in a format similar to an explanation of benefits as part of the system to calculate the QPA. The cost to issuers and TPAs of making the changes

¹⁸² See May 2020 Bureau of Labor Statistics, Occupational Employment Statistics, National

Occupational Employment and Wage Estimates,

available at https://www.bls.gov/oes/current/oes_nat.htm.

to their IT systems is discussed previously in the RIA.

The Departments estimate that a total of 1,758 issuers and TPAs will incur burden to comply with this provision. Currently, 14 states have established some payment standards for services provided by nonparticipating providers or nonparticipating emergency facilities. Therefore, the Departments assume that issuers and TPAs will potentially need to calculate the QPA for two-thirds of the claims involving nonparticipating providers or nonparticipating emergency facilities.

In 2018, there were approximately 39,690,940 emergency department visits for patients with individual market or group health coverage.¹⁸³ The Departments estimate that approximately 18 percent of these visits¹⁸⁴ will include services provided by nonparticipating providers or nonparticipating emergency facilities and plans and issuers will need to calculate the QPA for two-thirds of such claims. Therefore, plans and issuers will be required to provide the specified information along with the initial payment or denial notice for approximately 4,786,727 claims annually from nonparticipating providers or nonparticipating emergency facilities for emergency department visits. In addition, in 2018, there were approximately 4,146,476 emergency department visits that resulted in hospital admission for patients with individual market or group health coverage. Using this as an estimate of post-stabilization services provided in emergency facilities, and assuming that in 16 percent of cases the patient is treated at a nonparticipating emergency facility or by a nonparticipating provider at a

participating facility,¹⁸⁵ the Departments estimate that approximately 663,436 individuals will have the potential to be treated by a nonparticipating provider or facility. In the absence of data, the Departments assume that in 50 percent of cases services will be provided by nonparticipating providers without satisfying the notice and consent criteria in these interim final rules for reasons such as unforeseen, urgent medical needs and lack of participating providers in the facility. The Departments estimate that plans and issuers will need to calculate the QPA for two-thirds of such claims. Therefore, plans and issuers will be required to provide the required information along with the initial payment or denial notice for approximately 222,251 claims from nonparticipating providers or nonparticipating emergency facilities for post-stabilization services. Additionally, based on 2016 data, the Departments estimate that there will be 11,107,056 visits to health care facilities annually for surgical and non-surgical procedures for individuals with group health coverage or individual market coverage.¹⁸⁶ The Departments assume that in 16 percent of cases the patient will have the potential to receive care from a nonparticipating provider at a participating facility, and that in approximately 5 percent of those cases services will be provided by nonparticipating providers without satisfying the notice and consent criteria in these interim final rules for reasons such as the services being ancillary services or related to unforeseen, urgent medical needs, and plans and issuers will need to calculate the QPA for two-thirds of such claims. Therefore, plans and issuers will be required to provide the required information along with the initial payment or denial notice for approximately 59,534 claims annually for non-emergency services furnished by

a nonparticipating provider at a participating health care facility. In total, plans and issuers will be required to provide documents related to QPAs along with the initial payment or denial of payment for approximately 5,068,512 claims annually from nonparticipating providers or facilities.

The Departments estimate that for each issuer or TPA it will take a medical secretary 10 minutes (at an hourly rate of \$37.50) to prepare the documentation and attach it to each payment or denial notice or explanation of benefits sent to the nonparticipating provider or facility. The Departments assume that this information will be sent electronically at minimal cost. The total annual burden for all issuers and TPAs to provide the QPA information and certification along with 5,068,512 payments or denial notices, is estimated to be approximately 844,752 hours, with an associated equivalent cost of approximately \$31.7 million.

The Departments assume that for the 5,068,512 QPA information sent to nonparticipating providers or nonparticipating emergency facilities, 50 percent will result in requests to provide additional information and plans and issuers will be required to send additional information to approximately 2,534,256 providers or facilities. The Departments estimate that it will take a medical secretary 15 minutes (at an hourly rate of \$37.50) to prepare the document and provide it to the provider or facility that requested it. The Departments assume that this information will be delivered electronically with minimal additional cost. The total estimated burden, for all issuers and TPAs, will be approximately 633,564 hours annually, with an associated equivalent cost of approximately \$23.8 million.

The total annual burden for all issuers and TPAs for providing the initial and additional information related to QPA will be 1,478,316 hours, with an equivalent cost of \$55,436,853. As DOL, the Treasury Department and HHS share jurisdiction, HHS will account for 50 percent of the burden, or approximately 739,158 burden hours with an equivalent cost of approximately \$27,718,427. The Departments seek comment on these burden estimates.

¹⁸³ Agency for Healthcare Research and Quality, HCUP Fast Stats—Trends in Emergency Department Visits. <https://www.hcup-us.ahrq.gov/faststats/NationalTrendsEDServlet?measure1=01&characteristic1=14&measure2=&characteristic2=11&expansionInfoState=hide&dataTablesState=hide&definitionsState=hide&exportState=hide>.

¹⁸⁴ Estimate from Pollitz, K. et al., Surprise Bills Vary by Diagnosis and Type of Admission, Peterson-KFF Health System tracker, December 9, 2019, <https://www.healthsystemtracker.org/brief/surprise-bills-vary-by-diagnosis-and-type-of-admission/>.

¹⁸⁵ Estimate from Pollitz, K. et al., Surprise Bills Vary by Diagnosis and Type of Admission, Peterson-KFF Health System tracker, December 9, 2019, <https://www.healthsystemtracker.org/brief/surprise-bills-vary-by-diagnosis-and-type-of-admission/>.

¹⁸⁶ Estimates based on data on postoperative office visits. Centers for Disease Control, National Ambulatory Medical Care Survey: 2016 National Summary Tables. Available at <https://www.cdc.gov/nchs/fastats/physician-visits.htm>.

TABLE 5—ANNUAL BURDEN AND COST FOR PLANS AND ISSUERS TO PROVIDE INFORMATION RELATED TO QPA TO NONPARTICIPATING PROVIDERS AND NONPARTICIPATING EMERGENCY FACILITIES

	Estimated number of respondents	Estimated number of responses	Burden per response (hours)	Total annual burden (hours)	Total estimated cost
Initial information	879	2,534,256	0.167	422,376	\$15,839,100.93
Additional Information	879	1,267,128	0.25	316,782	11,879,325.70
Total	879	3,801,384	.....	739,158	27,718,427.63

3. ICRs Regarding Audits of QPA (45 CFR 149.140(f))

The No Surprises Act provides that rulemaking must establish a process under which group health plans and health insurance issuers offering group or individual health insurance coverage are audited by the applicable Secretary or applicable state authority to ensure that such plans and coverage are in compliance with the requirement of applying a QPA and that the QPA applied satisfies the definition under the No Surprises Act with respect to the year involved.

These interim final rules include an audit provision establishing that the Departments' existing enforcement procedures will apply with respect to ensuring that a plan or coverage is in compliance with the requirement of determining and applying a QPA consistent with these interim final rules.

HHS has primary enforcement authority over issuers (in a state if the Secretary of HHS makes a determination that a state is failing to substantially enforce a provision (or provisions) of Part A or D of title XXVII of the PHS Act) and non-federal governmental plans, such as those sponsored by state and local government employers and expects to conduct no more than 9 audits annually. Therefore, this

collection is exempt from the PRA under 44 U.S.C. 3502(3)(A)(i).

4. ICRs Regarding Disclosure for Self-Insured Plans Opting-In to State Law (45 CFR 149.30)

These interim final rules allow self-insured group health plans, including self-insured non-federal governmental plans, to voluntarily opt in to state law that provides for a method for determining the cost-sharing amount or total amount payable under such a plan, where a state has chosen to expand access to such plans, to satisfy their obligations under section 9816(a)–(d) of the Code, section 716(a)–(d) of ERISA, and section 2799A–1(a)–(d) of the PHS Act. A self-insured plan that has chosen to opt-in to a state law must prominently display in its plan materials describing the coverage of out-of-network services a statement that the plan has opted in to a specified state law, identify the relevant state (or states), and include a general description of the items and services provided by nonparticipating facilities and providers that are covered by the specified state law.

Based on available data, HHS estimates that approximately 84 self-insured non-federal governmental plans in New Jersey, Nevada, Virginia and

Washington¹⁸⁷ will opt-in and incur the one-time burden and cost to include the disclosure in their plan documents in 2022. It is estimated that for each plan an administrative assistant will spend 1 hour (at an hourly rate of \$38.86) and a compensation and benefits manager will spend 30 minutes (at an hourly rate of \$131.88) to prepare the disclosure. The estimated total burden for each plan will be 1.5 hours with an equivalent cost of approximately \$105. The estimated total annual burden for all 84 plans will be approximately 126 hours with an equivalent cost of approximately \$8,783. HHS estimates that there are approximately 11,956 policyholders in these plans that will be provided the disclosure. HHS assumes that only printing and material costs are associated with the disclosure requirement, because the notice can be incorporated into existing plan documents. HHS estimates that the disclosure will require one-half of a page, at a cost of \$0.05 per page for printing and materials, and 34 percent of plan documents will be delivered electronically at minimal cost.¹⁸⁸ Therefore, the cost to deliver 66 percent of these disclosures in print is estimated to be approximately \$197. The total one-time cost for all plans, incurred in 2022, is estimated to be approximately \$8,981.

TABLE 6—ONE-TIME BURDEN AND COST TO PROVIDE DISCLOSURE REGARDING OPTING IN TO STATE LAW

Year	Estimated number of respondents	Estimated number of responses	Burden per response (hours)	Total annual burden (hours)	Total estimated labor cost	Total estimated printing and materials cost	Total estimated cost
2022	84	84	1.5	126	\$8,783	\$197	\$8,981

5. ICRs Regarding Complaints Process for Surprise Medical Bills (45 CFR 149.150, 45 CFR 149.450)

The No Surprises Act directs the Departments to establish a process to

receive complaints regarding violations of the application of the QPA requirements by group health plans and health insurance issuers offering group or individual health coverage under

section 9816(a)(2)(B)(iv) of the Code, section 716(a)(2)(B)(iv) of ERISA, and section 2799A–1(a)(2)(B)(iv) of the PHS Act, and violations by health care provider, facilities, and providers of air

¹⁸⁷ Based on data on self-insured plans that have opted in available at: <https://www.insurance.wa.gov/self-funded-group-health-plans>, <https://www.dol.gov/sites/dolgov/files/EBSA/researchers/data/health-and-welfare/health->

[insurance-coverage-bulletin-2019.pdf](https://www.insurance-coverage-bulletin-2019.pdf), <https://scc.virginia.gov/balancebilling>.

¹⁸⁸ According to data from the National Telecommunications and Information Agency, 34 percent of households in the United States accessed

health records or health insurance online. <https://www.ntia.doc.gov/blog/2020/more-half-american-households-used-internet-health-related-activities-2019-ntia-data-show>.

ambulance services of the requirements under sections 2799B–1, 2799B–2, 2799B–3, and 2799B–5 of the PHS Act. The Departments are of the view that the complaints process should extend to all of the balance billing requirements and define a complainant as any individual, or their authorized representative, who files a complaint, as described and defined in these interim final rules. This regulatory action is taken as required by the No Surprises Act, which directs the Departments to

create a process for balance billing complaints regarding plans and issuers, and directs HHS to create a process for balance billing complaints regarding providers and facilities.

HHS estimates that there will be, on average, 3,600 balance billing complaints against providers, facilities, providers of air ambulance services, plans, and issuers submitted annually. HHS estimates that it will take each complainant 30 minutes (at an hourly rate of \$54.14)¹⁸⁹ to collect all relevant

documentation related to the alleged violation and to access and complete the provided complaint form, with an equivalent cost of approximately \$27. The total burden for all complainants is estimated to be 1,800 hours, with an equivalent annual cost of approximately \$97,452. As DOL, the Treasury Department and HHS share jurisdiction, HHS will account for 50 percent of the burden, approximately 900 burden hours with an equivalent cost of approximately \$48,726.

TABLE 7—ANNUAL BURDEN AND COSTS FOR COMPLAINTS RELATED TO SURPRISE BILLING

Estimated number of respondents	Estimated number of responses	Burden per response (hours)	Cost per response	Total annual burden (hours)	Total estimated cost
1,800	1,800	0.5	\$27.07	900	\$48,726

6. ICRs Regarding Notice of Right To Designate a Primary Care Provider (45 CFR 149.310(a)(4))

These interim final rules continue to require that if a group health plan or health insurance issuer requires the designation by a participant, beneficiary, or enrollee of a primary care provider, the plan or issuer must provide a notice informing each participant (in the individual market, primary subscriber) of the terms of the plan or coverage and their right to designate a primary care provider. For group health plans and group health insurance coverage, the notice must be included whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or coverage. For individual health insurance coverage, the notice must be included whenever the issuer provides a primary subscriber with a policy, certificate, or contract of health insurance. These interim final rules continue to include model language to satisfy the notice requirements. The No Surprises Act extends the applicability of the patient protections for choice of health care professionals to grandfathered health plans. The patient protections under section 2719A of the PHS Act apply to only non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage. In contrast, the patient protections under the No Surprises Act apply generally to all group health plans and group and

individual health insurance coverage, including grandfathered health plans. Therefore, the requirements regarding patient protections for choice of health care professional under these interim final rules will newly apply to grandfathered health plans for plan years beginning on or after January 1, 2022.

In order to satisfy the patient protection disclosure requirement, state and local government plans and issuers in the individual market will need to notify policy holders of their plans' policy in regards to designating a primary care physician and for obstetrical or gynecological visits and will incur a one-time burden and cost to incorporate the notice into plan documents. Non-federal governmental plans and individual market plans that are currently not grandfathered have already incurred the one-time cost to prepare and incorporate this notice in their existing plan documents.

There are an estimated 90,126 non-federal governmental employers offering health plans to employees and 388 health insurance issuers in the individual market. HHS estimates that there are approximately 14,417 grandfathered non-federal government employer-sponsored plans and approximately 837,543 grandfathered individual market policies, with approximately 6,055 grandfathered non-federal governmental plans offering HMO and point-of-service (POS) options.¹⁹⁰ HHS assumes that all individual market issuers offer at least

one HMO, exclusive provider organization (EPO) or POS options.

It is estimated that in 2022, 5,450 grandfathered non-federal governmental plans and individual market policies will be subject to this notice requirement. While not all HMO, EPO, and POS options require the designation of a primary care physician or a prior authorization or referral before an OB/GYN visit, HHS is unable to estimate this number. Therefore, this estimate should be considered an overestimate of the number of affected entities.

These interim final rules continue to provide model language for the notice. It is estimated that each plan or issuer will require a compensation and benefits manager (at an hourly rate of \$131.88) to spend 10 minutes customizing the model notice to fit the plan's specifications. Each plan or issuer will also require clerical staff (at an hourly rate of \$38.86) to spend 5 minutes adding the notice to the plan's documents. The estimated total burden for each plan or issuer will be 0.25 hours with an equivalent cost of approximately \$25. In 2022, the estimated total annual burden for all 5,450 plans and issuers will be approximately 1,362 hours with an equivalent cost of approximately \$137,430. There will be no additional burden and cost in 2023 to prepare the notice, since all plans and issuers will have incurred the burden and cost by 2022.

HHS estimates that there are approximately 1.8 million non-federal governmental plan policyholders in grandfathered plans, with an estimated

¹⁸⁹ The Departments use the average wage rate for all occupations.

¹⁹⁰ According to 2020 Kaiser/HRET survey of Employer Health Benefits, 11 percent of employers offer a health maintenance organization (HMO) option and that 31 percent of employers offer a

point-of-service (POS) option. Available at <https://www.kff.org/health-costs/report/2020-employer-health-benefits-survey/>.

413,976 policyholders enrolled in grandfathered HMO and POS plans options.¹⁹¹ In addition, there are an estimated 837,543 policyholders with grandfathered individual market plans. It is estimated that approximately 75 percent of individual market enrollees are enrolled in HMO, EPO, and POS options.¹⁹² Therefore, an estimated 627,146 policyholders in the individual market have grandfathered plans with

HMO, EPO, and POS options. It is estimated that approximately 937,010 policyholders will remain in grandfathered non-federal government employer sponsored and individual market plans with HMO, EPO, and POS options in 2022 and will receive the required notice for the first time in 2022. HHS assumes that only printing and material costs are associated with the disclosure requirement, because the

notice can be incorporated into existing plan documents. HHS estimates that the notice will require one-half of a page, at a cost of \$0.05 per page for printing and materials, and 34 percent of the notices will be delivered electronically at minimal cost.¹⁹³ Therefore, the cost to deliver 66 percent of these notices in print is estimated to be approximately \$15,461.¹⁹⁴

TABLE 8—ONE-TIME BURDEN AND COST TO PROVIDE NOTICE OF RIGHT TO DESIGNATE A PRIMARY CARE PROVIDER

Year	Estimated number of respondents	Estimated number of responses	Burden per response (hours)	Total annual burden (hours)	Total estimated labor cost	Total estimated printing and materials cost	Total estimated cost
2022	5,450	5,450	0.25	1,362	\$137,430	\$15,461	\$152,891

HHS will revise the burden currently approved under OMB Control Number 0938–1094, (Notice of Rescission of Coverage and Disclosure Requirements for Patient Protection under the Affordable Care Act, CMS–10330, expiration: July 31, 2022) to account for this burden.

7. ICRs Regarding Notice and Consent To Waive Balance Billing Protections, Retention of Certain Documents, and Notice to Plan or Issuer (45 CFR 149.410(b)–(e), 45 CFR 149.420(c)–(i))

The No Surprises Act and these interim final rules require that a plan or issuer providing coverage of emergency services do so without the individual or the health care provider having to obtain prior authorization and without regard to whether the health care provider furnishing the emergency services is a participating provider or a participating emergency facility with respect to the services (regardless of the department of the hospital in which such items and services are furnished). Emergency services include any additional items and services that are covered under a plan or coverage after a participant, beneficiary, or enrollee is stabilized (referred to as post-stabilization services) unless certain notice and consent requirements are met. The No Surprises Act and these interim final rules further apply surprise billing protections in the case of non-emergency services furnished by nonparticipating providers during a visit by a participant, beneficiary, or

enrollee at participating health care facilities unless notice and consent as specified in these interim final rules have been met. The requirements related to the notice and consent, applicable exceptions, and timing are set forth in section 2799B–2 of the PHS Act, and implemented at 45 CFR 149.410 and 45 CFR 149.420 of these interim final rules.

In order to meet the notice and consent requirements of these interim final rules, nonparticipating providers and nonparticipating emergency facilities must provide the participant, beneficiary, or enrollee with a notice, meet certain timing requirements, and obtain consent from the participant, beneficiary, or enrollee as described in 45 CFR 149.420 and these interim final rules. The provided notice must: (1) State the health care provider or facility is a nonparticipating provider or facility; (2) include the good faith estimate of what the individual may be charged, including any item or service that is reasonably expected to be provided in conjunction with such items and services; (3) provide information about whether prior authorization or other care management limitations may be required; and (4) clearly state that consent to receive such items or services is optional and that the participant, beneficiary, or enrollee may instead seek care from an available participating provider, in which case the individual's cost-sharing responsibility would be at the in-network level. In cases where post-

stabilization services are furnished by a nonparticipating provider at a participating emergency facility, the notice must also include a list of participating providers at the participating emergency facility who are able to furnish the items or services involved and inform the individual that they may be referred, at their option, to such a participating provider. Additionally, a nonparticipating provider or nonparticipating emergency facility must provide the participant, beneficiary, or enrollee, or such individual's authorized representative, with the notice and consent documents in any of the 15 most common languages in the state, or a geographic region that reasonably reflects the geographic region served by the applicable facility. If the individual's preferred language is not among the 15 most common languages made available or the individual cannot understand the language in which the notice and consent document are provided the individual must be provided with a qualified interpreter.

In addition to providing the required notice and consent, nonparticipating emergency facilities, participating health care facilities, and nonparticipating providers are obligated to retain written notice and consent documents for at least a 7-year period after the date on which the item or service in question was furnished. Where the notice and consent requirements described in this interim final rule have been met, the

¹⁹¹ According to the 2020 Kaiser/HRET Survey of Employer Sponsored Health Benefits, 12 percent of covered workers in non-federal government plans have an HMO option and that 11 percent of covered workers have a POS option.

¹⁹² Estimate based of data reported in Unified Review Template Submissions for 2018 plan. Rate

review data available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/ratereview.html>.

¹⁹³ According to data from the National Telecommunications and Information Agency, 34 percent of households in the United States accessed health records or health insurance online. <https://www.ntia.doc.gov/blog/2020/more-half-american->

[households-used-internet-health-related-activities-2019-ntia-data-show](https://www.ntia.doc.gov/blog/2020/more-half-american-households-used-internet-health-related-activities-2019-ntia-data-show).

¹⁹⁴ 937,010 notices × 66% = 618,427 notices printed × \$0.05 per page × 1/2 pages per notice = approximately \$15,461.

nonparticipating provider, the participating health care facility on behalf of the nonparticipating provider, or the nonparticipating emergency facility, as applicable, must timely notify the plan or issuer, respectively, that the notice and consent criteria have been met, and if applicable, provide to the plan or issuer a copy of the signed notice and consent documents. In instances where, to the extent permitted by these rules, the nonparticipating provider bills the participant, beneficiary, or enrollee directly, the provider may satisfy the requirement to notify the plan or issuer by including the notice and consent documents with the bill to the participant, beneficiary, or enrollee. In addition, for items and services furnished by a nonparticipating provider at a participating health care facility, the provider (or the participating facility on behalf of the provider) must timely notify the plan or issuer that the item or service was furnished during a visit at a participating health care facility.

In order to meet the notice and consent requirements of the statute and these interim final rules, nonparticipating providers and nonparticipating emergency facilities must provide the participant, beneficiary, or enrollee with a notice. HHS is specifying in guidance mandatory notice and consent forms that will require customization by the provider or facility.

HHS assumes that emergency facilities and health care facilities will provide the notice and obtain consent on behalf of nonparticipating providers, retain records and notify plans and issuers. HHS estimates that a total of 17,467 health care facilities and emergency departments (including 475 hospital-affiliated satellite and 270 independent freestanding emergency departments) will be subject to these requirements. HHS assumes that for hospital-affiliated satellite freestanding emergency departments, the notice and consent will be developed by the parent hospital. Therefore, the burden to develop the notice and consent documents will be incurred by 16,992 emergency facilities and health care facilities. HHS estimates that for each facility it will take a lawyer 1 hour (at an hourly rate of \$143.18) to read and understand the notice and consent forms and make any required and applicable alteration, an administrative assistant half an hour (at an hourly rate of \$38.86) to make any alterations to the provided notice and consent documents and prepare the final documentation, a computer programmer 1 hour (at an hourly rate of \$91.96) to digitize and

post on a shared network server or push to networked computers fillable versions of the notice and consent documents, and a Computer and Information Systems Manager half an hour (at an hourly rate of \$155.52) to verify accessibility to, and ensure functionality of, the notice and consent documents. HHS also estimates each facility will incur an additional cost of approximately \$1,000 (at \$500 per document) to contract with an outside firm to translate the notice and consent documents into the 15 most common languages in the state or a geographic region that reasonably reflects the geographic region served by the applicable facility. HHS estimates the one-time first-year burden, to be incurred in 2021, to make alterations, prepare the final versions, translate and make accessible to the providers within the facility the notice and consent documentation, for each facility will be approximately 3 hours, with an associated equivalent cost of approximately \$1,332. For all 16,992 emergency facilities and health care facilities, HHS estimates a total one-time first-year burden of 50,976 hours, with an associated equivalent cost of approximately \$22.6 million.

In order to meet the notice and consent requirements of 45 CFR 149.420 with respect to post-stabilization services, when emergency services are provided by nonparticipating providers or nonparticipating emergency facilities, the provider or facility must provide the participant, beneficiary, or enrollee with a notice and obtain consent to be treated by the nonparticipating emergency facility or nonparticipating provider. HHS estimates there are approximately 5,533 emergency departments (including hospital-affiliated satellite and independent freestanding emergency departments)¹⁹⁵ that could be subject to the notice and consent requirements in these interim final rules and will incur ongoing annual costs and burdens, beginning in 2022. In 2018, there were approximately 4,146,476 emergency department visits that resulted in hospital admission for patients with individual market or group health coverage.¹⁹⁶ Using this as an estimate of post-stabilization services

provided in emergency facilities, and assuming that in 16 percent of cases the patient is treated at a nonparticipating emergency facility or by a nonparticipating provider at a participating facility, HHS estimates that approximately 663,436 individuals will be provided with a notice and consent document for post-stabilization services. HHS anticipates that the notice and consent will be used infrequently for post-stabilization services, so this estimate is an upper bound. HHS estimates it will take a medical secretary 2 hours (at an hourly rate of \$37.50) to customize the required notice and consent documents, generate a list of participating providers, provide and explain the documents to the individual (or authorized representative), answer questions, and obtain the signed consent if the individual agrees, provide the signed documents on paper or, as practicable, electronically, as selected by the individual, and retain the documentation as required by these interim final rules. The total burden for providing the notice and consent documents to individuals at all emergency facilities will be 1,326,872 hours with an equivalent cost of approximately \$49.8 million. HHS assumes that these documents will be provided directly to each affected individual (or authorized representative) in paper format and will be 4 pages (2 pages printed double-sided) on average. Assuming a cost of \$0.10 (at \$0.05 per page for printing and material cost) for each notice and consent document, the total printing and material costs for all notices will be approximately \$66,344. The total ongoing cost for all emergency facilities will be approximately \$49.8 million annually. HHS assumes that nonparticipating providers and nonparticipating emergency facilities will notify the plan or issuer and provide a copy of the signed notice and consent documents along with the claim form electronically at minimal cost.

HHS estimates that each individual that receives notice and consent from an emergency facility will require, on average, 45 minutes (at an hourly rate of \$54.14) to read and understand and sign the required notice and consent documents, with a total cost of approximately \$41. For all 663,436 individuals that could potentially receive the notice and consent documents, HHS estimates a total annual burden of 497,577 hours, with an associated total annual cost of approximately \$26.9 million.

In order to meet the notice and consent requirements of 45 CFR 149.420 with respect to non-emergency services

¹⁹⁵ Emergency Medicine Network, 2018 National Emergency Department Inventory—USA. Available at <https://www.emnet-usa.org/research/studies/medi/medi2018/>.

¹⁹⁶ Agency for Healthcare Research and Quality, HCUP Fast Stats—Trends in Emergency Department Visits. Available at <https://www.hcup-us.ahrq.gov/faststats/NationalTrendsEDServlet?measure1=01&characteristic1=14&measure2=&characteristic2=11&expansionInfoState=hide&dataTableState=hide&definitionsState=hide&exportState=hide>.

furnished by a nonparticipating provider at a participating health care facility, if an individual schedules an appointment for such items or services at least 72 hours before the date of the appointment, the provider or facility must provide the notice to the individual, or their authorized representative, no later than 72 hours before the date of the appointment. If an individual schedules an appointment for such items or services within 72 hours of the date of the appointment, the provider or facility must provide the notice to the individual, or their authorized representative, on the day that the appointment is made. In the situation where an individual is provided the notice on the same day that the items or services are furnished, providers and facilities are required to provide the notice no later than 3 hours prior to furnishing items or services to which the notice and consent requirements applies.

HHS estimates there are approximately 16,722 health care facilities that will be subject to the notice requirement described in these interim final rules and will incur ongoing annual costs and burdens beginning in 2022. Based on 2016 data, HHS estimates that there will be 11,107,056 visits to health care facilities annually for surgical and non-surgical procedures for individuals with group

health coverage or individual market coverage¹⁹⁷ and that approximately 16 percent of those visits will involve a nonparticipating provider.¹⁹⁸ This estimate is a lower bound since it is based on the number of postoperative office visits and potentially excludes situations where such visits were not needed or such follow-up was conducted at a different setting. HHS therefore estimates that approximately 1,777,129 individuals could potentially face balance billing and will be subject to the notice requirements of these interim final rules. With respect to non-emergency services furnished by a nonparticipating provider at a participating health care facility, HHS estimates it will take a medical secretary 1 hour (at an hourly rate of \$37.50) to customize the required notice, generate a list of participating providers, provide the document via email or mail, as selected by the individual, and answer any questions. For all health care facilities, HHS estimates a total annual ongoing annual burden of approximately 1,777,129 hours, with an associated annual cost of approximately \$66.6 million. HHS estimates that approximately 66 percent of the notices will be mailed to individuals (34 percent sent electronically) at a cost of \$0.65 (at \$0.05 per page for printing and material cost and \$0.55 postage).¹⁹⁹ Assuming minimal cost for electronic

delivery, the total cost of printing and mailing the notice and consent documents will be approximately \$762,388 annually. The total ongoing cost for all health care facilities will be approximately \$67.4 million annually.

HHS estimates that each individual that receives the notice will require, on average, 45 minutes (at an hourly rate of \$54.14) to read and understand the required notice, with a total cost of \$41. For all 1,777,129 individuals that could receive the notice document, HHS estimates a total annual burden of 1,332,847 hours, with an associated total annual cost of \$72.2 million. HHS assumes that nonparticipating providers (or the participating facilities on behalf of the providers) will notify the plan or issuer and provide a copy of the signed notice and consent documents along with the claim from the participating facility electronically at minimal cost.

For all emergency and health care facilities, the total ongoing burden will be 3,104,001 hours annually and the total cost, including printing and materials cost, will be approximately \$117,228,780 annually starting in 2022. For all consumers, the total annual burden to read and understand the notice will be 1,830,424 hours with an equivalent cost of \$99,099,147 starting in 2022.

TABLE 9—ONE-TIME AND ANNUAL BURDEN AND COST FOR EMERGENCY DEPARTMENTS AND FACILITIES RELATED TO NOTICE AND CONSENT

Year	Estimated number of respondents	Estimated number of responses	Total annual burden (hours)	Total estimated labor cost	Total estimated translating, printing and materials cost	Total estimated cost
2021	16,992	16,992	50,976	\$5,646,951	\$16,992,000	\$22,638,951
2022	17,467	2,440,565	3,104,001	116,400,048	828,732	117,228,780
2023	17,467	2,440,565	3,104,001	116,400,048	828,732	117,228,780
3 Year Average	17,309	1,632,707	2,086,326	79,482,349	6,216,488	85,698,837

TABLE 10—ANNUAL BURDEN AND COST FOR INDIVIDUALS RELATED TO NOTICE AND CONSENT STARTING IN 2022

Estimated number of respondents	Estimated number of responses	Total annual burden (hours)	Total estimated labor cost	Total estimated cost
2,440,565	2,440,565	1,830,424	\$99,099,147	\$99,099,147

¹⁹⁷ Estimates based on data on postoperative office visits. Centers for Disease Control, National Ambulatory Medical Care Survey: 2016 National Summary Tables. Available at <https://www.cdc.gov/nchs/fastats/physician-visits.htm>.

¹⁹⁸ Estimated based on information provided by KFF. Available at: <https://www.kff.org/health-costs/poll-finding/data-note-public-worries-about-and-experience-with-surprise-medical-bills/>.

¹⁹⁹ According to data from the National Telecommunications and Information Agency, 34

percent of households in the United States accessed health records or health insurance online. <https://www.ntia.doc.gov/blog/2020/more-half-american-households-used-internet-health-related-activities-2019-ntia-data-show>.

8. ICRs Regarding Provider Disclosure on Patient Protections Against Balance Billing (45 CFR 149.430)

Section 2799B–3 of the PHS Act, as added by the No Surprises Act and codified at 45 CFR 149.430, requires providers and facilities to provide disclosures regarding patient protections against balance billing. Specifically, health care providers and facilities (including an emergency department of a hospital or independent freestanding emergency department) are required to make publicly available, post on a public website of the provider or facility, and provide to participants, beneficiaries, and enrollees a one-page notice about surprise billing protections, which must include information about any applicable state requirements, and about how to contact appropriate state and federal agencies if the individual believes the provider or facility has violated the balance billing rules. The required notice must include clear and understandable language that explains the requirements and prohibitions relating to the prohibitions on balance billing in cases of emergency services and in cases of non-emergency services performed by a nonparticipating provider at certain participating facilities, explain any other applicable state laws, and provide contact information for the appropriate state and federal agencies that an individual may contact if they believe the provider or facility has violated a requirement described in the notice.

Health care providers and facilities are required to publicly post and make the disclosure publicly available through a public website accessible free of charge that is easily accessible, without barriers, including via search engines, and that ensures that the information is accessible to the general public. HHS assumes that providers and facilities will enter into agreements for the facilities to provide the disclosure on behalf of the providers and that the required language and information will be developed, posted within the facility, and posted on a public website by the facility. This will ameliorate the burden and cost for the individual provider. Many facilities and providers will be able to enter into an agreement at minimal cost if they renew their contracts prior to 2022. For each facility whose contracts with providers are not due to be renewed before 2022, the burden to enter into agreements related to this disclosure will vary based on the number of providers that practice within the facility. HHS estimates that for each facility, on average, it will take a lawyer 2 hours (at an hourly rate of

\$143.18) to draft an agreement and an administrative assistant 2 hours (at an hourly rate of \$38.86) to provide electronic copies to all providers to sign. The total burden for all 17,467 facilities will be 69,868 hours with an equivalent cost of approximately \$6,359,385, to be incurred as one-time costs in 2021. HHS is unable to estimate how many providers will incur burden to sign the agreement, but anticipates that the burden to sign each agreement will be minimal. In future years, this agreement can be included in the contract between the facilities and providers at no additional cost.

HHS estimates a total of 17,467 health care facilities (including 475 hospital-affiliated satellite and 270 independent freestanding emergency departments) will incur burden and costs to comply with this provision. HHS assumes that for hospital-affiliated satellite freestanding emergency departments, the disclosure will be developed by the parent hospital. HHS estimates that for each facility, on average, it will take a lawyer 2 hours (at an hourly rate of \$143.18) to read and understand the provided notice and draft any additional, clear, and understandable language as may be needed, an administrative assistant 30 minutes (at an hourly rate of \$38.86) to prepare the final document for distribution and make the information publicly available within the facility, and a computer programmer 1 hour (at an hourly rate of \$91.96) to post the information on a separate or existing web page, in a searchable manner, and to make the content available in an easily downloadable format. The burden will be higher for facilities in states with state laws or All-Payer Model Agreements, but lower for facilities in states without any state laws. HHS assumes that each facility will post a single page document in at least two prominent locations, such as where individuals schedule care, check-in for appointments, or pay bills, and estimates that each facility will incur a printing cost of \$0.10 (at \$0.05 per page for printing and materials) in order to post the required disclosure information prominently at each health care facility. HHS anticipates that hospitals will post 6 notices on average, and incur an additional cost of \$0.20 each. In addition, HHS assumes that each of the 475 hospital-affiliated satellite freestanding emergency departments will post two notices on average and incur a cost of \$0.10 each. HHS estimates the one-time burden, to be incurred in 2021, to develop, prepare, and post the required disclosure

information, for each facility will be approximately 3.5 hours, with an associated equivalent cost of approximately \$398. For all facilities, HHS estimates a total one-time burden of 59,472 hours, with an associated cost of approximately \$6.8 million, including materials and printing costs. HHS recognizes that there are some small providers and facilities that do not maintain or provide a publicly available website. Such entities are not required to make a disclosure on a public website. Therefore, HHS considers the estimate to be a high-end estimate.

HHS encourages states to develop language to assist providers and facilities in fulfilling this disclosure requirement. There are currently 33 states that have enacted laws to provide some protection to consumers for surprise billing. Some or all of these states may choose to develop model language. HHS assumes that it will take a lawyer 2 hours (at an hourly rate of \$143.18) and an administrative assistant 1 hour (at an hourly rate of \$38.86) to develop and amend the model language. The total one-time burden, to be incurred in 2021, for each state will be 3 hours with an equivalent cost of approximately \$325. For all 33 states, HHS estimates the total one-time burden will be 99 hours with an equivalent cost of approximately \$10,732.

In addition to requiring providers and facilities to publicly post and make the required disclosure publicly available through a public website, providers and facilities are required to provide individuals the required disclosure information in a one-page notice. The required notice must be provided in-person, through the mail or via email, as selected by the participant, beneficiary, or enrollee no later than the date on which the health care provider or health care facility requests payment from the individual (including requests for copayment made at the time of a visit to the provider or facility), or with respect to individual from whom the health care facility or health care provider does not request payment, no later than the date on which the health care provider or health care facility submits a claim to the group health plan or health insurance issuer. HHS assumes that, in order to reduce burden and costs, facilities will choose to provide the required disclosure to the individual (or their selected representative) at the time the individual is processed for any visit, upon check-in, or when other standard disclosures are shared with individuals with minimal additional burden. HHS estimates that there will be approximately 39,690,940 emergency

department visits²⁰⁰ and 11,107,056 visits to health care facilities annually for surgical and non-surgical procedures²⁰¹ for individuals with group health coverage or individual market coverage. This is a lower bound for the number of patients who will receive the disclosure since HHS lacks comprehensive data on patients who receive services on all health care facilities. In order to provide the required disclosure to individuals each facility will incur a cost of approximately \$0.05 for printing and materials for each disclosure. HHS assumes that this disclosure will be

provided along with other forms and notices usually provided to individuals without incurring significant labor cost. For all facilities, HHS estimates a total annual ongoing annual cost of \$2.5 million, starting in 2022. HHS recognizes that the number of notices provided by each facility will vary depending on the number of annual visits and that some facilities could incur higher costs to provide the disclosure while others could incur lower costs. HHS assumes that all disclosures will be provided in-person; however, HHS acknowledges that some individuals will choose to have this

notice provided to them via email, at a minimal cost to the facility, and others may choose to receive the disclosure via mail, in which case the facility will incur additional postage costs.

HHS seeks comment on these burden estimates. Specifically, HHS seeks comment on the costs and burdens associated with posting the required information on a public website. HHS also seeks comment on the number of facilities that will be affected by these requirements and the number of individuals that would be required to receive the required notice.

TABLE 11—ONE-TIME BURDEN AND COSTS RELATED TO AGREEMENTS BETWEEN FACILITIES AND PROVIDERS

Year	Estimated number of respondents	Estimated number of responses	Burden per response (hours)	Cost per response	Total annual burden (hours)	Total estimated cost
2021	17,467	17,467	4	\$364.08	69,868	\$6,359,385

TABLE 12—ONE-TIME AND ANNUAL BURDEN AND COST FOR FACILITIES TO PROVIDE DISCLOSURE ON PATIENT PROTECTIONS AGAINST BALANCE BILLING

Year	Estimated number of respondents	Estimated number of responses	Total annual burden (hours)	Total estimated labor cost	Total estimated printing and materials cost	Total estimated cost
2021	17,467	17,467	59,472	\$6,758,568	\$2,965	\$6,761,533
2022	17,467	50,797,996	0	0	2,539,900	2,539,900
2023	17,467	50,797,996	0	0	2,539,900	2,539,900
3 Year Average	17,467	33,871,153	19,824	2,252,856	1,694,255	3,947,111

TABLE 13—ONE-TIME BURDEN AND COST FOR STATES TO DEVELOP STATE SPECIFIC LANGUAGE FOR FACILITIES TO PROVIDE DISCLOSURE ON PATIENT PROTECTIONS AGAINST BALANCE BILLING

Year	Estimated number of respondents	Estimated number of responses	Total annual burden (hours)	Total estimated labor cost
2021	33	33	99	\$10,732.26

9. ICRs Regarding Plan and Issuer Disclosure on Patient Protections Against Balance Billing

Section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A–5(c) of the PHS Act require plans and issuers to make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 9816 of the Code, section 716 of ERISA, and section 2799A–1 of the PHS Act apply, information in plain language on

the provisions in these sections, and sections 2799B–1 and 2799B–2 of the PHS Act, and other applicable state laws on out-of-network balance billing, and information on contacting appropriate state and federal agencies in the case that an individual believes that such a provider or facility has violated the prohibition against balance billing.

The Departments assume that plans and issuers will use the model notice developed by HHS, and that TPAs will develop the notice for self-insured plans. The Departments estimate that on average for each plan or issuer it will

take a lawyer 2 hours (at an hourly rate of \$143.18) to read and understand the provided notice and draft any additional, clear, and understandable language as may be needed, an administrative assistant 30 minutes (at an hourly rate of \$38.86) to prepare the final document for distribution and make the information publicly available within the facility, and a computer programmer 1 hour (at an hourly rate of \$91.96) to post the information on a separate or existing web page, in a searchable manner, and to make the content available in an easily

²⁰⁰ Agency for Healthcare Research and Quality, HCUP Fast Stats—Trends in Emergency Department Visits.

²⁰¹ Estimates based on data on postoperative office visits. Centers for Disease Control, National Ambulatory Medical Care Survey: 2016 National Summary Tables. Available at <https://www.cdc.gov/nchs/fastats/physician-visits.htm>.

²⁰² Estimated based on information provided by KFF. Available at: <https://www.kff.org/health-costs/poll-finding/data-note-public-worries-about-and-experience-with-surprise-medical-bills/>.

downloadable format. The total burden for an individual plan or issuer will be 3.5 hours with an equivalent cost of approximately \$398. The burden will be higher for issuers and TPAs in states with applicable state laws or All-Payer Model Agreements, but lower for issuers and TPAs in states without any applicable state laws. The Departments estimate that there are 1,553 issuers and 205 TPAs. The total burden for all issuers and TPAs will be 6,153 hours with an equivalent cost of \$699,245, to be incurred as a one-time cost in 2021. As DOL, the Treasury Department, and HHS share jurisdiction, HHS will account for 50 percent of the burden, or approximately 3,077 hours with an equivalent cost of approximately \$349,622.

The Departments assume that plans and issuers will also include the disclosure along with the explanation of

benefits at no additional cost. Under the same assumptions used to estimate the number of disclosures provided by nonparticipating facilities and nonparticipating providers, the Departments estimate that issuers and TPAs will include the disclosure to approximately 39,690,940 individuals who receive services at emergency facilities and 11,107,056 individuals who received non-emergency services at health care facilities, for a total of 50,797,996 disclosures. The Departments assume that 66 percent of these notices will be provided by mail and the cost of printing is \$0.05 per page.²⁰² Therefore, the total printing and materials cost for sending 33,526,677 notices by mail will be \$1,676,334 annually, starting in 2022. The Departments assume that for the disclosures sent by mail, it will take an administrative assistant 1 minute (at an

hourly rate of \$38.86) to print and enclose the notice with the explanation of benefits. The disclosures sent electronically can be sent at minimal cost. The total burden for all issuers and TPAs is estimated to be 558,778 hours with an equivalent cost of \$21,714,111. There will be no additional mailing costs, since the disclosure will be enclosed with the explanation of benefits. The total annual cost to all issuers and TPAs for sending the notices is estimated to be approximately \$23,390,445 starting in 2022. As DOL, the Treasury Department and HHS share jurisdiction, HHS will account for 50 percent of the burden, or approximately 279,389 hours, with an equivalent cost of \$10,857,056, and printing and materials cost of \$838,167, for a total annual cost of \$11,695,223 starting in 2022.

TABLE 14—ONE-TIME AND ANNUAL BURDEN AND COST FOR PLANS AND ISSUERS TO PROVIDE DISCLOSURE ON PATIENT PROTECTIONS AGAINST BALANCE BILLING

Year	Estimated number of respondents	Estimated number of responses	Total annual burden (hours)	Total estimated labor cost	Total estimated printing and materials cost	Total estimated cost
2021	879	879	3,077	\$349,622	0	\$349,622
2022	879	25,398,998	279,389	10,857,056	838,167	11,695,223
2023	879	25,398,998	279,389	10,857,056	838,167	11,695,223
3 year Average	879	16,932,958	187,285	7,354,578	558,778	7,913,356

10. Summary of Annual Burden Estimates for Information Collection Requirements

TABLE 15—ANNUAL RECORDKEEPING AND REPORTING REQUIREMENTS

Regulation section	OMB control No.	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)	Hourly labor cost of reporting	Total labor cost of reporting	Printing and materials cost	Total cost
45 CFR 149.140(d)	0938—NEW ...	879	3,801,384	0.19	739,158	\$37.50	\$27,718,427	0	\$27,718,427
45 CFR 149.30	0938—NEW ...	84	84	1.50	126	69.87	8,783	197	8,981
45 CFR 149.150, 149.450.	0938—NEW ...	1,800	1,800	0.5	900	54.14	48,726	0	48,726
45 CFR 149.310(a)(4)	0938—1094	5,450	5,450	0.25	1362	100.87	137,430	15,461	152,891
45 CFR 149.410(b)—(e), 149.420(c)—(i)—Facilities and Providers.	0938—NEW ...	17,309	1,632,707	1.28	2,086,326	38.10	79,482,349	6,216,488	85,698,837
45 CFR 149.410(b)—(e), 149.420(c)—(i)—Consumers.	0938—NEW ...	2,440,565	2,440,565	0.75	1,830,424	54.14	99,099,147	0	99,099,147
45 CFR 149.430—Facilities and Providers.	0938—NEW ...	17,467	33,871,153	* 3.5	19,824	* 113.67	2,252,856	1,694,255	3,947,111
45 CFR 149.430—Facility and Provider agreements.	0938—NEW ...	17,467	17,467	4	69,868	91.02	6,359,385	0	6,359,385
45 CFR 149.430—States	0938—NEW ...	33	33	3	99	108.41	10,732	0	10,732
Section 2799A–5(c) of the PHS Act.	0938—NEW ...	879	16,932,958	0.01	187,285	39.27	7,354,578	558,778	7,913,356
Total .....	.....	2,501,933	58,703,602	.....	4,935,372	.....	222,472,414	8,485,179	230,957,592

* Estimate based on burden incurred in first year only.

²⁰² According to data from the National Telecommunications and Information Agency, 34 percent of households in the United States accessed

health records or health insurance online. [https://www.ntia.doc.gov/blog/2020/more-half-american-](https://www.ntia.doc.gov/blog/2020/more-half-american-households-used-internet-health-related-activities-2019-ntia-data-show)

[households-used-internet-health-related-activities-2019-ntia-data-show.](https://www.ntia.doc.gov/blog/2020/more-half-american-households-used-internet-health-related-activities-2019-ntia-data-show)

11. Submission of PRA-Related Comments

HHS has submitted a copy of this final rule to OMB for its review of the rule's information collection requirements. The requirements are not effective until they have been approved by OMB.

To obtain copies of the supporting statement and any related forms for the collections discussed in this rule (CMS–9909–IFC), please visit the CMS website at www.cms.hhs.gov/PaperworkReductionActof1995, or call the Reports Clearance Office at 410–786–1326.

E. Paperwork Reduction Act—Department of Labor and Department of the Treasury

As part of the continuing effort to reduce paperwork and respondent burden, the Departments conduct a preclearance consultation program to provide the general public and federal agencies with an opportunity to comment on proposed and continuing collections of information in accordance with the PRA. This helps to ensure that the public understands the Departments' collection instructions, respondents can provide the requested data in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the Departments can properly assess the impact of collection requirements on respondents.

Under the PRA, an agency may not conduct or sponsor, and an individual is not required to respond to, a collection of information unless it displays a valid OMB control number.

The information collections are summarized as follows:

1. ICRs Regarding Notice of Right To Designate a Primary Care Provider (26 CFR 54.9822–1T, 29 CFR 2590.722)

These interim final rules require that if a group health plan or health insurance issuer requires the designation by a participant, beneficiary, or enrollee of a primary care provider, the plan or issuer must provide a notice informing each participant (in the individual market, primary subscriber) of the terms of the plan or coverage and their right to designate a primary care provider. For group health plans and group health insurance coverage, the notice must be included whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or coverage. For individual health

insurance coverage, the notice must be included whenever the issuer provides a primary subscriber with a policy, certificate, or contract of health insurance. These interim final rules include model language to satisfy the notice requirements. The No Surprises Act extends the applicability of the patient protections for choice of health care professionals. The patient protections under section 2719A of the PHS Act apply to only non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage. In contrast, the patient protections under the No Surprises Act apply generally to all group health plans and group and individual health insurance coverage, including grandfathered health plans. Therefore, the requirements regarding patient protections for choice of health care professional under these interim final rules will newly apply to grandfathered health plans for plan years beginning on or after January 1, 2022.

DOL estimates that there are 2.5 million ERISA-covered plans. Data obtained from the 2020 Kaiser/HRET Survey of Employer Sponsored Health Benefits finds that 16 percent of firms offering health benefits offer at least one grandfathered health plan. DOL estimates that five percent of plans will relinquish their grandfathered status in 2021. The data from the 2020 Kaiser/HRET Survey of Employer Sponsored Health Benefits also finds that 11 percent of plans have an HMO option and that 31 percent of plans offer a POS option. Thus, DOL estimates that in 2022, 161,148 grandfathered plans will be subject to this notice requirement.²⁰³

While not all HMO and POS options require the designation of a primary care physician or a prior authorization or referral before an OB/GYN visit, DOL is unable to estimate this number. Therefore, these estimates should be considered an overestimate of the number of affected entities.

Each of the plans will require a compensation and benefits manager to spend 10 minutes individualizing the model notice to fit the plan's specifications at an hourly rate of \$134.21.²⁰⁴ In 2022, this results in

²⁰³ 2.5 million ERISA-covered plans × 16% grandfathered plans × (100% minus 5% newly non-grandfathered plans) × (11% HMOs + 31% POSs) = 161,148 affected plans.

²⁰⁴ For more information on how the Department estimates labor costs see: <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/rules-and-regulations/technical-appendices/labor-cost-inputs-used-in-ebsa-opr-ria-and-pra-burden-calculations-june-2019.pdf>.

26,858 hours of burden at an equivalent cost of \$3,604,602.

Each plan will also require clerical staff to spend 5 minutes adding the notice to the plan's documents at an hourly rate of \$55.14. In 2022, this results in 13,429 hours of burden at an equivalent cost of \$740,473.

Thus, the total hour burden associated with this ICR is 40,287 hours at an equivalent cost of \$4,345,075. DOL shares this burden equally with the Department of the Treasury. Therefore, the total hour burden for DOL and the Treasury Department is each approximately 20,143 hours at an equivalent cost of \$2,172,537.

The Departments assume that only printing and material costs are associated with the disclosure requirement, because the final regulations provide model language that can be incorporated into existing plan documents, such as an SPD. The Departments estimate that the notice will require one-half of a page, five cents per page printing and material cost will be incurred, and 58.2 percent of the notices will be delivered electronically.²⁰⁵

DOL estimates that there are 62.6 million ERISA-covered policyholders. Data obtained from the 2020 Kaiser/HRET Survey of Employer Sponsored Health Benefits finds that 14 percent of covered workers are enrolled in a grandfathered plan. DOL estimates that 5 percent of plans would relinquish their grandfathered status annually in 2021. The data from the 2020 Kaiser/HRET Survey of Employer Sponsored Health Benefits also finds that 13 percent of covered workers have an HMO option and that 8 percent of covered workers have a POS option. DOL estimates that plans will produce

²⁰⁵ According to data from the National Telecommunications and Information Agency (NTIA), 40.0 percent of individuals age 25 and over have access to the internet at work. According to a Greenwald & Associates survey, 84 percent of plan participants find it acceptable to make electronic delivery the default option, which is used as the proxy for the number of participants who will not opt-out of electronic disclosure that are automatically enrolled (for a total of 33.6 percent receiving electronic disclosure at work). Additionally, the NTIA reports that 40.4 percent of individuals age 25 and over have access to the internet outside of work. According to a Pew Research Center survey, 61.0 percent of internet users use online banking, which is used as the proxy for the number of internet users who will affirmatively consent to receiving electronic disclosures (for a total of 24.7 percent receiving electronic disclosure outside of work). Combining the 33.6 percent who receive electronic disclosure at work with the 24.7 percent who receive electronic disclosure outside of work produces a total of 58.2 percent who will receive electronic disclosure overall.

730,346 notices in 2022.²⁰⁶ This results in a cost burden of approximately \$18,259 in 2022.²⁰⁷ DOL shares this burden equally with the Department of the Treasury. Therefore, the total cost burden for DOL is approximately \$9,129 and the total cost burden for the Treasury Department is \$9,129. The summary of burden for this information collection has also been provided below.

Summary of Burden

Type of Review: Revised Collection.

Agency: DOL–EBSA, Treasury–IRS.

Title: Affordable Care Act Patient Protection Notice.

OMB Numbers: 1210–0142, 1545–2181.

Affected Public: Businesses or other for-profits, Not-for-profit institutions.

Total Respondents: 161,148.

Total Responses: 730,346.

Frequency of Response: Occasionally.

Estimated Total Annual Burden

Hours: 40,287 (DOL—20,143;

Treasury—20,143).

Estimated Total Annual Burden Cost: \$18,259 (DOL—\$9,129; Treasury—\$9,129).

2. ICRs Regarding Information To Be Shared About QPA (26 CFR 54.9816–6T(d), 29 CFR 2590.716–6(d))

These interim final rules require plans and issuers to provide certain information to nonparticipating providers or nonparticipating emergency facilities in cases in which the recognized amount with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility is the QPA. Specifically, plans and issuers must provide the following information to providers (including air ambulance providers) and facilities, when making an initial payment or notice of denial of payment: (i) The QPA for each item or service involved; and (ii) a statement certifying that the plan or issuer has determined that the QPA applies for the purposes of the recognized amount (or, in the case of air ambulance services, for calculating the participant's, beneficiary's, or enrollee's cost sharing), and that each QPA was determined in compliance with 26 CFR 54.9816–6T(d), 29 CFR 2590.716–6, or 45 CFR 149.140, as applicable. Additionally, upon request of the provider or facility, the plan or issuer must provide in a timely

manner the following information: (i) Whether the QPA for items and services involved included contracted rates that were not on a fee-for-service basis for those specific items and services and whether the QPA for those items and services was determined using underlying fee schedule rates or a derived amount; (ii) if applicable, information to identify which database was used to determine the QPA; and (iii) if applicable, a statement that the plan's or issuer's contracted rates include risk-sharing, bonus, or incentive based payments for covered items and services (as applicable) that were excluded for purposes of calculating the QPA.

As discussed earlier in HHS' PRA section, the total annual burden for all issuers and TPAs for providing the initial and additional information related to QPA will be 1,478,316 hours, with an equivalent cost of \$55,436,853. As HHS, DOL, and the Treasury Department share jurisdiction, it is estimated that 50 percent of the burden will be accounted for by the HHS, 25 percent of the burden will be accounted for by the Treasury Department, and the remaining 25 percent will be accounted for by DOL. Thus, HHS will account for approximately 739,158 burden hours with an equivalent cost of approximately \$27,718,427. DOL and the Treasury Department will each account for 369,579 burden hours with an equivalent cost of approximately \$13,859,214.

3. ICRs Regarding Complaints Process for Surprise Medical Bills (26 CFR 54.9816–7T, 29 CFR 2590.716–7)

The No Surprises Act directs the Departments to establish a process to receive complaints regarding violations of the application of the QPA by group health plans and health insurance issuers offering group or individual health coverage, and violations by health care providers, facilities, and providers of air ambulance services of the requirements under sections 2799B–2 and 2799B–3 of the PHS Act. The Departments define a complainant as any individual, or their authorized representative, who files a complaint, as described and defined in these interim final rules. This regulatory action is taken as required by the No Surprises Act, which directs the Departments to create a process for balance billing complaints regarding plans and issuers, and directs HHS to create a process for balance billing complaints regarding providers and facilities.

As discussed earlier in HHS' PRA section, the total burden for all complainants is estimated to be 1,800

hours, with an equivalent annual cost of approximately \$97,452. As HHS, DOL, and the Treasury Department share jurisdiction, it is estimated that 50 percent of the burden will be accounted for by the HHS, 25 percent of the burden will be accounted for by the Treasury Department, and the remaining 25 percent will be accounted for by DOL. HHS will account for approximately 900 burden hours with an equivalent cost of approximately \$48,726. DOL and the Treasury Department will each account for approximately 450 burden hours with an equivalent cost of approximately \$24,363.

4. ICRs Regarding Opt-In State Balance Bill Process (26 CFR 54.9816–3T, 29 CFR 2590.716–3)

The interim final rules allow plans to voluntarily opt in to state law that provides for a method for determining the cost-sharing amount or total amount payable under such a plan, where a state has chosen to expand access to such plans, to satisfy their obligations under section 9816(a)–(d) of the Code, section 716(a)–(d) of ERISA, and section 2799A–1(a)–(d) of the PHS Act. A plan that has chosen to opt into a state law must prominently display in its plan materials describing the coverage of out-of-network services a statement that the plan has opted into a specified state law, identify the state (or states), and include a general description of the items and services provided by nonparticipating facilities and providers that are covered by the specified state law.

Currently, there are four states that allow self-insured plans to opt in: Nevada, New Jersey, Washington, and Virginia. According to the Nevada Department of Health and Human Services' 2020 Annual Report, 20 private entities or organizations have elected to participate in the state's balance billing law. In addition, according to the Virginia State Corporation Commission, 231 private self-insured plans in Virginia have elected to participate in the state's balance billing law.²⁰⁸ Furthermore, according to Washington's Office of the Insurance Commissioner, 309 private self-insured plans in Washington have elected to participate in the state's balance billing law.²⁰⁹ DOL does not have data on the number of self-insured plans that have opted into New Jersey's

²⁰⁶ 2022: 62.6 million ERISA-covered policyholders × 14% of covered employees in grandfathered plans × (100% minus 5% newly non-grandfathered plans) × (13% in HMOs + 8% in POSs) × 41.8% = 730,346 notices.

²⁰⁷ 2022: \$0.05 per page × 1/2 pages per notice × 730,346 notices = \$18,259.

²⁰⁸ Virginia State Corporation Commission. <https://scc.virginia.gov/balancebilling#>.

²⁰⁹ Washington's Office of Insurance Commissioner. "Self-Funded Group Health Plans Participating in the Balance Billing Protection Act." <https://www.insurance.wa.gov/self-funded-group-health-plans>.

balance billing law. In order to estimate the number of self-insured plans that have opted into the balance billing law for New Jersey, DOL has scaled Washington's estimate by the number of participants with self-insured ERISA-covered plans.²¹⁰ According to the 2019 Health Insurance Coverage Bulletin, there are respectively, 0.7 million, 2.1 million, and 2.7 million with self-insured ERISA-covered plans in Nevada, Virginia, and New Jersey. Additionally, according to the Washington's Office of Insurance Commissioner, about 0.5 million self-insured participants have opted into Washington's balance billing law.²¹¹ This results in a total of 6 million participants.²¹² Thus, DOL estimates that 20, 231, 309, and 57 private self-insured plans will opt in respectively in Nevada, Virginia, Washington, and New Jersey, resulting in a total of 617 self-insured plans.²¹³ These plans will incur the one-time burden and cost to include the disclosure in their plan documents in 2022.

DOL estimates that it will take 1 hour for an administrative assistant, with a wage rate of \$55.14, to gather information and review information.²¹⁴ This results in hour burden of 617 hours, with an equivalent cost of \$34,023. DOL estimates that it will take 30 minutes for a benefits manager, with a wage rate of \$134.21, to gather information and review information.²¹⁵ This results in hour burden of 309

hours, with an equivalent cost of \$41,406. In 2022, the total hour burden is 926 hours, with an equivalent cost of \$75,430.

The average number of participants in a self-insured ERISA-covered plan that will opt into the four states' balance billing laws is 9,724.²¹⁶ DOL assumes that only printing and material costs are associated with the disclosure requirement, because the notice can be incorporated into existing plan documents. DOL estimates that the disclosure will require one-half of a page, at a cost of \$0.05 per page for printing and materials, and 34 percent of plan documents will be delivered electronically at minimal cost.²¹⁷ Thus, in 2022, the cost to deliver 66 percent of these disclosures in print is estimated to be approximately \$321.²¹⁸

Thus, the 3-year average hour burden is 309 hours, with an equivalent cost of \$25,143. The 3-year average cost burden is \$107.

5. ICRs Regarding Plan and Issuer Disclosure on Patient Protections Against Balance Billing

Section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act require plans and issuers to make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 9816 of the Code, section 716 of ERISA, and section 2799A-1 of the PHS Act apply, information in plain language on the provisions in these sections, and sections 2799B-1 and 2799B-2 of the PHS Act, and other applicable state laws on out-of-network balance billing, and information on contacting appropriate state and federal agencies in the case that an individual believes that such a provider or facility has violated the prohibition against balance billing.

As discussed earlier in HHS' PRA section, the total burden for all issuers and TPAs will be 6,153 hours with an equivalent cost of \$699,245 in 2021. As HHS, DOL, and the Treasury Department share jurisdiction, it is estimated that 50 percent of the burden will be accounted for by the HHS, 25 percent of the burden will be accounted

for by the Treasury Department, and the remaining 25 percent will be accounted for by DOL. HHS will account for approximately 3,077 hours with an equivalent cost of approximately \$349,622. DOL and the Treasury Department will each account for approximately 1,539 hours with an equivalent cost of approximately \$174,811.

Starting in 2022, the total burden for all issuers and TPAs is estimated to be 558,778 hours with an equivalent cost of \$21,714,111. The total printing and materials cost for sending 33,526,677 notices by mail will be \$1,676,334 annually. As HHS, DOL, and the Treasury Department share jurisdiction, it is estimated that 50 percent of the burden will be accounted for by the HHS, 25 percent of the burden will be accounted for by the Treasury Department, and the remaining 25 percent will be accounted for by DOL. Thus, HHS will account for 279,389 hours, with an equivalent cost of \$10,857,056, and printing and materials cost of \$838,167 starting in 2022. DOL and the Treasury Department will each account for 139,695 hours with an equivalent cost of \$419,084.

Thus, the 3-year average hour burden associated with this requirement for DOL and the Treasury Department is 93,643 hours each with an equivalent cost of \$7,354,578. The 3-year average cost burden for DOL and Treasury is \$279,389 each.

The summary of burden below encompasses the following ICRs: (1) Information to be Shared about the QPA (26 CFR 54.9816-6T(d), 29 CFR 2590.716-6(d)), (2) Complaints Process for Surprise Medical Bills (26 CFR 54.9816-7T, 29 CFR 2590.716-7), (3) Opt-In State Balance Bill Process (26 CFR 54.9816-3T, 29 CFR 2590.716-3), and (4) Plan and Issuer Disclosure on Patient Protections Against Balance Billing.

Summary of Burden

Type of Review: New Collection.

Agency: DOL-EBSA, Treasury.

Title: No Surprise Billing.

OMB Numbers: 1210-NEW, 1545-NEW.

Affected Public: Businesses or other for-profits, Not-for-profit institutions.

Total Respondents: DOL—1,985; Treasury—1,779.

Total Responses: DOL—10,368,277; Treasury—10,368,071.

Frequency of Response: Occasionally.

Estimated Total Annual Burden Hours: 927,652 (DOL—463,980, Treasury—463,672).

²¹⁰ Nevada Department of Health and Human Services' Office of Consumer Health Assistance. "Payment for Medically Necessary Emergency Services Provided Out-of-Network 2020 Annual Report." (2020). <https://dhhs.nv.gov/uploadedFiles/dhhsnv.gov/content/Programs/CHA/AB469%20LCB%20Annual%20Report%202020.pdf>.

²¹¹ Washington's Office of Insurance Commissioner. "Self-Funded Group Health Plans Participating in the Balance Billing Protection Act." <https://www.insurance.wa.gov/self-funded-group-health-plans>.

²¹² Employee Benefits Security Administration. "Health Insurance Coverage Bulletin: Abstract of Auxiliary Data for the March 2019 Annual Social and Economic Supplement to the Current Population Survey." (2019). <https://www.dol.gov/sites/dolgov/files/EBSA/researchers/data/health-and-welfare/health-insurance-coverage-bulletin-2019.pdf>.

²¹³ New Jersey: $335 \times (0.5/2.7) = 62$ self-insured plans; 62 self-insured plans—5 non-federal self-insured plans = 57 private self-insured plans.

²¹⁴ For more information on how the Department estimates labor costs see: <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/rules-and-regulations/technical-appendices/labor-cost-inputs-used-in-ebsa-opr-ria-and-pra-burden-calculations-june-2019.pdf>.

²¹⁵ For more information on how the Department estimates labor costs see: <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/rules-and-regulations/technical-appendices/labor-cost-inputs-used-in-ebsa-opr-ria-and-pra-burden-calculations-june-2019.pdf>.

²¹⁶ (6,000,000 participants with self-insured ERISA-covered plans) / 617 self-insured ERISA-covered plans = 9,724 participants per self-insured ERISA-covered plan.

²¹⁷ According to data from the National Telecommunications and Information Agency, 34 percent of households in the United States accessed health records or health insurance online. <https://www.ntia.doc.gov/blog/2020/more-half-american-households-used-internet-health-related-activities-2019-ntia-data-show>.

²¹⁸ $9,724 \text{ participants} \times 0.66 \times \$0.05 = \$321$.

Estimated Total Annual Burden Cost: \$558,885 (DOL—\$279,496, Treasury—\$279, 389).

F. Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA), (5 U.S.C. 601 *et seq.*), requires agencies to analyze options for regulatory relief of small entities to prepare an initial regulatory flexibility analysis to describe the impact of the proposed rule on small entities, unless the head of the agency can certify that the rule will not have a significant economic impact on a substantial number of small entities. The RFA generally defines a “small entity” as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a not-for-profit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of “small entity.” HHS uses a change in revenues of more than 3 to 5 percent as its measure of significant economic impact on a substantial number of small entities. Individuals and states are not included in the definition of a small entity. These interim final rules are not preceded by a general notice of proposed rulemaking, and thus the requirements of RFA do not apply.

G. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a proposed rule or any final rule for which a general notice of proposed rulemaking was published that includes any Federal mandate that may result in expenditures in any 1 year by state, local, or Tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. In 2021, that threshold is approximately \$158 million. These interim final rules were not preceded by a general notice of proposed rulemaking, and thus the requirements of UMRA do not apply.

H. Federalism

Executive Order 13132 outlines fundamental principles of federalism. It requires adherence to specific criteria by federal agencies in formulating and implementing policies that have “substantial direct effects” on the states, the relationship between the national government and states, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have these federalism implications must

consult with state and local officials, and describe the extent of their consultation and the nature of the concerns of state and local officials in the preamble to the interim final rules.

These interim final rules protect participants, beneficiaries, or enrollees in group health plans and group and individual health insurance coverage, and covered individuals in FEHB plans, from surprise medical bills for emergency services, air ambulance services furnished by nonparticipating providers, and non-emergency services furnished by nonparticipating providers at participating facilities in certain circumstances. A number of states currently have laws related to surprise medical bills. The Departments are of the view that Congress did not intend to supplant state laws regarding balance billing, but rather to supplement such laws. The provisions in these interim final rules are consistent with the statute’s general approach of supplementing state law. In addition, the No Surprises Act and these interim final rules recognize states’ traditional role as the primary regulators of health insurance issuers, providers, and facilities. The No Surprises Act authorizes states to enforce the new requirements regarding health insurance coverage, including those related to balance billing, with respect to issuers, providers, facilities, and providers of air ambulance services, with HHS enforcing only in cases where the state has notified HHS that the state does not have the authority to enforce or is not otherwise enforcing, or HHS has made a determination that a state has failed to substantially enforce the requirements.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the states, the Departments have engaged in efforts to consult with and work cooperatively with affected states, including participating in conference calls with and attending conferences of the NAIC, and consulting with state insurance officials on a state-by-state basis. In addition, the Departments consulted with the NAIC, as required by the No Surprises Act, to establish the geographic regions to be used in the methodology for calculating the QPA.

OPM concluded that it would be inappropriate for FEHB plans to adopt varying state standards, and consistent with the FEHBA, it would adopt state laws where appropriate pursuant to bilaterally negotiated FEHB contracts.

While developing these interim final rules, the Departments attempted to balance the states’ interests in regulating

health insurance issuers, providers, and facilities with the need to ensure at least the minimum federal consumer protections in every state. By doing so, the Departments complied with the requirements of Executive Order 13132.

I. Congressional Review Act

These interim final rules are subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and will be transmitted to the Congress and to the Comptroller General for review in accordance with such provisions.

Statutory Authority

The Office of Personnel Management regulations are adopted pursuant to the authority contained in 5 U.S.C. 8902(p) and 5 U.S.C. 8913.

The Department of the Treasury regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor regulations are adopted pursuant to the authority contained in 29 U.S.C. 1002, 1135, 1182, 1185d, 1191a, 1191b, and 1191c; Secretary of Labor’s Order 1–2011, 77 FR 1088 (Jan. 9, 2012).

The Department of Health and Human Services regulations are adopted pursuant to the authority contained in sections 2701 through 2763, 2791, 2792, 2794, 2799A–1 through 2799B–9 of the PHS Act (42 U.S.C. 300gg–300gg–63, 300gg–91, 300gg–92, 300gg–94, 300gg–300gg139), as amended; sections 1311 and 1321 of the ACA (42 U.S.C. 13031 and 18041).

List of Subjects

5 CFR Part 890

Administrative practice and procedure, Government employees, Health facilities, Health insurance, Health professions, Hostages, Iraq, Kuwait, Lebanon, Military personnel, Reporting and recordkeeping requirements, Retirement.

26 CFR Part 54

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Part 144

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 147

Health care, Health insurance, Reporting and recordkeeping requirements, and State regulation of health insurance.

45 CFR Part 149

Balance billing, Health care, Health insurance, Reporting and recordkeeping requirements, Surprise billing, State regulation of health insurance, Transparency in coverage.

45 CFR Part 156

Administrative practice and procedure, Advertising, Advisory committees, Age discrimination, Alaska, Brokers, Citizenship and naturalization, Civil rights, Conflict of interests, Consumer protection, Grant programs—health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Intergovernmental relations, Loan programs—health, Medicaid, Organization and functions (Government agencies), Prescription drugs, Public assistance programs, Reporting and recordkeeping requirements, Sex discrimination, State and local governments, Sunshine Act, Technical assistance, Women, Youth.

Laurie Bodenheimer,

Associate Director, Healthcare and Insurance Office of Personnel Management.

Douglas W. O'Donnell,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Mark J. Mazur,

Acting Assistant Secretary of the Treasury (Tax Policy).

Ali Khawar,

Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

Xavier Becerra,

Secretary, Department of Health and Human Services.

Office of Personnel Management

For the reasons stated in the preamble, the Office of Personnel Management amends 5 CFR part 890 as follows:

PART 890—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

- 1. The authority citation for part 890 continues to read as follows:

Authority: 5 U.S.C. 8913; Sec. 890.102 also issued under sections 11202(f), 11232(e), and 11246 (b) of Pub. L. 105–33, 111 Stat. 251; Sec. 890.111 also issued under section 1622(b) of Pub. L. 104–106, 110 Stat. 521 (36 U.S.C. 5522); Sec. 890.112 also issued under

section 1 of Pub. L. 110–279, 122 Stat. 2604 (2 U.S.C. 2051); Sec. 890.113 also issued under section 1110 of Pub. L. 116–92, 133 Stat. 1198 (5 U.S.C. 8702 note); Sec. 890.301 also issued under section 311 of Pub. L. 111–3, 123 Stat. 64 (26 U.S.C. 9801); Sec. 890.302(b) also issued under section 1001 of Pub. L. 111–148, 124 Stat. 119, as amended by Pub. L. 111–152, 124 Stat. 1029 (42 U.S.C. 300gg–14); Sec. 890.803 also issued under 50 U.S.C. 3516 (formerly 50 U.S.C. 403p) and 22 U.S.C. 4069c and 4069c–1; subpart L also issued under section 599C of Pub. L. 101–513, 104 Stat. 2064 (5 U.S.C. 5561 note), as amended; and subpart M also issued under section 721 of Pub. L. 105–261 (10 U.S.C. 1108), 112 Stat. 2061.

Subpart A—Administration and General Provisions

- 2. Section 890.107 is amended by adding paragraph (e) to read as follows:

§ 890.107 Court review.

* * * * *

(e) A suit for equitable relief founded on 5 U.S.C. chapter 89 that is based on 5 U.S.C. 8902(p) and is governed by 5 CFR part 890 must be brought against OPM by December 31 of the 3rd year after the year in which disputed services were rendered.

- 3. Section 890.114 is added to subpart A to read as follows:

§ 890.114 Surprise billing.

(a) A carrier must comply with requirements described in 26 CFR 54.9816–3T through 54.9816–6T, 54.9817–1T, and 54.9822–1T, 29 CFR 2590.716–3 through 2590.716–6, 2590.717–1, and 2590.722, and 45 CFR 149.30, 149.110 through 149.140, and 149.310 in the same manner as such provisions apply to a group health plan or health insurance issuer offering group or individual health insurance coverage, subject to 5 U.S.C. 8902(m)(1), and the provisions of the carrier's contract. For purposes of application of such sections, all carriers are deemed to offer health benefits in the large group market.

(b) For purposes of the provisions referenced in paragraph (a) of this section:

Group health plan or plan shall mean a “health benefits plan” defined at 5 U.S.C. 8901(6), which is a Federal governmental plan offered pursuant to 5 U.S.C. chapter 89.

Health insurance issuer or issuer shall include a carrier defined at 5 U.S.C. 8901(7). Where the carrier for a health benefits plan is a voluntary association, an association of organizations or entities, or is otherwise comprised of multiple entities, each entity is responsible for compliance in the same manner as such sections apply to group

health plans and issuers. If and to the extent an entity offering a health benefits plan under 5 U.S.C. chapter 89 is licensed under state law and is properly considered an issuer as defined at section 2791 of the Public Health Service Act, the entity is considered a carrier to the extent of its FEHB health benefits plan contractual and regulatory compliance.

Participant, beneficiary, or enrollee shall include an “enrollee” or “covered individual” as defined by 5 CFR 890.101, as appropriate.

(c) When a complaint challenges a carrier's action or inaction with respect to the surprise billing provisions, OPM will coordinate with the Departments of Health and Human Services, Labor, and the Treasury to resolve the complaint.

Department of the Treasury**Internal Revenue Service**

Accordingly, 26 CFR part 54 is amended as follows:

PART 54—PENSION EXCISE TAXES

- **Paragraph 4.** The authority citation for part 54 continues to read, in part, as follows:

Authority: 26 U.S.C. 7805, unless otherwise noted.

* * * * *

- **Par. 5.** Section 54.9801–1T is added to read as follows:

§ 54.9801–1T Basis and scope (temporary).

(a) *Statutory basis.* This section and §§ 54.9801–2 through 54.9801–6, 54.9802–1, 54.9802–2, 54.9802–3T, 54.9802–4, 54.9811–1, 54.9812–1, 54.9815–1251, 54.9815–2704, 54.9815–2705, 54.9815–2708, 54.9815–2711, 54.9815–2712, 54.9815–2713, 54.9815–2713A, 54.9815–2714, 54.9815–2715, 54.9815–2715A1, 54.9815–2715A2, 54.9815–2715A3, 54.9815–2719, 54.9815–2715A, 54.9816–1 through 9816–7, 54.9831–1, and 54.9833–1 implement Chapter 100 of Subtitle K of the Internal Revenue Code of 1986.

(b) *Scope.* A group health plan or health insurance issuer offering group health insurance coverage may provide greater rights to participants and beneficiaries than those set forth in the portability and market reform sections of this part. This part sets forth minimum requirements for group health plans and group health insurance issuers offering group health insurance coverage concerning certain consumer protections of the Health Insurance Portability and Accountability Act (HIPAA), including special enrollment periods and the prohibition against

discrimination based on a health factor, as amended by the Patient Protection and Affordable Care Act (Affordable Care Act). Other consumer protection provisions, including other protections provided by the Affordable Care Act, the Mental Health Parity and Addiction Equity Act, and the No Surprises Act are set forth in this part.

(c) *Similar requirements under the Employee Retirement Income Security Act and the Public Health Service Act.* Sections 701, 702, 703, 711, 712, 716, 717, 732, and 733 of the Employee Retirement Income Security Act of 1974 and sections 2701, 2702, 2704, 2705, 2721, 2791, 2799A–1, and 2799A–2 of the Public Health Service Act impose requirements similar to those imposed under Chapter 100 of Subtitle K with respect to health insurance issuers offering group health insurance coverage. See 29 CFR part 2590 and 45 CFR parts 144, 146, 148, and 149. See also part B of Title XXVII of the Public Health Service Act and 45 CFR parts 148 and 149 for other rules applicable to health insurance offered in the individual market (defined in § 54.9801–2).

■ **Par. 6.** Section 54.9801–2T is added to read as follows:

§ 54.9801–2T Definitions (temporary).

Unless otherwise provided, the definitions in this section and § 54.9801–2 govern in applying the provisions of sections 9801 through 9825 and 9831 through 9834.

Affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

COBRA definitions:

(1) *COBRA* means title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(2) *COBRA continuation coverage* means coverage, under a group health plan, that satisfies an applicable COBRA continuation provision.

(3) *COBRA continuation provision* means section 4980B (other than paragraph (f)(1) of section 4980B insofar as it relates to pediatric vaccines), sections 601–608 of ERISA, or title XXII of the PHS Act.

(4) *Exhaustion of COBRA continuation coverage* means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An

individual is considered to have exhausted COBRA continuation coverage if such coverage ceases—

(i) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis;

(ii) When the individual no longer resides, lives, or works in the service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual; or

(iii) When the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual.

Condition means a *medical condition*. *Creditable coverage* means *creditable coverage* within the meaning of § 54.9801–4(a).

Dependent means any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant.

Employee Retirement Income Security Act of 1974 (ERISA) means the Employee Retirement Income Security Act of 1974, as amended (29 U.S.C. 1001 *et seq.*).

Enroll means to become covered for benefits under a group health plan (that is, when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to become covered under the plan. For this purpose, an individual who has health coverage under a group health plan is enrolled in the plan regardless of whether the individual elects coverage, the individual is a dependent who becomes covered as a result of an election by a participant, or the individual becomes covered without an election.

Enrollment date means the first day of coverage or, if there is a waiting period, the first day of the waiting period. If an individual receiving benefits under a group health plan changes benefit packages, or if the plan changes group health insurance issuers, the individual's enrollment date does not change.

Excepted benefits means the benefits described as excepted in § 54.9831(c).

First day of coverage means, in the case of an individual covered for benefits under a group health plan, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy or contract.

Genetic information has the meaning given the term in § 54.9802–3T(a)(3).

Group health insurance coverage means health insurance coverage offered in connection with a group health plan. Individual health insurance coverage reimbursed by the arrangements described in 29 CFR 2510.3–1(l) is not offered in connection with a group health plan, and is not group health insurance coverage, provided all the conditions in 29 CFR 2510.3–1(l) are satisfied.

Group health plan or *plan* means a *group health plan* within the meaning of § 54.9831–1(a).

Group market means the market for health insurance coverage offered in connection with a group health plan. (However, certain very small plans may be treated as being in the *individual market*, rather than the group market; see the definition of individual market in this section.)

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance. However, benefits described in § 54.9831(c)(2) are not treated as benefits consisting of medical care.

Health insurance issuer or *issuer* means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of ERISA). Such term does not include a group health plan.

Health maintenance organization or *HMO* means—

(1) A federally qualified health maintenance organization (as defined in section 1301(a) of the PHS Act);

(2) An organization recognized under State law as a health maintenance organization; or

(3) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

Individual health insurance coverage means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance. Individual health insurance coverage can include dependent coverage.

Individual market means the market for health insurance coverage offered to individuals other than in connection

with a group health plan. Unless a State elects otherwise in accordance with section 2791(e)(1)(B)(ii) of the PHS Act, such term also includes coverage offered in connection with a group health plan that has fewer than two participants who are current employees on the first day of the plan year.

Issuer means a *health insurance issuer*.

Late enrollee means an individual whose enrollment in a plan is a late enrollment.

Late enrollment means enrollment of an individual under a group health plan other than on the earliest date on which coverage can become effective for the individual under the terms of the plan; or through special enrollment. (For rules relating to special enrollment, see § 54.9801–6.) If an individual ceases to be eligible for coverage under a plan, and then subsequently becomes eligible for coverage under the plan, only the individual's most recent period of eligibility is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

Medical care has the meaning given such term by section 213(d), determined without regard to section 213(d)(1)(C) and so much of section 213(d)(1)(D) as relates to qualified long-term care insurance.

Medical condition or *condition* means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

Participant means *participant* within the meaning of section 3(7) of ERISA.

Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation.

Plan year means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is—

(1) The deductible or limit year used under the plan;

(2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

(4) In any other case, the plan year is the calendar year.

Preexisting condition exclusion means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR part 148), whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan, or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR part 148), such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

Public health plan means *public health plan* within the meaning of § 54.9801–4(a)(1)(ix).

Public Health Service Act (PHS Act) means the Public Health Service Act (42 U.S.C. 201, *et seq.*).

Short-term, limited-duration insurance means health insurance coverage provided pursuant to a contract with an issuer that:

(1) Has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract and, taking into account renewals or extensions, has a duration of no longer than 36 months in total;

(2) With respect to policies having a coverage start date before January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the language in the following Notice 1, excluding the heading "Notice 1," with any additional information required by applicable state law:

Notice 1

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Also, this coverage is not "minimum essential coverage." If you don't have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

(3) With respect to policies having a coverage start date on or after January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the language in the following Notice 2, excluding the heading "Notice 2," with any additional information required by applicable state law:

Notice 2

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

(4) If a court holds the 36-month maximum duration provision set forth in paragraph (1) of this definition or its applicability to any person or circumstances invalid, the remaining provisions and their applicability to other people or circumstances shall continue in effect.

Significant break in coverage means a *significant break in coverage* within the meaning of § 54.9801–4(b)(2)(iii).

Special enrollment means enrollment in a group health plan under the rights described in § 54.9801–6 or in group health insurance coverage under the rights described in 29 CFR 2590.701–6 or 45 CFR 146.117.

State health benefits risk pool means a *State health benefits risk pool* within the meaning of § 54.9801–4(a)(1)(vii).

Travel insurance means insurance coverage for personal risks incident to planned travel, which may include, but is not limited to, interruption or cancellation of trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, the term travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed.

Waiting period means *waiting period* within the meaning of § 54.9815–2708(b).

■ **Par. 7.** Section 54.9815–2719AT is added to read as follows:

§ 54.9815–2719AT Patient protections (temporary).

(a)–(b) [Reserved]

(c) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning before January 1, 2022. *See also* §§ 54.9816–4T through 54.9816–7T, 54.9817–1T, and 54.9822–1T for rules applicable with respect to plan years beginning on or after January 1, 2022.

■ **Par. 8.** Sections 54.9816–1T, 54.9816–2T, 54.9816–3T, 54.9816–4T, 54.9816–5T, 54.9816–6T, 54.9816–7T, 54.9817–1T, and 54.9822–1T are added to read as follows:

Sec.

- 54.9816–1T Basis and scope (temporary).
- 54.9816–2T Applicability (temporary).
- 54.9816–3T Definitions (temporary).
- 54.9816–4T Preventing surprise medical bills for emergency services (temporary).
- 54.9816–5T Preventing surprise medical bills for non-emergency services performed by nonparticipating providers at certain participating facilities (temporary).
- 54.9816–6T Methodology for calculating qualifying payment amount (temporary).
- 54.9816–7T Complaints process for surprise medical bills regarding group health plans (temporary).
- 54.9817–1T Preventing surprise medical bills for air ambulance services (temporary).
- 54.9822–1T Choice of health care professional (temporary).

* * * * *

§ 54.9816–1T Basis and scope (temporary).

(a) *Basis.* This section and §§ 54.9816–2T through 54.9816–7T, 54.9817–1T, and 54.9822–1T implement subchapter B of chapter 100 of the Internal Revenue Code of 1986.

(b) *Scope.* This part establishes standards for group health plans with respect to surprise medical bills, transparency in health care coverage, and additional patient protections.

§ 54.9816–2T Applicability (temporary).

(a) *In general.* The requirements in §§ 54.9816–4T through 54.9816–7T, 54.9817–1T, and 54.9822–1T apply to group health plans (including grandfathered health plans as defined in § 54.9815–1251T), except as specified in paragraph (b) of this section.

(b) *Exceptions.* The requirements in §§ 54.9816–4T through 54.9816–7T, 54.9817–1T, and 54.9822–1T do not apply to the following:

- (1) Excepted benefits as described in § 54.9831–1(c).
- (2) Short-term, limited-duration insurance as defined in § 54.9801–2.
- (3) Health reimbursement arrangements or other account-based group health plans as described in § 54.9815–2711(d).

§ 54.9816–3T Definitions (temporary).

The definitions in § 54.9801–2T apply to §§ 54.9816–4T through 54.9816–7T, 54.9817–1T, and 54.9822–1T unless otherwise specified. In addition, for purposes of §§ 54.9816–4T through 54.9816–7T, 54.9817–1T, and 54.9822–1T, the following definitions apply:

Air ambulance service means medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.

Cost sharing means the amount a participant, beneficiary, or enrollee is responsible for paying for a covered item or service under the terms of the group health plan or health insurance coverage. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by out-of-network providers, or the cost of items or services that are not covered under a group health plan or health insurance coverage.

Emergency department of a hospital includes a hospital outpatient department that provides emergency services.

Emergency medical condition has the meaning given the term in § 54.9816–4T(c)(1).

Emergency services has the meaning given the term in § 54.9816–4T(c)(2).

Health care facility, with respect to a group health plan, in the context of non-emergency services, is each of the following:

- (1) A hospital (as defined in section 1861(e) of the Social Security Act);
- (2) A hospital outpatient department;
- (3) A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
- (4) An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Independent freestanding emergency department means a health care facility (not limited to those described in the definition of health care facility with respect to non-emergency services) that—

- (1) Is geographically separate and distinct and licensed separately from a hospital under applicable State law; and
- (2) Provides any emergency services as described in § 54.9816–4T(c)(2)(i).

Nonparticipating emergency facility means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to services that pursuant to § 54.9816–4T(c)(2)(ii) are included as emergency services), that does not have a contractual relationship directly or indirectly with a group health plan, with respect to the furnishing of an item or service under the plan.

Nonparticipating provider means any physician or other health care provider who does not have a contractual relationship directly or indirectly with a group health plan, with respect to the furnishing of an item or service under the plan.

Notice of denial of payment means, with respect to an item or service for which benefits subject to the protections of §§ 54.9816–4T, 54.9816–5T, and 54.9817–1T are provided or covered, a written notice from the plan to the health care provider, facility, or provider of air ambulance services, as applicable, that payment for such item or service will not be made by the plan and which explains the reason for denial. The term notice of denial of payment does not include a notice of benefit denial due to an adverse benefit determination as defined in 29 CFR 2560.503–1.

Out-of-network rate means, with respect to an item or service furnished by a nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services—

- (1) Subject to paragraph (3) of this definition, in a State that has in effect a specified State law, the amount determined in accordance with such law;

(2) Subject to paragraph (3) of this definition, in a State that does not have in effect a specified State law—

(i) Subject to paragraph (2)(ii) of this definition, if the nonparticipating provider or nonparticipating emergency facility and the plan agree on an amount of payment (including if the amount agreed upon is the initial payment sent by the plan under § 54.9816–4T(b)(3)(iv)(A), § 54.9816–5T(c)(3), or § 54.9817–1T(b)(4)(i); 29 CFR 2590.716–4(b)(3)(iv)(A), 2590.716–5(c)(3), or 2590.717–1(b)(4)(i); or 45 CFR 149.110(b)(3)(iv)(A), 149.120(c)(3), or 149.130(b)(4)(i), as applicable, or is agreed on through negotiations with respect to such item or service), such as agreed on amount; or

(ii) If the nonparticipating provider or nonparticipating emergency facility and the plan enter into the independent dispute resolution (IDR) process under section 9816(c) or 9817(b) of the Internal Revenue Code, section 716(c) or 717(b) of ERISA, or section 2799A–1(c) or 2799A–2(b) of the PHS Act, as applicable, and do not agree before the date on which a certified IDR entity makes a determination with respect to such item or service under such subsection, the amount of such determination; or

(3) In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies with respect to the plan; the nonparticipating provider or nonparticipating emergency facility; and the item or service, the amount that the State approves under the All-Payer Model Agreement for the item or service.

Participating emergency facility means any emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to services that pursuant to § 54.9816–4T(c)(2)(ii) are included as emergency services), that has a contractual relationship directly or indirectly with a group health plan setting forth the terms and conditions on which a relevant item or service is provided to a participant or beneficiary under the plan. A single case agreement between an emergency facility and a plan that is used to address unique situations in which a participant or beneficiary requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

Participating health care facility means any health care facility described in this section that has a contractual relationship directly or indirectly with a group health plan setting forth the terms

and conditions on which a relevant item or service is provided to a participant or beneficiary under the plan. A single case agreement between a health care facility and a plan that is used to address unique situations in which a participant or beneficiary requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

Participating provider means any physician or other health care provider who has a contractual relationship directly or indirectly with a group health plan setting forth the terms and conditions on which a relevant item or service is provided to a participant or beneficiary under the plan.

Physician or health care provider means a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, but does not include a provider of air ambulance services.

Provider of air ambulance services means an entity that is licensed under applicable State and Federal law to provide air ambulance services.

Same or similar item or service has the meaning given the term in § 54.9816–6T(a)(13).

Service code has the meaning given the term in § 54.9816–6T(a)(14).

Qualifying payment amount has the meaning given the term in § 54.9816–6T(a)(16).

Recognized amount means, with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility—

(1) Subject to paragraph (3) of this definition, in a State that has in effect a specified State law, the amount determined in accordance with such law.

(2) Subject to paragraph (3) of this definition, in a State that does not have in effect a specified State law, the lesser of—

(i) The amount that is the qualifying payment amount (as determined in accordance with § 54.9816–6T); or

(ii) The amount billed by the provider or facility.

(3) In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies with respect to the plan; the nonparticipating provider or nonparticipating emergency facility; and the item or service, the amount that the State approves under the All-Payer Model Agreement for the item or service.

Specified State law means a State law that provides for a method for

determining the total amount payable under a group health plan to the extent such State law applies for an item or service furnished by a nonparticipating provider or nonparticipating emergency facility (including where it applies because the State has allowed a plan that is not otherwise subject to applicable State law an opportunity to opt in, subject to section 514 of the Employee Retirement Income Security Act of 1974). A group health plan that opts into such a specified State law must do so for all items and services to which the specified State law applies and in a manner determined by the applicable State authority, and must prominently display in its plan materials describing the coverage of out-of-network services a statement that the plan has opted into the specified State law, identify the relevant State (or States), and include a general description of the items and services provided by nonparticipating facilities and providers that are covered by the specified State law.

State means each of the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Treating provider is a physician or health care provider who has evaluated the individual.

Visit, with respect to items and services furnished to an individual at a health care facility, includes, in addition to items and services furnished by a provider at the facility, equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is at the facility.

§ 54.9816–4T Preventing surprise medical bills for emergency services (temporary).

(a) *In general.* If a group health plan provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department, the plan must cover emergency services, as defined in paragraph (c)(2) of this section, and this coverage must be provided in accordance with paragraph (b) of this section.

(b) *Coverage requirements.* A plan described in paragraph (a) of this section must provide coverage for emergency services in the following manner—

(1) Without the need for any prior authorization determination, even if the services are provided on an out-of-network basis.

(2) Without regard to whether the health care provider furnishing the emergency services is a participating provider or a participating emergency facility, as applicable, with respect to the services.

(3) If the emergency services are provided by a nonparticipating provider or a nonparticipating emergency facility—

(i) Without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities.

(ii) Without imposing cost-sharing requirements that are greater than the requirements that would apply if the services were provided by a participating provider or a participating emergency facility.

(iii) By calculating the cost-sharing requirement as if the total amount that would have been charged for the services by such participating provider or participating emergency facility were equal to the recognized amount for such services.

(iv) The plan—

(A) Not later than 30 calendar days after the bill for the services is transmitted by the provider or facility (or, in cases where the recognized amount is determined by a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement), determines whether the services are covered under the plan and, if the services are covered, sends to the provider or facility, as applicable, an initial payment or a notice of denial of payment. For purposes of this paragraph (b)(3)(iv)(A), the 30-calendar-day period begins on the date the plan receives the information necessary to decide a claim for payment for the services.

(B) Pays a total plan payment directly to the nonparticipating provider or nonparticipating facility that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services (as determined in accordance with paragraphs (b)(3)(ii) and (iii) of this section), less any initial payment amount made under paragraph (b)(3)(iv)(A) of this section. The total plan payment must be made in accordance with the timing requirement described in section 9816(c)(6), or in cases where the out-of-network rate is determined under a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement.

(v) By counting any cost-sharing payments made by the participant or beneficiary with respect to the emergency services toward any in-network deductible or in-network out-of-pocket maximums (including the annual limitation on cost sharing under section 2707(b) of the Public Health Service Act) (as applicable) applied under the plan (and the in-network deductible and in-network out-of-pocket maximums must be applied) in the same manner as if the cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility.

(4) Without limiting what constitutes an emergency medical condition (as defined in paragraph (c)(1) of this section) solely on the basis of diagnosis codes.

(5) Without regard to any other term or condition of the coverage, other than—

(i) The exclusion or coordination of benefits (to the extent not inconsistent with benefits for an emergency medical condition, as defined in paragraph (c)(1) of this section).

(ii) An affiliation or waiting period (each as defined in § 54.9801-2).

(iii) Applicable cost sharing.

(c) *Definitions.* In this section—

(1) *Emergency medical condition* means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)

(2) *Emergency services* means, with respect to an emergency medical condition—

(i) *In general.* (A) An appropriate medical screening examination (as required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a

hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

(ii) *Inclusion of additional services.*

(A) Subject to paragraph (c)(2)(ii)(B) of this section, items and services—

(1) For which benefits are provided or covered under the plan; and

(2) That are furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the participant or beneficiary is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in paragraph (c)(2)(i) of this section are furnished.

(B) Items and services described in paragraph (c)(2)(ii)(A) of this section are not included as emergency services if all of the conditions in 45 CFR 149.410(b) are met.

(3) *To stabilize*, with respect to an emergency medical condition, has the meaning given such term in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(d) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022.

§ 54.9816-5T Preventing surprise medical bills for non-emergency services performed by nonparticipating providers at certain participating facilities (temporary).

(a) *In general.* If a group health plan provides or covers any benefits with respect to items and services described in paragraph (b) of this section, the plan must cover the items and services when furnished by a nonparticipating provider in accordance with paragraph (c) of this section.

(b) *Items and services described.* The items and services described in this paragraph (b) are items and services (other than emergency services) furnished to a participant or beneficiary

by a nonparticipating provider with respect to a visit at a participating health care facility, unless the provider has satisfied the notice and consent criteria of 45 CFR 149.420(c) through (i) with respect to such items and services.

(c) *Coverage requirements.* In the case of items and services described in paragraph (b) of this section, the plan—

(1) Must not impose a cost-sharing requirement for the items and services that is greater than the cost-sharing requirement that would apply if the items or services had been furnished by a participating provider.

(2) Must calculate the cost-sharing requirements as if the total amount that would have been charged for the items and services by such participating provider were equal to the recognized amount for the items and services.

(3) Not later than 30 calendar days after the bill for the items or services is transmitted by the provider (or in cases where the recognized amount is determined by a specified State law or All-Payer Model Agreement, such other timeframe as specified under the State law or All-Payer Model Agreement), must determine whether the items and services are covered under the plan and, if the items and services are covered, send to the provider an initial payment or a notice of denial of payment. For purposes of this paragraph (c)(3), the 30-calendar-day period begins on the date the plan receives the information necessary to decide a claim for payment for the items or services.

(4) Must pay a total plan payment directly to the nonparticipating provider that is equal to the amount by which the out-of-network rate for the items and services involved exceeds the cost-sharing amount for the items and services (as determined in accordance with paragraphs (c)(1) and (2) of this section), less any initial payment amount made under paragraph (c)(3) of this section. The total plan payment must be made in accordance with the timing requirement described in section 9816(c)(6) or in cases where the out-of-network rate is determined under a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement.

(5) Must count any cost-sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums (including the annual limitation on cost sharing under section 2707(b) of the Public Health Service Act) (as applicable) applied under the plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such

cost-sharing payments were made with respect to items and services furnished by a participating provider.

(d) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022.

§ 54.9816–6T Methodology for calculating qualifying payment amount (temporary).

(a) *Definitions.* For purposes of this section, the following definitions apply:

(1) *Contracted rate* means the total amount (including cost sharing) that a group health plan has contractually agreed to pay a participating provider, facility, or provider of air ambulance services for covered items and services, whether directly or indirectly, including through a third-party administrator or pharmacy benefit manager. Solely for purposes of this definition, a single case agreement, letter of agreement, or other similar arrangement between a provider, facility, or air ambulance provider and a plan, used to supplement the network of the plan for a specific participant or beneficiary in unique circumstances, does not constitute a contract.

(2) *Derived amount* has the meaning given the term in § 54.9815–2715A1.

(3) *Eligible database* means—

(i) A State all-payer claims database; or

(ii) Any third-party database which—
(A) Is not affiliated with, or owned or controlled by, any health insurance issuer, or a health care provider, facility, or provider of air ambulance services (or any member of the same controlled group as, or under common control with, such an entity). For purposes of this paragraph (a)(3)(ii)(A), the term controlled group means a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended;

(B) Has sufficient information reflecting in-network amounts paid by group health plans or health insurance issuers offering group or individual health insurance coverage to providers, facilities, or providers of air ambulance services for relevant items and services furnished in the applicable geographic region; and

(C) Has the ability to distinguish amounts paid to participating providers and facilities by commercial payers, such as group health plans and health insurance issuers offering group or individual health insurance coverage, from all other claims data, such as amounts billed by nonparticipating providers or facilities and amounts paid by public payers, including the Medicare program under title XVIII of the Social Security Act, the Medicaid

program under title XIX of the Social Security Act (or a demonstration project under title XI of the Social Security Act), or the Children's Health Insurance Program under title XXI of the Social Security Act.

(4) *Facility of the same or similar facility type* means, with respect to emergency services, either—

(i) An emergency department of a hospital; or

(ii) An independent freestanding emergency department.

(5) *First coverage year* means, with respect to an item or service for which coverage is not offered in 2019 under a group health plan, the first year after 2019 for which coverage for such item or service is offered under that plan.

(6) *First sufficient information year* means, with respect to a group health plan—

(i) In the case of an item or service for which the plan does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section in 2019, the first year after 2022 for which the plan has sufficient information to calculate the median of such contracted rates in the year immediately preceding that first year after 2022; and

(ii) In the case of a newly covered item or service, the first year after the first coverage year for such item or service with respect to such plan for which the plan has sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section in the year immediately preceding that first year.

(7) *Geographic region* means—

(i) For items and services other than air ambulance services—

(A) Subject to paragraphs (a)(7)(i)(B) and (C) of this section, one region for each metropolitan statistical area, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in a State, and one region consisting of all other portions of the State.

(B) If a plan does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an item or service provided in a geographic region described in paragraph (a)(7)(i)(A) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in the State, and one region consisting of all other portions of the State.

(C) If a plan does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an item

or service provided in a geographic region described in paragraph (a)(7)(i)(B) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in each Census division and one region consisting of all other portions of the Census division, as described by the U.S. Census Bureau.

(ii) For air ambulance services—

(A) Subject to paragraph (a)(7)(ii)(B) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in the State, and one region consisting of all other portions of the State, determined based on the point of pick-up (as defined in 42 CFR 414.605).

(B) If a plan does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an air ambulance service provided in a geographic region described in paragraph (a)(7)(ii)(A) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in each Census division and one region consisting of all other portions of the Census division, as described by the U.S. Census Bureau, determined based on the point of pick-up (as defined in 42 CFR 414.605).

(8) *Insurance market* is, irrespective of the State, one of the following:

(i) The individual market (other than short-term, limited-duration insurance or individual health insurance coverage that consists solely of excepted benefits).

(ii) The large group market (other than coverage that consists solely of excepted benefits).

(iii) The small group market (other than coverage that consists solely of excepted benefits).

(iv) In the case of a self-insured group health plan, all self-insured group health plans (other than account-based plans, as defined in § 54.9815–2711(d)(6)(i), and plans that consist solely of excepted benefits) of the same plan sponsor, or at the option of the plan sponsor, all self-insured group health plans administered by the same entity (including a third-party administrator contracted by the plan), to the extent otherwise permitted by law, that is responsible for calculating the qualifying payment amount on behalf of the plan.

(9) *Modifiers* mean codes applied to the service code that provide a more

specific description of the furnished item or service and that may adjust the payment rate or affect the processing or payment of the code billed.

(10) *Newly covered item or service* means an item or service for which coverage was not offered in 2019 under a group health plan, but that is offered under the plan in a year after 2019.

(11) *New service code* means a service code that was created or substantially revised in a year after 2019.

(12) *Provider in the same or similar specialty* means the practice specialty of a provider, as identified by the plan consistent with the plan's usual business practice, except that, with respect to air ambulance services, all providers of air ambulance services are considered to be a single provider specialty.

(13) *Same or similar item or service* means a health care item or service billed under the same service code, or a comparable code under a different procedural code system.

(14) *Service code* means the code that describes an item or service using the Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS), or Diagnosis-Related Group (DRG) codes.

(15) *Sufficient information* means, for purposes of determining whether a group health plan has sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section—

(i) The plan has at least three contracted rates on January 31, 2019, to calculate the median of the contracted rates in accordance with paragraph (b) of this section; or

(ii) For an item or service furnished during a year after 2022 that is used to determine the first sufficient information year—

(A) The plan has at least three contracted rates on January 31 of the year immediately preceding that year to calculate the median of the contracted rates in accordance with paragraph (b) of this section; and

(B) The contracted rates under paragraph (a)(15)(ii)(A) of this section account (or are reasonably expected to account) for at least 25 percent of the total number of claims paid for that item or service for that year with respect to all plans of the sponsor (or the administering entity as provided in paragraph (a)(8)(iv) of this section, if applicable) that are offered in the same insurance market.

(16) *Qualifying payment amount* means, with respect to a sponsor of a group health plan, the amount calculated using the methodology

described in paragraph (c) of this section.

(17) *Underlying fee schedule rate* means the rate for a covered item or service from a particular participating provider, providers, or facility that a group health plan uses to determine a participant's or beneficiary's cost-sharing liability for the item or service, when that rate is different from the contracted rate.

(b) *Methodology for calculation of median contracted rate*—(1) *In general.* The median contracted rate for an item or service is calculated by arranging in order from least to greatest the contracted rates of all group health plans of the plan sponsor (or the administering entity as provided in paragraph (a)(8)(iv) of this section, if applicable) in the same insurance market for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the geographic region in which the item or service is furnished and selecting the middle number. If there are an even number of contracted rates, the median contracted rate is the average of the middle two contracted rates. In determining the median contracted rate, the amount negotiated under each contract is treated as a separate amount. If a plan or issuer has a contract with a provider group or facility, the rate negotiated with that provider group or facility under the contract is treated as a single contracted rate if the same amount applies with respect to all providers of such provider group or facility under the single contract. However, if a plan or issuer has a contract with multiple providers, with separate negotiated rates with each particular provider, each unique contracted rate with an individual provider constitutes a single contracted rate. Further, if a plan or issuer has separate contracts with individual providers, the contracted rate under each such contract constitutes a single contracted rate (even if the same amount is paid to multiple providers under separate contracts).

(2) *Calculation rules.* In calculating the median contracted rate, a plan must:

(i) Calculate the median contracted rate with respect to all plans of such sponsor (or the administering entity as provided in paragraph (a)(8)(iv) of this section, if applicable) that are offered in the same insurance market;

(ii) Calculate the median contracted rate using the full contracted rate applicable to the service code, except that the plan must—

(A) Calculate separate median contracted rates for CPT code modifiers

“26” (professional component) and “TC” (technical component);

(B) For anesthesia services, calculate a median contracted rate for the anesthesia conversion factor for each service code;

(C) For air ambulance services, calculate a median contracted rate for the air mileage service codes (A0435 and A0436); and

(D) Where contracted rates otherwise vary based on applying a modifier code, calculate a separate median contracted rate for each such service code-modifier combination;

(iii) In the case of payments made by a plan that are not on a fee-for-service basis (such as bundled or capitation payments), calculate a median contracted rate for each item or service using the underlying fee schedule rates for the relevant items or services. If the plan does not have an underlying fee schedule rate for the item or service, it must use the derived amount to calculate the median contracted rate; and

(iv) Exclude risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments.

(3) *Provider specialties; facility types.*

(i) If a plan has contracted rates that vary based on provider specialty for a service code, the median contracted rate is calculated separately for each provider specialty, as applicable.

(ii) If a plan has contracted rates for emergency services that vary based on facility type for a service code, the median contracted rate is calculated separately for each facility of the same or similar facility type.

(c) *Methodology for calculation of the qualifying payment amount—(1) In general.* (i) For an item or service (other than items or services described in paragraphs (c)(1)(iii) through (vii) of this section) furnished during 2022, the plan must calculate the qualifying payment amount by increasing the median contracted rate (as determined in accordance with paragraph (b) of this section) for the same or similar item or service under such plans, on January 31, 2019, by the combined percentage increase as published by the Department of the Treasury and the Internal Revenue Service to reflect the percentage increase in the CPI-U over 2019, such percentage increase over 2020, and such percentage increase over 2021.

(A) The combined percentage increase for 2019, 2020, and 2021 will be published in guidance by the Internal Revenue Service. The Department of the Treasury and the Internal Revenue Service will calculate the percentage

increase using the CPI-U published by the Bureau of Labor Statistics of the Department of Labor.

(B) For purposes of this paragraph (c)(1)(i), the CPI-U for each calendar year is the average of the CPI-U as of the close of the 12-month period ending on August 31 of the calendar year, rounded to 10 decimal places.

(C) The combined percentage increase for 2019, 2020, and 2021 will be calculated as:

$$(\text{CPI-U } 2019 / \text{CPI-U } 2018) \times (\text{CPI-U } 2020 / \text{CPI-U } 2019) \times (\text{CPI-U } 2021 / \text{CPI-U } 2020)$$

(ii) For an item or service (other than items or services described in paragraphs (c)(1)(iii) through (vii) of this section) furnished during 2023 or a subsequent year, the plan must calculate the qualifying payment amount by increasing the qualifying payment amount determined under paragraph (c)(1)(i) of this section, for such an item or service furnished in the immediately preceding year, by the percentage increase as published by the Department of the Treasury and the Internal Revenue Service.

(A) The percentage increase for any year after 2022 will be published in guidance by the Internal Revenue Service. The Department of the Treasury and Internal Revenue Service will calculate the percentage increase using the CPI-U published by the Bureau of Labor Statistics of the Department of Labor.

(B) For purposes of this paragraph (c)(1)(ii), the CPI-U for each calendar year is the average of the CPI-U as of the close of the 12-month period ending on August 31 of the calendar year, rounded to 10 decimal places.

(C) The combined percentage increase for any year will be calculated as CPI-U present year/CPI-U prior year.

(iii) For anesthesia services furnished during 2022, the plan must calculate the qualifying payment amount by first increasing the median contracted rate for the anesthesia conversion factor (as determined in accordance with paragraph (b) of this section) for the same or similar item or service under such plans, on January 31, 2019, in accordance with paragraph (c)(1)(i) of this section (referred to in this section as the indexed median contracted rate for the anesthesia conversion factor). The plan must then multiply the indexed median contracted rate for the anesthesia conversion factor by the sum of the base unit, time unit, and physical status modifier units of the participant or beneficiary to whom anesthesia services are furnished to determine the qualifying payment amount.

(A) The base units for an anesthesia service code are the base units for that service code specified in the most recent edition (as of the date of service) of the American Society of Anesthesiologists Relative Value Guide.

(B) The time unit is measured in 15-minute increments or a fraction thereof.

(C) The physical status modifier on a claim is a standard modifier describing the physical status of the patient and is used to distinguish between various levels of complexity of the anesthesia services provided, and is expressed as a unit with a value between zero (0) and three (3).

(D) The anesthesia conversion factor is expressed in dollars per unit and is a contracted rate negotiated with the plan.

(iv) For anesthesia services furnished during 2023 or a subsequent year, the plan must calculate the qualifying payment amount by first increasing the indexed median contracted rate for the anesthesia conversion factor, determined under paragraph (c)(1)(iii) of this section for such services furnished in the immediately preceding year, in accordance with paragraph (c)(1)(ii) of this section. The plan must then multiply that amount by the sum of the base unit, time unit, and physical status modifier units for the participant or beneficiary to whom anesthesia services are furnished to determine the qualifying payment amount.

(v) For air ambulance services billed using the air mileage service codes (A0435 and A0436) that are furnished during 2022, the plan must calculate the qualifying payment amount for services billed using the air mileage service codes by first increasing the median contracted rate (as determined in accordance with paragraph (b) of this section), in accordance with paragraph (c)(1)(i) of this section (referred to in this section as the indexed median air mileage rate). The plan must then multiply the indexed median air mileage rate by the number of loaded miles provided to the participant or beneficiary to determine the qualifying payment amount.

(A) The air mileage rate is expressed in dollars per loaded mile flown, is expressed in statute miles (not nautical miles), and is a contracted rate negotiated with the plan.

(B) The number of loaded miles is the number of miles a patient is transported in the air ambulance vehicle.

(C) The qualifying payment amount for other service codes associated with air ambulance services is calculated in accordance with paragraphs (c)(1)(i) and (ii) of this section.

(vi) For air ambulance services billed using the air mileage service codes (A0435 and A0436) that are furnished during 2023 or a subsequent year, the plan must calculate the qualifying payment amount by first increasing the indexed median air mileage rate, determined under paragraph (c)(1)(v) of this section for such services furnished in the immediately preceding year, in accordance with paragraph (c)(1)(ii) of this section. The plan must then multiply the indexed median air mileage rate by the number of loaded miles provided to the participant or beneficiary to determine the qualifying payment amount.

(vii) For any other items or services for which a plan generally determines payment for the same or similar items or services by multiplying a contracted rate by another unit value, the plan must calculate the qualifying payment amount using a methodology that is similar to the methodology required under paragraphs (c)(1)(iii) through (vi) of this section and reasonably reflects the payment methodology for same or similar items or services.

(2) *New plans.* With respect to a sponsor of a group health plan in a geographic region in which the sponsor did not offer any group health plan during 2019—

(i) For the first year in which the group health plan is offered in such region—

(A) If the plan has sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section, the plan must calculate the qualifying payment amount in accordance with paragraph (c)(1) of this section for items and services that are covered by the plan and furnished during the first year; and

(B) If the plan does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an item or service provided in a geographic region, the plan must determine the qualifying payment amount for the item or service in accordance with paragraph (c)(3)(i) of this section.

(ii) For each subsequent year the group health plan is offered in the region, the plan must calculate the qualifying payment amount by increasing the qualifying payment amount determined under this paragraph (c)(2) for the items and services furnished in the immediately preceding year, in accordance with paragraph (c)(1)(ii), (iv), or (vi) of this section, as applicable.

(3) *Insufficient information; newly covered items and services.* In the case of a plan that does not have sufficient

information to calculate the median of the contracted rates described in paragraph (b) of this section in 2019 (or, in the case of a newly covered item or service, in the first coverage year for such item or service with respect to such plan or coverage if the plan does not have sufficient information) for an item or service provided in a geographic region—

(i) For an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for the item or service with respect to the plan or coverage), the plan must calculate the qualifying payment amount by first identifying the rate that is equal to the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in the year immediately preceding the year in which the item or service is furnished (or, in the case of a newly covered item or service, the year immediately preceding such first coverage year) determined by the plan through use of any eligible database, and then increasing that rate by the percentage increase in the CPI-U over such preceding year. For purposes of this section, in cases in which an eligible database is used to determine the qualifying payment amount with respect to an item or service furnished during a calendar year, the plan must use the same database for determining the qualifying payment amount for that item or service furnished through the last day of the calendar year, and if a different database is selected for some items or services, the basis for that selection must be one or more factors not directly related to the rate of those items or services (such as sufficiency of data for those items or services).

(ii) For an item or service furnished in a subsequent year (before the first sufficient information year for such item or service with respect to such plan), the plan must calculate the qualifying payment amount by increasing the qualifying payment amount determined under paragraph (c)(3)(i) of this section or this paragraph (c)(3)(ii), as applicable, for such item or service for the year immediately preceding such subsequent year, by the percentage increase in CPI-U over such preceding year;

(iii) For an item or service furnished in the first sufficient information year for such item or service with respect to such plan, the plan must calculate the qualifying payment amount in accordance with paragraph (c)(1)(i), (iii), or (v) of this section, as applicable, except that in applying such paragraph to such item or service, the reference to ‘furnished during 2022’ is treated as a

reference to furnished during such first sufficient information year, the reference to ‘in 2019’ is treated as a reference to such sufficient information year, and the increase described in such paragraph is not applied; and

(iv) For an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan, the plan must calculate the qualifying payment amount in accordance with paragraph (c)(1)(ii), (iv), or (vi) of this section, as applicable, except that in applying such paragraph to such item or service, the reference to ‘furnished during 2023 or a subsequent year’ is treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

(4) *New service codes.* In the case of a plan that does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section and determine the qualifying payment amount under paragraphs (c)(1) through (3) of this section because the item or service furnished is billed under a new service code—

(i) For an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for the item or service with respect to the plan), the plan must identify a reasonably related service code that existed in the immediately preceding year and—

(A) If the Centers for Medicare & Medicaid Services has established a Medicare payment rate for the item or service billed under the new service code, the plan must calculate the qualifying payment amount by first calculating the ratio of the rate that Medicare pays for the item or service billed under the new service code compared to the rate that Medicare pays for the item or service billed under the related service code, and then multiplying the ratio by the qualifying payment amount for an item or service billed under the related service code for the year in which the item or service is furnished.

(B) If the Centers for Medicare & Medicaid Services has not established a Medicare payment rate for the item or service billed under the new service code, the plan must calculate the qualifying payment amount by first calculating the ratio of the rate that the plan reimburses for the item or service billed under the new service code compared to the rate that the plan reimburses for the item or service billed under the related service code, and then multiplying the ratio by the qualifying

payment amount for an item or service billed under the related service code.

(ii) For an item or service furnished in a subsequent year (before the first sufficient information year for such item or service with respect to such plan or coverage or before the first year for which an eligible database has sufficient information to calculate a rate under paragraph (c)(3)(i) of this section in the immediately preceding year), the plan must calculate the qualifying payment amount by increasing the qualifying payment amount determined under paragraph (c)(4)(i) of this section or this paragraph (c)(4)(ii), as applicable, for such item or service for the year immediately preceding such subsequent year, by the percentage increase in CPI-U over such preceding year;

(iii) For an item or service furnished in the first sufficient information year for such item or service with respect to such plan or the first year for which an eligible database has sufficient information to calculate a rate under paragraph (c)(3)(i) of this section in the immediately preceding year, the plan or issuer must calculate the qualifying payment amount in accordance with paragraph (c)(3) of this section.

(d) *Information to be shared about qualifying payment amount.* In cases in which the recognized amount with respect to an item or service furnished by a nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services is the qualifying payment amount, the plan must provide in writing, in paper or electronic form, to the provider or facility, as applicable—

(1) With an initial payment or notice of denial of payment under § 54.9816–4T, § 54.9816–5T, or § 54.9817–1T:

(i) The qualifying payment amount for each item or service involved;

(ii) A statement to certify that, based on the determination of the plan—

(A) The qualifying payment amount applies for purposes of the recognized amount (or, in the case of air ambulance services, for calculating the participant's, beneficiary's, or enrollee's cost sharing); and

(B) Each qualifying payment amount shared with the provider or facility was determined in compliance with this section;

(iii) A statement that if the provider or facility, as applicable, wishes to initiate a 30-day open negotiation period for purposes of determining the amount of total payment, the provider or facility may contact the appropriate person or office to initiate open negotiation, and that if the 30-day negotiation period does not result in a

determination, generally, the provider or facility may initiate the independent dispute resolution process within 4 days after the end of the open negotiation period; and

(iv) Contact information, including a telephone number and email address, for the appropriate person or office to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service.

(2) In a timely manner upon request of the provider or facility:

(i) Information about whether the qualifying payment amount for items and services involved included contracted rates that were not on a fee-for-service basis for those specific items and services and whether the qualifying payment amount for those items and services was determined using underlying fee schedule rates or a derived amount;

(ii) If a plan uses an eligible database under paragraph (c)(3) of this section to determine the qualifying payment amount, information to identify which database was used; and

(iii) If a related service code was used to determine the qualifying payment amount for an item or service billed under a new service code under paragraph (c)(4)(i) or (ii) of this section, information to identify the related service code; and

(iv) If applicable, a statement that the plan's contracted rates include risk-sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments for the items and services involved (as applicable) that were excluded for purposes of calculating the qualifying payment amount.

(e) *Certain access fees to databases.* In the case of a plan that, pursuant to this section, uses an eligible database to determine the qualifying payment amount for an item or service, the plan is responsible for any costs associated with accessing such database.

(f) *Audits.* See 45 CFR 149.140(f) for audit procedures that apply with respect to ensuring that a plan is in compliance with the requirement of applying a qualifying payment amount under §§ 54.9816–4T, 54.9816–5T, 54.9817–1T, and this section, and ensuring that such amount so applied satisfies the requirements under this section, as applicable.

(g) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022.

§ 54.9816–7T Complaints process for surprise medical bills regarding group health plans (temporary).

See 45 CFR 149.150 for the process to receive and resolve complaints that a specific group health plan may be failing to meet the requirement of applying a qualifying payment amount under §§ 54.9816–4T, 54.9816–5T, 54.9816–6T, and 54.9817–1T, which may warrant an investigation.

§ 54.9817–1T Preventing surprise medical bills for air ambulance services (temporary).

(a) *In general.* If a group health plan provides or covers any benefits for air ambulance services, the plan must cover such services from a nonparticipating provider of air ambulance services in accordance with paragraph (b) of this section.

(b) *Coverage requirements.* A plan described in paragraph (a) of this section must provide coverage of air ambulance services in the following manner—

(1) The cost-sharing requirements with respect to the services must be the same requirements that would apply if the services were provided by a participating provider of air ambulance services.

(2) The cost-sharing requirement must be calculated as if the total amount that would have been charged for the services by a participating provider of air ambulance services were equal to the lesser of the qualifying payment amount (as determined in accordance with § 54.9816–6T) or the billed amount for the services.

(3) The cost-sharing amounts must be counted towards any in-network deductible and in-network out-of-pocket maximums (including the annual limitation on cost sharing under section 2707(b) of the Public Health Service Act) (as applicable) applied under the plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if the cost-sharing payments were made with respect to services furnished by a participating provider of air ambulance services.

(4) The plan must—

(i) Not later than 30 calendar days after the bill for the services is transmitted by the provider of air ambulance services, determine whether the services are covered under the plan and, if the services are covered, send to the provider an initial payment or a notice of denial of payment. For purposes of this paragraph (b)(4)(i), the 30-calendar-day period begins on the date the plan receives the information necessary to decide a claim for payment for the services.

(ii) Pay a total plan payment directly to the nonparticipating provider furnishing such air ambulance services that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services (as determined in accordance with paragraphs (b)(1) and (2) of this section), less any initial payment amount made under paragraph (b)(4)(i) of this section. The total plan payment must be made in accordance with the timing requirement described in section 9817(b)(6), or in cases where the out-of-network rate is determined under a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement.

(c) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022.

§ 54.9822–1T Choice of health care professional (temporary).

(a) *Choice of health care professional*—(1) *Designation of primary care provider*—(i) *In general.* If a group health plan, requires or provides for designation by a participant or beneficiary of a participating primary care provider, then the plan must permit each participant or beneficiary to designate any participating primary care provider who is available to accept the participant or beneficiary. In such a case, the plan must comply with the rules of paragraph (a)(4) of this section by informing each participant of the terms of the plan regarding designation of a primary care provider.

(ii) *Construction.* Nothing in paragraph (a)(1)(i) of this section is to be construed to prohibit the application of reasonable and appropriate geographic limitations with respect to the selection of primary care providers, in accordance with the terms of the plan, the underlying provider contracts, and applicable State law.

(iii) *Example.* The rules of this paragraph (a)(1) are illustrated by the following example:

(A) *Facts.* A group health plan requires individuals covered under the plan to designate a primary care provider. The plan permits each individual to designate any primary care provider participating in the plan's network who is available to accept the individual as the individual's primary care provider. If an individual has not designated a primary care provider, the plan designates one until the individual has made a designation. The plan provides a notice that satisfies the requirements of paragraph (a)(4) of this

section regarding the ability to designate a primary care provider.

(B) *Conclusion.* In this *Example*, the plan has satisfied the requirements of this paragraph (a).

(2) *Designation of pediatrician as primary care provider*—(i) *In general.* If a group health plan requires or provides for the designation of a participating primary care provider for a child by a participant or beneficiary, the plan must permit the participant or beneficiary to designate a physician (allopathic or osteopathic) who specializes in pediatrics (including pediatric subspecialties, based on the scope of that provider's license under applicable State law) as the child's primary care provider if the provider participates in the network of the plan and is available to accept the child. In such a case, the plan must comply with the rules of paragraph (a)(4) of this section by informing each participant of the terms of the plan regarding designation of a pediatrician as the child's primary care provider.

(ii) *Construction.* Nothing in paragraph (a)(2)(i) of this section is to be construed to waive any exclusions of coverage under the terms and conditions of the plan with respect to coverage of pediatric care.

(iii) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

(A) *Example 1*—(1) *Facts.* A group health plan's HMO designates for each participant a physician who specializes in internal medicine to serve as the primary care provider for the participant and any beneficiaries. Participant A requests that Pediatrician B be designated as the primary care provider for A's child. B is a participating provider in the HMO's network and is available to accept the child.

(2) *Conclusion.* In this *Example 1*, the HMO must permit A's designation of B as the primary care provider for A's child in order to comply with the requirements of this paragraph (a)(2).

(B) *Example 2*—(1) *Facts.* Same facts as *Example 1* (paragraph (a)(2)(iii)(A) of this section), except that A takes A's child to B for treatment of the child's severe shellfish allergies. B wishes to refer A's child to an allergist for treatment. The HMO, however, does not provide coverage for treatment of food allergies, nor does it have an allergist participating in its network, and it therefore refuses to authorize the referral.

(2) *Conclusion.* In this *Example 2*, the HMO has not violated the requirements of this paragraph (a)(2) because the exclusion of treatment for food allergies

is in accordance with the terms of A's coverage.

(3) *Patient access to obstetrical and gynecological care*—(i) *General rights*—(A) *Direct access.* A group health plan described in paragraph (a)(3)(ii) of this section, may not require authorization or referral by the plan, or any person (including a primary care provider) in the case of a female participant or beneficiary who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. In such a case, the plan must comply with the rules of paragraph (a)(4) of this section by informing each participant that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology. The plan may require such a professional to agree to otherwise adhere to the plan's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan. For purposes of this paragraph (a)(3), a health care professional who specializes in obstetrics or gynecology is any individual (including a person other than a physician) who is authorized under applicable State law to provide obstetrical or gynecological care.

(B) *Obstetrical and gynecological care.* A group health plan described in paragraph (a)(3)(ii) of this section must treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under paragraph (a)(3)(i)(A) of this section, by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(ii) *Application of paragraph.* A group health plan is described in this paragraph (a)(3) if the plan—

(A) Provides coverage for obstetrical or gynecological care; and

(B) Requires the designation by a participant or beneficiary of a participating primary care provider.

(iii) *Construction.* Nothing in paragraph (a)(3)(i) of this section is to be construed to—

(A) Waive any exclusions of coverage under the terms and conditions of the plan with respect to coverage of obstetrical or gynecological care; or

(B) Preclude the group health plan involved from requiring that the obstetrical or gynecological provider notify the primary care health care

professional or the plan of treatment decisions.

(iv) *Examples.* The rules of this paragraph (a)(3) are illustrated by the following examples:

(A) *Example 1—(1) Facts.* A group health plan requires each participant to designate a physician to serve as the primary care provider for the participant and the participant's family. Participant A, a female, requests a gynecological exam with Physician B, an in-network physician specializing in gynecological care. The group health plan requires prior authorization from A's designated primary care provider for the gynecological exam.

(2) *Conclusion.* In this *Example 1*, the group health plan has violated the requirements of this paragraph (a)(3) because the plan requires prior authorization from A's primary care provider prior to obtaining gynecological services.

(B) *Example 2—(1) Facts.* Same facts as *Example 1* (paragraph (a)(3)(iv)(A) of this section) except that A seeks gynecological services from C, an out-of-network provider.

(2) *Conclusion.* In this *Example 2*, the group health plan has not violated the requirements of this paragraph (a)(3) by requiring prior authorization because C is not a participating health care provider.

(C) *Example 3—(1) Facts.* Same facts as *Example 1* (paragraph (a)(3)(iv)(A) of this section) except that the group health plan only requires B to inform A's designated primary care physician of treatment decisions.

(2) *Conclusion.* In this *Example 3*, the group health plan has not violated the requirements of this paragraph (a)(3) because A has direct access to B without prior authorization. The fact that the group health plan requires the designated primary care physician to be notified of treatment decisions does not violate this paragraph (a)(3).

(D) *Example 4—(1) Facts.* A group health plan requires each participant to designate a physician to serve as the primary care provider for the participant and the participant's family. The group health plan requires prior authorization before providing benefits for uterine fibroid embolization.

(2) *Conclusion.* In this *Example 4*, the plan requirement for prior authorization before providing benefits for uterine fibroid embolization does not violate the requirements of this paragraph (a)(3) because, though the prior authorization requirement applies to obstetrical services, it does not restrict access to any providers specializing in obstetrics or gynecology.

(4) *Notice of right to designate a primary care provider—(i) In general.* If a group health plan requires the designation by a participant or beneficiary of a primary care provider, the plan must provide a notice informing each participant of the terms of the plan regarding designation of a primary care provider and of the rights—

(A) Under paragraph (a)(1)(i) of this section, that any participating primary care provider who is available to accept the participant or beneficiary can be designated;

(B) Under paragraph (a)(2)(i) of this section, with respect to a child, that any participating physician who specializes in pediatrics can be designated as the primary care provider; and

(C) Under paragraph (a)(3)(i) of this section, that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology.

(ii) *Timing.* In the case of a group health plan, the notice described in paragraph (a)(4)(i) of this section must be included whenever the plan provides a participant with a summary plan description or other similar description of benefits under the plan.

(iii) *Model language.* The following model language can be used to satisfy the notice requirement described in paragraph (a)(4)(i) of this section:

(A) For plans that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

[Name of group health plan] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator] at [insert contact information].

(B) For plans that require or allow for the designation of a primary care provider for a child, add:

For children, you may designate a pediatrician as the primary care provider.

(C) For plans that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from [name of group health plan] or from any other person (including a primary care

provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator] at [insert contact information].

(b) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022.

Department of Labor

Employee Benefits Security Administration

29 CFR Chapter XXV

For the reasons set forth in the preamble, the Department of Labor amends 29 CFR part 2590 as set forth below:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS.

■ 9. The authority citation for part 2590 is revised to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a–n, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L. 104–191, 110 Stat. 1936; sec. 401(b), Pub. L. 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111–148, 124 Stat. 119, as amended by Pub. L. 111–152, 124 Stat. 1029; Division M, Pub. L. 113–235, 128 Stat. 2130; Pub. L. 116–260 134 Stat. 1182; Secretary of Labor's Order 1–2011, 77 FR 1088 (Jan. 9, 2012).

■ 10. Section 2590.715–2719A is amended by revising paragraph (c) to read as follows:

§ 2590.715–2719A Patient protections.

* * * * *

(c) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning before January 1, 2022. *See also* §§ 2590.716–4 through 2590.716–7, 2590.717–1, and 2590.722 of this part for rules applicable with respect to plan years beginning on or after January 1, 2022.

Subpart D [Redesignated as Subpart E]

■ 11. Redesignate subpart D as subpart E and add a new subpart D to read as follows:

Subpart D—Surprise Billing and Transparency Requirements

Sec.

- 2590.716–1 Basis and scope.
- 2590.716–2 Applicability.
- 2590.716–3 Definitions.
- 2590.716–4 Preventing surprise medical bills for emergency services.
- 2590.716–5 Preventing surprise medical bills for non-emergency services performed by nonparticipating providers at certain participating facilities.
- 2590.716–6 Methodology for calculating qualifying payment amount.
- 2590.716–7 Complaints process for surprise medical bills regarding group health plans and group health insurance coverage.
- 2590.717–1 Preventing surprise medical bills for air ambulance services.
- 2590.722 Choice of health care professional.

Subpart D—Surprise Billing and Transparency Requirements**§ 2590.716–1 Basis and scope.**

(a) *Basis.* Sections 2590.716–1 through 2590.722 implement section 716–722 of ERISA.

(b) *Scope.* This part establishes standards for group health plans and health insurance issuers offering group health insurance coverage with respect to surprise medical bills, transparency in health care coverage, and additional patient protections.

§ 2590.716–2 Applicability.

(a) *In general.* The requirements in §§ 2590.716–4 through 2590.716–7, 2590.717–1, and 2590.722 apply to group health plans and health insurance issuers offering group health insurance coverage (including grandfathered health plans as defined in § 2590.715–1251), except as specified in paragraph (b) of this section.

(b) *Exceptions.* The requirements in §§ 2590.716–4 through 2590.716–7, 2590.717–1, and 2590.722 do not apply to the following:

(1) Excepted benefits as described in § 2590.732.

(2) Short-term, limited-duration insurance as defined in § 2590.701–2.

(3) Health reimbursement arrangements or other account-based group health plans as described in § 2590.715–2711(d).

§ 2590.716–3 Definitions.

The definitions in this part apply to §§ 2590.716 through 2590.722, unless otherwise specified. In addition, for purposes of §§ 2590.716 through 2590.722, the following definitions apply:

Air ambulance service means medical transport by a rotary wing air ambulance, as defined in 42 CFR

414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.

Cost sharing means the amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the group health plan or health insurance coverage. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by out-of-network providers, or the cost of items or services that are not covered under a group health plan or health insurance coverage.

Emergency department of a hospital includes a hospital outpatient department that provides emergency services.

Emergency medical condition has the meaning given the term in § 2590.716–4(c)(1).

Emergency services has the meaning given the term in § 2590.716–4(c)(2).

Health care facility, with respect to a group health plan or group health insurance coverage, in the context of non-emergency services, is each of the following:

- (1) A hospital (as defined in section 1861(e) of the Social Security Act);
- (2) A hospital outpatient department;
- (3) A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
- (4) An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Independent freestanding emergency department means a health care facility (not limited to those described in the definition of health care facility with respect to non-emergency services) that—

- (1) Is geographically separate and distinct and licensed separately from a hospital under applicable State law; and
- (2) Provides any emergency services as described in § 2590.716–4(c)(2)(i).

Nonparticipating emergency facility means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to services that pursuant to § 2590.716–4(c)(2)(ii) are included as emergency services), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage, respectively.

Nonparticipating provider means any physician or other health care provider who does not have a contractual relationship directly or indirectly with a group health plan or group health

insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage, respectively.

Notice of denial of payment means, with respect to an item or service for which benefits subject to the protections of §§ 2590.716–4, 2590.716–5, and 2590.717–1 are provided or covered, a written notice from the plan or issuer to the health care provider, facility, or provider of air ambulance services, as applicable, that payment for such item or service will not be made by the plan or coverage and which explains the reason for denial. The term notice of denial of payment does not include a notice of benefit denial due to an adverse benefit determination as defined in § 2560.503–1 of this chapter.

Out-of-network rate means, with respect to an item or service furnished by a nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services—

(1) Subject to paragraph (3) of this definition, in a State that has in effect a specified State law, the amount determined in accordance with such law;

(2) Subject to paragraph (3) of this definition, in a State that does not have in effect a specified State law—

(i) Subject to paragraph (2)(ii) of this definition, if the nonparticipating provider or nonparticipating emergency facility and the plan or issuer agree on an amount of payment (including if the amount agreed upon is the initial payment sent by the plan or issuer under 26 CFR 54.9816–4T(b)(3)(iv)(A), 54.9816–5T(c)(3), or 54.9817–1T(b)(4)(i); § 2590.716–4(b)(3)(iv)(A), § 2590.716–5(c)(3), or § 2590.717–1(b)(4)(i); or 45 CFR 149.110(b)(3)(iv)(A), 149.120(c)(3), or 149.130(b)(4)(i), as applicable, or is agreed on through negotiations with respect to such item or service), such agreed on amount; or

(ii) If the nonparticipating provider or nonparticipating emergency facility and the plan or issuer enter into the independent dispute resolution (IDR) process under section 9816(c) or 9817(b) of the Internal Revenue Code, section 716(c) or 717(b) of ERISA, or section 2799A–1(c) or 2799A–2(b) of the PHS Act, as applicable, and do not agree before the date on which a certified IDR entity makes a determination with respect to such item or service under such subsection, the amount of such determination; or

(3) In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies with respect to the plan or issuer; the nonparticipating provider or

nonparticipating emergency facility; and the item or service, the amount that the State approves under the All-Payer Model Agreement for the item or service.

Participating emergency facility means any emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to services that pursuant to § 2590.716–4(c)(2)(ii) are included as emergency services), that has a contractual relationship directly or indirectly with a group health plan or health insurance issuer offering group health insurance coverage setting forth the terms and conditions on which a relevant item or service is provided to a participant or beneficiary under the plan or coverage, respectively. A single case agreement between an emergency facility and a plan or issuer that is used to address unique situations in which a participant or beneficiary requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

Participating health care facility means any health care facility described in this section that has a contractual relationship directly or indirectly with a group health plan or health insurance issuer offering group health insurance coverage setting forth the terms and conditions on which a relevant item or service is provided to a participant or beneficiary under the plan or coverage, respectively. A single case agreement between a health care facility and a plan or issuer that is used to address unique situations in which a participant or beneficiary requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

Participating provider means any physician or other health care provider who has a contractual relationship directly or indirectly with a group health plan or health insurance issuer offering group health insurance coverage setting forth the terms and conditions on which a relevant item or service is provided to a participant or beneficiary under the plan or coverage, respectively.

Physician or health care provider means a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, but does not include a provider of air ambulance services.

Provider of air ambulance services means an entity that is licensed under

applicable State and Federal law to provide air ambulance services.

Same or similar item or service has the meaning given the term in § 2590.716–6(a)(13).

Service code has the meaning given the term in § 2590.716–6(a)(14).

Qualifying payment amount has the meaning given the term in § 2590.716–6(a)(16).

Recognized amount means, with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility—

(1) Subject to paragraph (3) of this definition, in a State that has in effect a specified State law, the amount determined in accordance with such law.

(2) Subject to paragraph (3) of this definition, in a State that does not have in effect a specified State law, the lesser of—

(i) The amount that is the qualifying payment amount (as determined in accordance with § 2590.716–6); or

(ii) The amount billed by the provider or facility.

(3) In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies with respect to the plan or issuer; the nonparticipating provider or nonparticipating emergency facility; and the item or service, the amount that the State approves under the All-Payer Model Agreement for the item or service.

Specified State law means a State law that provides for a method for determining the total amount payable under a group health plan or group health insurance coverage offered by a health insurance issuer to the extent such State law applies for an item or service furnished by a nonparticipating provider or nonparticipating emergency facility (including where it applies because the State has allowed a plan that is not otherwise subject to applicable State law an opportunity to opt in, subject to section 514 of ERISA). A group health plan that opts into such a specified State law must do so for all items and services to which the specified State law applies and in a manner determined by the applicable State authority, and must prominently display in its plan materials describing the coverage of out-of-network services a statement that the plan has opted into the specified State law, identify the relevant State (or States), and include a general description of the items and services provided by nonparticipating facilities and providers that are covered by the specified State law.

State means each of the 50 States, the District of Columbia, Puerto Rico, the

Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Treating provider is a physician or health care provider who has evaluated the individual.

Visit, with respect to items and services furnished to an individual at a health care facility, includes, in addition to items and services furnished by a provider at the facility, equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is at the facility.

§ 2590.716–4 Preventing surprise medical bills for emergency services.

(a) *In general.* If a group health plan, or a health insurance issuer offering group health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department, the plan or issuer must cover emergency services, as defined in paragraph (c)(2) of this section, and this coverage must be provided in accordance with paragraph (b) of this section.

(b) *Coverage requirements.* A plan or issuer described in paragraph (a) of this section must provide coverage for emergency services in the following manner—

(1) Without the need for any prior authorization determination, even if the services are provided on an out-of-network basis.

(2) Without regard to whether the health care provider furnishing the emergency services is a participating provider or a participating emergency facility, as applicable, with respect to the services.

(3) If the emergency services are provided by a nonparticipating provider or a nonparticipating emergency facility—

(i) Without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities.

(ii) Without imposing cost-sharing requirements that are greater than the requirements that would apply if the services were provided by a participating provider or a participating emergency facility.

(iii) By calculating the cost-sharing requirement as if the total amount that would have been charged for the services by such participating provider

or participating emergency facility were equal to the recognized amount for such services.

(iv) The plan or issuer—

(A) Not later than 30 calendar days after the bill for the services is transmitted by the provider or facility (or, in cases where the recognized amount is determined by a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement), determines whether the services are covered under the plan or coverage and, if the services are covered, sends to the provider or facility, as applicable, an initial payment or a notice of denial of payment. For purposes of this paragraph (b)(3)(iv)(A), the 30-calendar-day period begins on the date the plan or issuer receives the information necessary to decide a claim for payment for the services.

(B) Pays a total plan or coverage payment directly to the nonparticipating provider or nonparticipating facility that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services (as determined in accordance with paragraphs (b)(3)(ii) and (iii) of this section), less any initial payment amount made under paragraph (b)(3)(iv)(A) of this section. The total plan or coverage payment must be made in accordance with the timing requirement described in section 716(c)(6) of ERISA, or in cases where the out-of-network rate is determined under a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement.

(v) By counting any cost-sharing payments made by the participant or beneficiary with respect to the emergency services toward any in-network deductible or in-network out-of-pocket maximums (including the annual limitation on cost sharing under section 2707(b) of the PHS Act) (as applicable) applied under the plan or coverage (and the in-network deductible and in-network out-of-pocket maximums must be applied) in the same manner as if the cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility.

(4) Without limiting what constitutes an emergency medical condition (as defined in paragraph (c)(1) of this section) solely on the basis of diagnosis codes.

(5) Without regard to any other term or condition of the coverage, other than—

(i) The exclusion or coordination of benefits (to the extent not inconsistent with benefits for an emergency medical condition, as defined in paragraph (c)(1) of this section).

(ii) An affiliation or waiting period (each as defined in § 2590.701–2).

(iii) Applicable cost sharing.

(c) *Definitions.* In this section—

(1) *Emergency medical condition* means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)

(2) *Emergency services* means, with respect to an emergency medical condition—

(i) *In general.* (A) An appropriate medical screening examination (as required under section 1867 of the Social Security Act (42 U.S.C. 1395dd)) or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

(ii) *Inclusion of additional services.* (A) Subject to paragraph (c)(2)(ii)(B) of this section, items and services—

(1) For which benefits are provided or covered under the plan or coverage; and

(2) That are furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the participant or beneficiary is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in paragraph (c)(2)(i) of this section are furnished.

(B) Items and services described in paragraph (c)(2)(ii)(A) of this section are not included as emergency services if all of the conditions in 45 CFR 149.410(b) are met.

(3) *To stabilize*, with respect to an emergency medical condition, has the meaning given such term in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(d) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022.

§ 2590.716–5 Preventing surprise medical bills for non-emergency services performed by nonparticipating providers at certain participating facilities.

(a) *In general.* If a group health plan, or a health insurance issuer offering group health insurance coverage, provides or covers any benefits with respect to items and services described in paragraph (b) of this section, the plan or issuer must cover the items and services when furnished by a nonparticipating provider in accordance with paragraph (c) of this section.

(b) *Items and services described.* The items and services described in this paragraph (b) are items and services (other than emergency services) furnished to a participant or beneficiary by a nonparticipating provider with respect to a visit at a participating health care facility, unless the provider has satisfied the notice and consent criteria of 45 CFR 149.420(c) through (i) with respect to such items and services.

(c) *Coverage requirements.* In the case of items and services described in paragraph (b) of this section, the plan or issuer—

(1) Must not impose a cost-sharing requirement for the items and services that is greater than the cost-sharing requirement that would apply if the items or services had been furnished by a participating provider.

(2) Must calculate the cost-sharing requirements as if the total amount that would have been charged for the items and services by such participating provider were equal to the recognized amount for the items and services.

(3) Not later than 30 calendar days after the bill for the items or services is

transmitted by the provider (or in cases where the recognized amount is determined by a specified State law or All-Payer Model Agreement, such other timeframe as specified under the State law or All-Payer Model Agreement), must determine whether the items and services are covered under the plan or coverage and, if the items and services are covered, send to the provider an initial payment or a notice of denial of payment. For purposes of this paragraph (c)(3), the 30-calendar-day period begins on the date the plan or issuer receives the information necessary to decide a claim for payment for the items or services.

(4) Must pay a total plan or coverage payment directly to the nonparticipating provider that is equal to the amount by which the out-of-network rate for the items and services involved exceeds the cost-sharing amount for the items and services (as determined in accordance with paragraphs (c)(1) and (2) of this section), less any initial payment amount made under paragraph (c)(3) of this section. The total plan or coverage payment must be made in accordance with the timing requirement described in section 716(c)(6) of ERISA, or in cases where the out-of-network rate is determined under a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement.

(5) Must count any cost-sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums (including the annual limitation on cost sharing under section 2707(b) of the PHS Act) (as applicable) applied under the plan or coverage (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a participating provider.

(d) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022.

§ 2590.716–6 Methodology for calculating qualifying payment amount.

(a) *Definitions.* For purposes of this section, the following definitions apply:

(1) *Contracted rate* means the total amount (including cost sharing) that a group health plan or health insurance issuer has contractually agreed to pay a participating provider, facility, or provider of air ambulance services for covered items and services, whether directly or indirectly, including through a third-party administrator or pharmacy benefit manager. Solely for purposes of

this definition, a single case agreement, letter of agreement, or other similar arrangement between a provider, facility, or air ambulance provider and a plan or issuer, used to supplement the network of the plan or coverage for a specific participant or beneficiary in unique circumstances, does not constitute a contract.

(2) *Derived amount* has the meaning given the term in § 2590.715–2715A1.

(3) *Eligible database* means—

(i) A State all-payer claims database; or

(ii) Any third-party database which—
(A) Is not affiliated with, or owned or controlled by, any health insurance issuer, or a health care provider, facility, or provider of air ambulance services (or any member of the same controlled group as, or under common control with, such an entity). For purposes of this paragraph (a)(3)(ii)(A), the term controlled group means a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended;

(B) Has sufficient information reflecting in-network amounts paid by group health plans or health insurance issuers offering group health insurance coverage to providers, facilities, or providers of air ambulance services for relevant items and services furnished in the applicable geographic region; and

(C) Has the ability to distinguish amounts paid to participating providers and facilities by commercial payers, such as group health plans and health insurance issuers offering group health insurance coverage, from all other claims data, such as amounts billed by nonparticipating providers or facilities and amounts paid by public payers, including the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of the Social Security Act (or a demonstration project under title XI of the Social Security Act), or the Children's Health Insurance Program under title XXI of the Social Security Act.

(4) *Facility of the same or similar facility type* means, with respect to emergency services, either—

(i) An emergency department of a hospital; or

(ii) An independent freestanding emergency department.

(5) *First coverage year* means, with respect to an item or service for which coverage is not offered in 2019 under a group health plan or group health insurance coverage offered by a health insurance issuer, the first year after 2019 for which coverage for such item or service is offered under that plan or coverage.

(6) *First sufficient information year* means, with respect to a group health plan or group health insurance coverage offered by a health insurance issuer—

(i) In the case of an item or service for which the plan or coverage does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section in 2019, the first year after 2022 for which the plan or issuer has sufficient information to calculate the median of such contracted rates in the year immediately preceding that first year after 2022; and

(ii) In the case of a newly covered item or service, the first year after the first coverage year for such item or service with respect to such plan or coverage for which the plan or issuer has sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section in the year immediately preceding that first year.

(7) *Geographic region* means—

(i) For items and services other than air ambulance services—

(A) Subject to paragraphs (a)(7)(i)(B) and (C) of this section, one region for each metropolitan statistical area, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in a State, and one region consisting of all other portions of the State.

(B) If a plan or issuer does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an item or service provided in a geographic region described in paragraph (a)(7)(i)(A) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in the State, and one region consisting of all other portions of the State.

(C) If a plan or issuer does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an item or service provided in a geographic region described in paragraph (a)(7)(i)(B) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in each Census division and one region consisting of all other portions of the Census division, as described by the U.S. Census Bureau.

(ii) For air ambulance services—

(A) Subject to paragraph (a)(7)(ii)(B) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of

Management and Budget and published by the U.S. Census Bureau, in the State, and one region consisting of all other portions of the State, determined based on the point of pick-up (as defined in 42 CFR 414.605).

(B) If a plan or issuer does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an air ambulance service provided in a geographic region described in paragraph (a)(7)(ii)(A) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in each Census division and one region consisting of all other portions of the Census division, as described by the U.S. Census Bureau, determined based on the point of pick-up (as defined in 42 CFR 414.605).

(8) *Insurance market* is, irrespective of the State, one of the following:

(i) The individual market (other than short-term, limited-duration insurance or individual health insurance coverage that consists solely of excepted benefits).

(ii) The large group market (other than coverage that consists solely of excepted benefits).

(iii) The small group market (other than coverage that consists solely of excepted benefits).

(iv) In the case of a self-insured group health plan, all self-insured group health plans (other than account-based plans, as defined in § 2590.715–2711(d)(6)(i), and plans that consist solely of excepted benefits) of the same plan sponsor, or at the option of the plan sponsor, all self-insured group health plans administered by the same entity (including a third-party administrator contracted by the plan), to the extent otherwise permitted by law, that is responsible for calculating the qualifying payment amount on behalf of the plan.

(9) *Modifiers* mean codes applied to the service code that provide a more specific description of the furnished item or service and that may adjust the payment rate or affect the processing or payment of the code billed.

(10) *Newly covered item or service* means an item or service for which coverage was not offered in 2019 under a group health plan or group health insurance coverage offered by a health insurance issuer, but that is offered under the plan or coverage in a year after 2019.

(11) *New service code* means a service code that was created or substantially revised in a year after 2019.

(12) *Provider in the same or similar specialty* means the practice specialty of a provider, as identified by the plan or issuer consistent with the plan's or issuer's usual business practice, except that, with respect to air ambulance services, all providers of air ambulance services are considered to be a single provider specialty.

(13) *Same or similar item or service* means a health care item or service billed under the same service code, or a comparable code under a different procedural code system.

(14) *Service code* means the code that describes an item or service using the Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS), or Diagnosis-Related Group (DRG) codes.

(15) *Sufficient information* means, for purposes of determining whether a group health plan or health insurance issuer offering group health insurance coverage has sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section—

(i) The plan or issuer has at least three contracted rates on January 31, 2019, to calculate the median of the contracted rates in accordance with paragraph (b) of this section; or

(ii) For an item or service furnished during a year after 2022 that is used to determine the first sufficient information year—

(A) The plan or issuer has at least three contracted rates on January 31 of the year immediately preceding that year to calculate the median of the contracted rates in accordance with paragraph (b) of this section; and

(B) The contracted rates under paragraph (a)(15)(ii)(A) of this section account (or are reasonably expected to account) for at least 25 percent of the total number of claims paid for that item or service for that year with respect to all plans of the sponsor (or the administering entity as provided in paragraph (a)(8)(iv) of this section, if applicable) or all coverage offered by the issuer that are offered in the same insurance market.

(16) *Qualifying payment amount* means, with respect to a sponsor of a group health plan or health insurance issuer offering group health insurance coverage, the amount calculated using the methodology described in paragraph (c) of this section.

(17) *Underlying fee schedule rate* means the rate for a covered item or service from a particular participating provider, providers, or facility that a group health plan or health insurance issuer uses to determine a participant's or beneficiary's cost-sharing liability for

the item or service, when that rate is different from the contracted rate.

(b) *Methodology for calculation of median contracted rate*—(1) *In general.* The median contracted rate for an item or service is calculated by arranging in order from least to greatest the contracted rates of all group health plans of the plan sponsor (or the administering entity as provided in paragraph (a)(8)(iv) of this section, if applicable) or all group health insurance coverage offered by the issuer in the same insurance market for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the geographic region in which the item or service is furnished and selecting the middle number. If there are an even number of contracted rates, the median contracted rate is the average of the middle two contracted rates. In determining the median contracted rate, the amount negotiated under each contract is treated as a separate amount. If a plan or issuer has a contract with a provider group or facility, the rate negotiated with that provider group or facility under the contract is treated as a single contracted rate if the same amount applies with respect to all providers of such provider group or facility under the single contract. However, if a plan or issuer has a contract with multiple providers, with separate negotiated rates with each particular provider, each unique contracted rate with an individual provider constitutes a single contracted rate. Further, if a plan or issuer has separate contracts with individual providers, the contracted rate under each such contract constitutes a single contracted rate (even if the same amount is paid to multiple providers under separate contracts).

(2) *Calculation rules.* In calculating the median contracted rate, a plan or issuer must:

(i) Calculate the median contracted rate with respect to all plans of such sponsor (or the administering entity as provided in paragraph (a)(8)(iv) of this section, if applicable) or all coverage offered by such issuer that are offered in the same insurance market;

(ii) Calculate the median contracted rate using the full contracted rate applicable to the service code, except that the plan or issuer must—

(A) Calculate separate median contracted rates for CPT code modifiers “26” (professional component) and “TC” (technical component);

(B) For anesthesia services, calculate a median contracted rate for the

anesthesia conversion factor for each service code;

(C) For air ambulance services, calculate a median contracted rate for the air mileage service codes (A0435 and A0436); and

(D) Where contracted rates otherwise vary based on applying a modifier code, calculate a separate median contracted rate for each such service code-modifier combination;

(iii) In the case of payments made by a plan or issuer that are not on a fee-for-service basis (such as bundled or capitation payments), calculate a median contracted rate for each item or service using the underlying fee schedule rates for the relevant items or services. If the plan or issuer does not have an underlying fee schedule rate for the item or service, it must use the derived amount to calculate the median contracted rate; and

(iv) Exclude risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments.

(3) *Provider specialties; facility types.*

(i) If a plan or issuer has contracted rates that vary based on provider specialty for a service code, the median contracted rate is calculated separately for each provider specialty, as applicable.

(ii) If a plan or issuer has contracted rates for emergency services that vary based on facility type for a service code, the median contracted rate is calculated separately for each facility of the same or similar facility type.

(c) *Methodology for calculation of the qualifying payment amount—(1) In general.* (i) For an item or service (other than items or services described in paragraphs (c)(1)(iii) through (vii) of this section) furnished during 2022, the plan or issuer must calculate the qualifying payment amount by increasing the median contracted rate (as determined in accordance with paragraph (b) of this section) for the same or similar item or service under such plans or coverage, respectively, on January 31, 2019, by the combined percentage increase as published by the Department of the Treasury and the Internal Revenue Service to reflect the percentage increase in the CPI-U over 2019, such percentage increase over 2020, and such percentage increase over 2021.

(A) The combined percentage increase for 2019, 2020, and 2021 will be published in guidance by the Internal Revenue Service. The Department of the Treasury and the Internal Revenue Service will calculate the percentage increase using the CPI-U published by the Bureau of Labor Statistics of the Department of Labor.

(B) For purposes of this paragraph (c)(1)(i), the CPI-U for each calendar year is the average of the CPI-U as of the close of the 12-month period ending on August 31 of the calendar year, rounded to 10 decimal places.

(C) The combined percentage increase for 2019, 2020, and 2021 will be calculated as:

$$\text{CPI-U 2019/CPI-U 2018} \times \text{CPI-U 2020/CPI-U 2019} \times \text{CPI-U 2021/CPI-U 2020}$$

(ii) For an item or service (other than items or services described in paragraphs (c)(1)(iii) through (vii) of this section) furnished during 2023 or a subsequent year, the plan or issuer must calculate the qualifying payment amount by increasing the qualifying payment amount determined under paragraph (c)(1)(i) of this section, for such an item or service furnished in the immediately preceding year, by the percentage increase as published by the Department of the Treasury and the Internal Revenue Service.

(A) The percentage increase for any year after 2022 will be published in guidance by the Internal Revenue Service. The Department of the Treasury and Internal Revenue Service will calculate the percentage increase using the CPI-U published by the Bureau of Labor Statistics of the Department of Labor.

(B) For purposes of this paragraph (c)(1)(ii), the CPI-U for each calendar year is the average of the CPI-U as of the close of the 12-month period ending on August 31 of the calendar year, rounded to 10 decimal places.

(C) The combined percentage increase for any year will be calculated as CPI-U present year/CPI-U prior year.

(iii) For anesthesia services furnished during 2022, the plan or issuer must calculate the qualifying payment amount by first increasing the median contracted rate for the anesthesia conversion factor (as determined in accordance with paragraph (b) of this section) for the same or similar item or service under such plans or coverage, respectively, on January 31, 2019, in accordance with paragraph (c)(1)(i) of this section (referred to in this section as the indexed median contracted rate for the anesthesia conversion factor). The plan or issuer must then multiply the indexed median contracted rate for the anesthesia conversion factor by the sum of the base unit, time unit, and physical status modifier units of the participant or beneficiary to whom anesthesia services are furnished to determine the qualifying payment amount.

(A) The base units for an anesthesia service code are the base units for that

service code specified in the most recent edition (as of the date of service) of the American Society of Anesthesiologists Relative Value Guide.

(B) The time unit is measured in 15-minute increments or a fraction thereof.

(C) The physical status modifier on a claim is a standard modifier describing the physical status of the patient and is used to distinguish between various levels of complexity of the anesthesia services provided, and is expressed as a unit with a value between zero (0) and three (3).

(D) The anesthesia conversion factor is expressed in dollars per unit and is a contracted rate negotiated with the plan or issuer.

(iv) For anesthesia services furnished during 2023 or a subsequent year, the plan or issuer must calculate the qualifying payment amount by first increasing the indexed median contracted rate for the anesthesia conversion factor, determined under paragraph (c)(1)(iii) of this section for such services furnished in the immediately preceding year, in accordance with paragraph (c)(1)(ii) of this section. The plan or issuer must then multiply that amount by the sum of the base unit, time unit, and physical status modifier units for the participant or beneficiary to whom anesthesia services are furnished to determine the qualifying payment amount.

(v) For air ambulance services billed using the air mileage service codes (A0435 and A0436) that are furnished during 2022, the plan or issuer must calculate the qualifying payment amount for services billed using the air mileage service codes by first increasing the median contracted rate (as determined in accordance with paragraph (b) of this section), in accordance with paragraph (c)(1)(i) of this section (referred to in this section as the indexed median air mileage rate). The plan or issuer must then multiply the indexed median air mileage rate by the number of loaded miles provided to the participant or beneficiary to determine the qualifying payment amount.

(A) The air mileage rate is expressed in dollars per loaded mile flown, is expressed in statute miles (not nautical miles), and is a contracted rate negotiated with the plan or issuer.

(B) The number of loaded miles is the number of miles a patient is transported in the air ambulance vehicle.

(C) The qualifying payment amount for other service codes associated with air ambulance services is calculated in accordance with paragraphs (c)(1)(i) and (ii) of this section.

(vi) For air ambulance services billed using the air mileage service codes (A0435 and A0436) that are furnished during 2023 or a subsequent year, the plan or issuer must calculate the qualifying payment amount by first increasing the indexed median air mileage rate, determined under paragraph (c)(1)(v) of this section for such services furnished in the immediately preceding year, in accordance with paragraph (c)(1)(ii) of this section. The plan or issuer must then multiply the indexed median air mileage rate by the number of loaded miles provided to the participant or beneficiary to determine the qualifying payment amount.

(vii) For any other items or services for which a plan or issuer generally determines payment for the same or similar items or services by multiplying a contracted rate by another unit value, the plan or issuer must calculate the qualifying payment amount using a methodology that is similar to the methodology required under paragraphs (c)(1)(iii) through (vi) of this section and reasonably reflects the payment methodology for same or similar items or services.

(2) *New plans and coverage.* With respect to a sponsor of a group health plan or health insurance issuer offering group health insurance coverage in a geographic region in which the sponsor or issuer, respectively, did not offer any group health plan or health insurance coverage during 2019—

(i) For the first year in which the group health plan or group health insurance coverage, respectively, is offered in such region—

(A) If the plan or issuer has sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section, the plan or issuer must calculate the qualifying payment amount in accordance with paragraph (c)(1) of this section for items and services that are covered by the plan or coverage and furnished during the first year; and

(B) If the plan or issuer does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an item or service provided in a geographic region, the plan or issuer must determine the qualifying payment amount for the item or service in accordance with paragraph (c)(3)(i) of this section.

(ii) For each subsequent year the group health plan or group health insurance coverage, respectively, is offered in the region, the plan or issuer must calculate the qualifying payment amount by increasing the qualifying

payment amount determined under this paragraph (c)(2) for the items and services furnished in the immediately preceding year, in accordance with paragraph (c)(1)(ii), (iv), or (vi) of this section, as applicable.

(3) *Insufficient information; newly covered items and services.* In the case of a plan or issuer that does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section in 2019 (or, in the case of a newly covered item or service, in the first coverage year for such item or service with respect to such plan or coverage if the plan or issuer does not have sufficient information) for an item or service provided in a geographic region—

(i) For an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for the item or service with respect to the plan or coverage), the plan or issuer must calculate the qualifying payment amount by first identifying the rate that is equal to the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in the year immediately preceding the year in which the item or service is furnished (or, in the case of a newly covered item or service, the year immediately preceding such first coverage year) determined by the plan or issuer, respectively, through use of any eligible database, and then increasing that rate by the percentage increase in the CPI-U over such preceding year. For purposes of this section, in cases in which an eligible database is used to determine the qualifying payment amount with respect to an item or service furnished during a calendar year, the plan or issuer must use the same database for determining the qualifying payment amount for that item or service furnished through the last day of the calendar year, and if a different database is selected for some items or services, the basis for that selection must be one or more factors not directly related to the rate of those items or services (such as sufficiency of data for those items or services).

(ii) For an item or service furnished in a subsequent year (before the first sufficient information year for such item or service with respect to such plan or coverage), the plan or issuer must calculate the qualifying payment amount by increasing the qualifying payment amount determined under paragraph (c)(3)(i) of this section or this paragraph (c)(3)(ii), as applicable, for such item or service for the year immediately preceding such subsequent

year, by the percentage increase in CPI-U over such preceding year;

(iii) For an item or service furnished in the first sufficient information year for such item or service with respect to such plan or coverage, the plan or issuer must calculate the qualifying payment amount in accordance with paragraph (c)(1)(i), (iii), or (v) of this section, as applicable, except that in applying such paragraph to such item or service, the reference to ‘furnished during 2022’ is treated as a reference to furnished during such first sufficient information year, the reference to ‘in 2019’ is treated as a reference to such sufficient information year, and the increase described in such paragraph is not applied; and

(iv) For an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan or coverage, the plan or issuer must calculate the qualifying payment amount in accordance with paragraph (c)(1)(ii), (iv), or (vi) of this section, as applicable, except that in applying such paragraph to such item or service, the reference to ‘furnished during 2023 or a subsequent year’ is treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

(4) *New service codes.* In the case of a plan or issuer that does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section and determine the qualifying payment amount under paragraphs (c)(1) through (3) of this section because the item or service furnished is billed under a new service code—

(i) For an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for the item or service with respect to the plan or coverage), the plan or issuer must identify a reasonably related service code that existed in the immediately preceding year and—

(A) If the Centers for Medicare & Medicaid Services has established a Medicare payment rate for the item or service billed under the new service code, the plan or issuer must calculate the qualifying payment amount by first calculating the ratio of the rate that Medicare pays for the item or service billed under the new service code compared to the rate that Medicare pays for the item or service billed under the related service code, and then multiplying the ratio by the qualifying payment amount for an item or service billed under the related service code for

the year in which the item or service is furnished.

(B) If the Centers for Medicare & Medicaid Services has not established a Medicare payment rate for the item or service billed under the new service code, the plan or issuer must calculate the qualifying payment amount by first calculating the ratio of the rate that the plan or issuer reimburses for the item or service billed under the new service code compared to the rate that the plan or issuer reimburses for the item or service billed under the related service code, and then multiplying the ratio by the qualifying payment amount for an item or service billed under the related service code.

(ii) For an item or service furnished in a subsequent year (before the first sufficient information year for such item or service with respect to such plan or coverage or before the first year for which an eligible database has sufficient information to calculate a rate under paragraph (c)(3)(i) of this section in the immediately preceding year), the plan or issuer must calculate the qualifying payment amount by increasing the qualifying payment amount determined under paragraph (c)(4)(i) of this section or this paragraph (c)(4)(ii), as applicable, for such item or service for the year immediately preceding such subsequent year, by the percentage increase in CPI-U over such preceding year;

(iii) For an item or service furnished in the first sufficient information year for such item or service with respect to such plan or coverage or the first year for which an eligible database has sufficient information to calculate a rate under paragraph (c)(3)(i) of this section in the immediately preceding year, the plan or issuer must calculate the qualifying payment amount in accordance with paragraph (c)(3) of this section.

(d) *Information to be shared about qualifying payment amount.* In cases in which the recognized amount with respect to an item or service furnished by a nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services is the qualifying payment amount, the plan or issuer must provide in writing, in paper or electronic form, to the provider or facility, as applicable—

(1) With each initial payment or notice of denial of payment under § 2590.716–4, § 2590.716–5, or § 2590.717–1 of this part:

(i) The qualifying payment amount for each item or service involved;

(ii) A statement to certify that, based on the determination of the plan or issuer—

(A) The qualifying payment amount applies for purposes of the recognized amount (or, in the case of air ambulance services, for calculating the participant's or beneficiary's cost sharing); and

(B) Each qualifying payment amount shared with the provider or facility was determined in compliance with this section;

(iii) A statement that if the provider or facility, as applicable, wishes to initiate a 30-day open negotiation period for purposes of determining the amount of total payment, the provider or facility may contact the appropriate person or office to initiate open negotiation, and that if the 30-day negotiation period does not result in a determination, generally, the provider or facility may initiate the independent dispute resolution process within 4 days after the end of the open negotiation period; and

(iv) Contact information, including a telephone number and email address, for the appropriate person or office to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service.

(2) In a timely manner upon request of the provider or facility:

(i) Information about whether the qualifying payment amount for items and services involved included contracted rates that were not on a fee-for-service basis for those specific items and services and whether the qualifying payment amount for those items and services was determined using underlying fee schedule rates or a derived amount;

(ii) If a plan or issuer uses an eligible database under paragraph (c)(3) of this section to determine the qualifying payment amount, information to identify which database was used; and

(iii) If a related service code was used to determine the qualifying payment amount for an item or service billed under a new service code under paragraph (c)(4)(i) or (ii) of this section, information to identify the related service code;

(iv) If applicable, a statement that the plan's or issuer's contracted rates include risk-sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments for the items and services involved (as applicable) that were excluded for purposes of calculating the qualifying payment amount.

(e) *Certain access fees to databases.* In the case of a plan or issuer that, pursuant to this section, uses an eligible database to determine the qualifying payment amount for an item or service, the plan or issuer is responsible for any

costs associated with accessing such database.

(f) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022.

§ 2590.716–7 Complaints process for surprise medical bills regarding group health plans and group health insurance coverage.

(a) *Scope and definitions*—(1) *Scope.* This section establishes a process to receive and resolve complaints regarding information that a specific group health plan or health insurance issuer offering group health insurance coverage may be failing to meet the requirements under subpart D of this part, which may warrant an investigation.

(2) *Definitions.* In this section—

(i) *Complaint* means a communication, written or oral, that indicates there has been a potential violation of the requirements under subpart D of this part, whether or not a violation actually occurred.

(ii) *Complainant* means any individual, or their authorized representative, who files a complaint as defined in paragraph (a)(2)(i) of this section.

(b) *Complaints process.* (1) DOL will consider the date a complaint is filed to be the date upon which DOL receives an oral or written statement that identifies information about the complaint sufficient to identify the parties involved and the action or inaction complained of.

(2) DOL will notify complainants, by oral or written means, of receipt of the complaint no later than 60 business days after the complaint is received. DOL will include a response acknowledging receipt of the complaint, notifying the complainant of their rights and obligations under the complaints process, and describing the next steps of the complaint resolution process. As part of the response, DOL may request additional information needed to process the complaint. Such additional information may include:

(i) Explanations of benefits;

(ii) Processed claims;

(iii) Information about the health care provider, facility, or provider of air ambulance services involved;

(iv) Information about the group health plan or health insurance issuer covering the individual;

(v) Information to support a determination regarding whether the service was an emergency service or non-emergency service;

(vi) The summary plan description, policy, certificate, contract of insurance,

membership booklet, outline of coverage, or other evidence of coverage the plan or issuer provides to participants or beneficiaries;

(vii) Documents regarding the facts in the complaint in the possession of, or otherwise attainable by, the complainant; or

(viii) Any other information DOL may need to make a determination of facts for an investigation.

(3) DOL will make reasonable efforts consistent with agency practices to notify the complainant of the outcome of the complaint after the submission is processed through appropriate methods as determined by DOL. A complaint is considered processed after DOL has reviewed the complaint and accompanying information and made an outcome determination. Based on the nature of the complaint and the plan or issuer involved, DOL may—

(i) Refer the complainant to another appropriate Federal or State resolution process;

(ii) Notify the complainant and make reasonable efforts to refer the complainant to the appropriate State or Federal regulatory authority if DOL receives a complaint where another entity has enforcement jurisdiction over the plan or issuer;

(iii) Refer the plan or issuer for an investigation for enforcement action; or

(iv) Provide the complainant with an explanation of the resolution of the complaint and any corrective action taken.

§ 2590.717–1 Preventing surprise medical bills for air ambulance services.

(a) *In general.* If a group health plan or a health insurance issuer offering group health insurance coverage provides or covers any benefits for air ambulance services, the plan or issuer must cover such services from a nonparticipating provider of air ambulance services in accordance with paragraph (b) of this section.

(b) *Coverage requirements.* A plan or issuer described in paragraph (a) of this section must provide coverage of air ambulance services in the following manner—

(1) The cost-sharing requirements with respect to the services must be the same requirements that would apply if the services were provided by a participating provider of air ambulance services.

(2) The cost-sharing requirement must be calculated as if the total amount that would have been charged for the services by a participating provider of air ambulance services were equal to the lesser of the qualifying payment amount (as determined in accordance with

§ 2590.716–6) or the billed amount for the services.

(3) The cost-sharing amounts must be counted towards any in-network deductible and in-network out-of-pocket maximums (including the annual limitation on cost sharing under section 2707(b) of the PHS Act) (as applicable) applied under the plan or coverage (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if the cost-sharing payments were made with respect to services furnished by a participating provider of air ambulance services.

(4) The plan or issuer must—

(i) Not later than 30 calendar days after the bill for the services is transmitted by the provider of air ambulance services, determine whether the services are covered under the plan or coverage and, if the services are covered, send to the provider an initial payment or a notice of denial of payment. For purposes of this paragraph (b)(4)(i), the 30-calendar-day period begins on the date the plan or issuer receives the information necessary to decide a claim for payment for the services.

(ii) Pay a total plan or coverage payment directly to the nonparticipating provider furnishing such air ambulance services that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services (as determined in accordance with paragraphs (b)(1) and (2) of this section), less any initial payment amount made under paragraph (b)(4)(i) of this section. The total plan or coverage payment must be made in accordance with the timing requirement described in section 717(b)(6) of ERISA, or in cases where the out-of-network rate is determined under a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement.

(c) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022.

§ 2590.722 Choice of health care professional.

(a) *Choice of health care professional—(1) Designation of primary care provider—(i) In general.* If a group health plan, or a health insurance issuer offering group health insurance coverage, requires or provides for designation by a participant or beneficiary of a participating primary care provider, then the plan or issuer must permit each participant or beneficiary to designate any participating primary care provider who

is available to accept the participant or beneficiary. In such a case, the plan or issuer must comply with the rules of paragraph (a)(4) of this section by informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider.

(ii) *Construction.* Nothing in paragraph (a)(1)(i) of this section is to be construed to prohibit the application of reasonable and appropriate geographic limitations with respect to the selection of primary care providers, in accordance with the terms of the plan or coverage, the underlying provider contracts, and applicable State law.

(iii) *Example.* The rules of this paragraph (a)(1) are illustrated by the following example:

(A) *Facts.* A group health plan requires individuals covered under the plan to designate a primary care provider. The plan permits each individual to designate any primary care provider participating in the plan's network who is available to accept the individual as the individual's primary care provider. If an individual has not designated a primary care provider, the plan designates one until the individual has made a designation. The plan provides a notice that satisfies the requirements of paragraph (a)(4) of this section regarding the ability to designate a primary care provider.

(B) *Conclusion.* In this *Example*, the plan has satisfied the requirements of paragraph (a) of this section.

(2) *Designation of pediatrician as primary care provider—(i) In general.* If a group health plan, or a health insurance issuer offering group health insurance coverage, requires or provides for the designation of a participating primary care provider for a child by a participant or beneficiary, the plan or issuer must permit the participant or beneficiary to designate a physician (allopathic or osteopathic) who specializes in pediatrics (including pediatric subspecialties, based on the scope of that provider's license under applicable State law) as the child's primary care provider if the provider participates in the network of the plan or issuer and is available to accept the child. In such a case, the plan or issuer must comply with the rules of paragraph (a)(4) of this section by informing each participant (in the individual market, primary subscriber) of the terms of the plan or health insurance coverage regarding designation of a pediatrician as the child's primary care provider.

(ii) *Construction.* Nothing in paragraph (a)(2)(i) of this section is to be construed to waive any exclusions of

coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

(iii) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

(A) *Example 1—(1) Facts.* A group health plan's HMO designates for each participant a physician who specializes in internal medicine to serve as the primary care provider for the participant and any beneficiaries. Participant A requests that Pediatrician B be designated as the primary care provider for A's child. B is a participating provider in the HMO's network and is available to accept the child.

(2) *Conclusion.* In this *Example 1*, the HMO must permit A's designation of B as the primary care provider for A's child in order to comply with the requirements of this paragraph (a)(2).

(B) *Example 2—(1) Facts.* Same facts as *Example 1* (paragraph (a)(2)(iii)(A) of this section), except that A takes A's child to B for treatment of the child's severe shellfish allergies. B wishes to refer A's child to an allergist for treatment. The HMO, however, does not provide coverage for treatment of food allergies, nor does it have an allergist participating in its network, and it therefore refuses to authorize the referral.

(2) *Conclusion.* In this *Example 2*, the HMO has not violated the requirements of this paragraph (a)(2) because the exclusion of treatment for food allergies is in accordance with the terms of A's coverage.

(3) *Patient access to obstetrical and gynecological care—(i) General rights—(A) Direct access.* A group health plan, or a health insurance issuer offering group health insurance coverage, described in paragraph (a)(3)(ii) of this section, may not require authorization or referral by the plan, issuer, or any person (including a primary care provider) in the case of a female participant or beneficiary who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. In such a case, the plan or issuer must comply with the rules of paragraph (a)(4) of this section by informing each participant that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology. The plan or issuer may require such a professional to agree to otherwise adhere to the plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior

authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer. For purposes of this paragraph (a)(3), a health care professional who specializes in obstetrics or gynecology is any individual (including a person other than a physician) who is authorized under applicable State law to provide obstetrical or gynecological care.

(B) *Obstetrical and gynecological care.* A group health plan or health insurance issuer described in paragraph (a)(3)(ii) of this section must treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under paragraph (a)(3)(i)(A) of this section, by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(ii) *Application of paragraph.* A group health plan, or a health insurance issuer offering group health insurance coverage, is described in this paragraph (a)(3) if the plan or issuer—

(A) Provides coverage for obstetrical or gynecological care; and

(B) Requires the designation by a participant or beneficiary of a participating primary care provider.

(iii) *Construction.* Nothing in paragraph (a)(3)(i) of this section is to be construed to—

(A) Waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(B) Preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

(iv) *Examples.* The rules of this paragraph (a)(3) are illustrated by the following examples:

(A) *Example 1—(1) Facts.* A group health plan requires each participant to designate a physician to serve as the primary care provider for the participant and the participant's family. Participant A, a female, requests a gynecological exam with Physician B, an in-network physician specializing in gynecological care. The group health plan requires prior authorization from A's designated primary care provider for the gynecological exam.

(2) *Conclusion.* In this *Example 1*, the group health plan has violated the requirements of this paragraph (a)(3) because the plan requires prior authorization from A's primary care

provider prior to obtaining gynecological services.

(B) *Example 2—(1) Facts.* Same facts as *Example 1* (paragraph (a)(3)(iv)(A) of this section) except that A seeks gynecological services from C, an out-of-network provider.

(2) *Conclusion.* In this *Example 2*, the group health plan has not violated the requirements of this paragraph (a)(3) by requiring prior authorization because C is not a participating health care provider.

(C) *Example 3—(1) Facts.* Same facts as *Example 1* (paragraph (a)(3)(iv)(A) of this section) except that the group health plan only requires B to inform A's designated primary care physician of treatment decisions.

(2) *Conclusion.* In this *Example 3*, the group health plan has not violated the requirements of this paragraph (a)(3) because A has direct access to B without prior authorization. The fact that the group health plan requires the designated primary care physician to be notified of treatment decisions does not violate this paragraph (a)(3).

(D) *Example 4—(1) Facts.* A group health plan requires each participant to designate a physician to serve as the primary care provider for the participant and the participant's family. The group health plan requires prior authorization before providing benefits for uterine fibroid embolization.

(2) *Conclusion.* In this *Example 4*, the plan requirement for prior authorization before providing benefits for uterine fibroid embolization does not violate the requirements of this paragraph (a)(3) because, though the prior authorization requirement applies to obstetrical services, it does not restrict access to any providers specializing in obstetrics or gynecology.

(4) *Notice of right to designate a primary care provider—(i) In general.* If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant (in the individual market, primary subscriber) of the terms of the plan or health insurance coverage regarding designation of a primary care provider and of the rights—

(A) Under paragraph (a)(1)(i) of this section, that any participating primary care provider who is available to accept the participant or beneficiary can be designated;

(B) Under paragraph (a)(2)(i) of this section, with respect to a child, that any participating physician who specializes in pediatrics can be designated as the primary care provider; and

(C) Under paragraph (a)(3)(i) of this section, that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology.

(ii) *Timing.* In the case of a group health plan or group health insurance coverage, the notice described in paragraph (a)(4)(i) of this section must be included whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage. In the case of individual health insurance coverage, the notice described in paragraph (a)(4)(i) of this section must be included whenever the issuer provides a primary subscriber with a policy, certificate, or contract of health insurance.

(iii) *Model language.* The following model language can be used to satisfy the notice requirement described in paragraph (a)(4)(i) of this section:

(A) For plans and issuers that require or allow for the designation of primary care providers by participants, or beneficiaries, insert:

[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

(B) For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

For children, you may designate a pediatrician as the primary care provider.

(C) For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in

obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].

(b) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022.

Department of Health and Human Services

45 CFR Subtitle A, Subchapter B

For the reasons stated in the preamble, the Department of Health and Human Services amends 45 CFR parts 144, 147, 149, and 156 as set forth below:

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

■ 12. The authority citation for part 144 is revised to read as follows:

Authority: 42 U.S.C. 300gg through 300gg–63, 300gg–91, 300gg–92, and 300gg–111 through 300gg–139, as amended.

■ 13. Section 144.101 is amended by:

- a. Redesignating paragraphs (d) and (e) as paragraphs (e) and (f), respectively; and
- b. Adding new paragraph (d).

The addition reads as follows:

§ 144.101 Basis and purpose.

* * * * *

(d) Part 149 of this subchapter implements the provisions of parts D and E of title XXVII of the PHS Act that apply to group health plans, health insurance issuers in the group and individual markets, health care providers and facilities, and providers of air ambulance services.

* * * * *

■ 14. Section 144.102 is revised to read as follows:

§ 144.102 Scope and applicability.

(a) For purposes of 45 CFR parts 144 through 149, all health insurance coverage is generally divided into two markets—the group market and the individual market. The group market is further divided into the large group market and the small group market.

(b) The protections afforded under 45 CFR parts 144 through 149 to individuals and employers (and other sponsors of health insurance offered in connection with a group health plan) are determined by whether the coverage involved is obtained in the small group market, the large group market, or the individual market.

(c) Coverage that is provided to associations, but not related to employment, and sold to individuals is not considered group coverage under 45

CFR parts 144 through 149. If the coverage is offered to an association member other than in connection with a group health plan, the coverage is considered individual health insurance coverage for purposes of 45 CFR parts 144 through 149. The coverage is considered coverage in the individual market, regardless of whether it is considered group coverage under state law. If the health insurance coverage is offered in connection with a group health plan as defined at 45 CFR 144.103, it is considered group health insurance coverage for purposes of 45 CFR parts 144 through 149.

(d) Provisions relating to CMS enforcement of parts 146, 147, 148, and 149 are contained in part 150 of this subchapter.

■ 15. Section 144.103 is amended by revising the introductory text to read as follows:

§ 144.103 Definitions.

For purposes of parts 146 (group market), 147 (group and individual market), 148 (individual market), 149 (surprise billing and transparency), and 150 (enforcement) of this subchapter, the following definitions apply unless otherwise provided:

* * * * *

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

■ 16. The authority citation for part 147 is revised to read as follows:

Authority: 42 U.S.C. 300gg through 300gg–63, 300gg–91, 300gg–92, and 300gg–111 through 300gg–139, as amended, and section 3203, Pub. L. 116–136, 134 Stat. 281.

■ 17. Section 147.138 is amended by revising paragraph (c) to read as follows:

§ 147.138 Patient protections.

* * * * *

(c) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers for plan years (in the individual market, policy years) beginning before January 1, 2022. *See also* subparts B and D of part 149 of this subchapter for rules applicable with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022.

■ 18. Add part 149 to read as follows:

PART 149—SURPRISE BILLING AND TRANSPARENCY REQUIREMENTS

Subpart A—General Provisions

Sec.

149.10 Basis and scope.

149.20 Applicability.

149.30 Definitions.

Subpart B—Protections against Balance Billing for the Group and Individual Health Insurance Markets

- 149.110 Preventing surprise medical bills for emergency services.
- 149.120 Preventing surprise medical bills for non-emergency services performed by nonparticipating providers at certain participating facilities.
- 149.130 Preventing surprise medical bills for air ambulance services.
- 149.140 Methodology for calculating qualifying payment amount.
- 149.150 Complaints process for surprise medical bills regarding group health plans and group and individual health insurance coverage.

Subpart C—[Reserved]**Subpart D—Additional Patient Protections**

- 149.310 Choice of health care professional.

Subpart E—Health Care Provider, Health Care Facility, and Air Ambulance Service Provider Requirements

- 149.410 Balance billing in cases of emergency services.
- 149.420 Balance billing in cases of non-emergency services performed by nonparticipating providers at certain participating health care facilities.
- 149.430 Provider and facility disclosure requirements regarding patient protections against balance billing.
- 149.440 Balance billing in cases of air ambulance services.
- 149.450 Complaints process for balance billing regarding providers and facilities.

Authority: 42 U.S.C. 300gg–111 through 300gg–139, as amended.

Subpart A—General Provisions**§ 149.10 Basis and scope.**

(a) *Basis.* This part implements parts D and E of title XXVII of the PHS Act.

(b) *Scope.* This part establishes standards for group health plans, health insurance issuers offering group or individual health insurance coverage, health care providers and facilities, and providers of air ambulance services with respect to surprise medical bills, transparency in health care coverage, and additional patient protections.

§ 149.20 Applicability.

(a) *In general.* (1) The requirements in subparts B and D of this part apply to group health plans and health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans as defined in § 147.140 of this subchapter), except as specified in paragraph (b) of this section.

(2) The requirements in subpart E of this part apply to health care providers, health care facilities, and providers of air ambulance services.

(b) *Exceptions.* The requirements in subparts B and D of this part do not apply to the following:

(1) Excepted benefits as described in §§ 146.145 and 148.220 of this subchapter.

(2) Short-term, limited-duration insurance as defined in § 144.103 of this subchapter.

(3) Health reimbursement arrangements or other account-based group health plans as described in § 147.126(d) of this subchapter.

§ 149.30 Definitions.

The definitions in part 144 of this subchapter apply to this part, unless otherwise specified. In addition, for purposes of this part, the following definitions apply:

Air ambulance service means medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.

Cost sharing means the amount a participant, beneficiary, or enrollee is responsible for paying for a covered item or service under the terms of the group health plan or health insurance coverage. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by out-of-network providers, or the cost of items or services that are not covered under a group health plan or health insurance coverage.

Emergency department of a hospital includes a hospital outpatient department that provides emergency services.

Emergency medical condition has the meaning given the term in § 149.110(c)(1).

Emergency services has the meaning given the term in § 149.110(c)(2).

Health care facility, with respect to a group health plan or group or individual health insurance coverage, in the context of non-emergency services, is each of the following:

- (1) A hospital (as defined in section 1861(e) of the Social Security Act);
- (2) A hospital outpatient department;
- (3) A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
- (4) An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Independent freestanding emergency department means a health care facility (not limited to those described in the definition of health care facility with respect to non-emergency services) that—

- (1) Is geographically separate and distinct and licensed separately from a hospital under applicable State law; and
- (2) Provides any emergency services as described in § 149.110(c)(2)(i).

Nonparticipating emergency facility means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to services that pursuant to § 149.110(c)(2)(ii) are included as emergency services), that does not have a contractual relationship directly or indirectly with a group health plan or group or individual health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage, respectively.

Nonparticipating provider means any physician or other health care provider who does not have a contractual relationship directly or indirectly with a group health plan or group or individual health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage, respectively.

Notice of denial of payment means, with respect to an item or service for which benefits subject to the protections of §§ 149.110 through 149.130 are provided or covered, a written notice from the plan or issuer to the health care provider, facility, or provider of air ambulance services, as applicable, that payment for such item or service will not be made by the plan or coverage and which explains the reason for denial. The term notice of denial of payment does not include a notice of benefit denial due to an adverse benefit determination as defined in 29 CFR 2560.503–1.

Out-of-network rate means, with respect to an item or service furnished by a nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services—

(1) Subject to paragraph (3) of this definition, in a State that has in effect a specified State law, the amount determined in accordance with such law;

(2) Subject to paragraph (3) of this definition, in a State that does not have in effect a specified State law—

- (i) Subject to paragraph (2)(ii) of this definition, if the nonparticipating provider or nonparticipating emergency facility and the plan or issuer agree on an amount of payment (including if the amount agreed upon is the initial payment sent by the plan or issuer under 26 CFR 54.9816–4T(b)(3)(iv)(A), 54.9816–5T(c)(3), or 54.9817–1T(b)(4)(i); 29 CFR 2590.716–4(b)(3)(iv)(A), 2590.716–5(c)(3), or 2590.717–1(b)(4)(i);

or § 149.110(b)(3)(iv)(A), § 149.120(c)(3), or § 149.130(b)(4)(i), as applicable, or is agreed on through negotiations with respect to such item or service), such agreed on amount; or

(ii) If the nonparticipating provider or nonparticipating emergency facility and the plan or issuer enter into the independent dispute resolution (IDR) process under section 9816(c) or 9817(b) of the Internal Revenue Code, section 716(c) or 717(b) of ERISA, or section 2799A–1(c) or 2799A–2(b) of the PHS Act, as applicable, and do not agree before the date on which a certified IDR entity makes a determination with respect to such item or service under such subsection, the amount of such determination; or

(3) In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies with respect to the plan or issuer; the nonparticipating provider or nonparticipating emergency facility; and the item or service, the amount that the State approves under the All-Payer Model Agreement for the item or service.

Participating emergency facility means any emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to services that pursuant to § 149.110(c)(2)(ii) are included as emergency services), that has a contractual relationship directly or indirectly with a group health plan or health insurance issuer offering group or individual health insurance coverage setting forth the terms and conditions on which a relevant item or service is provided to a participant, beneficiary, or enrollee under the plan or coverage, respectively. A single case agreement between an emergency facility and a plan or issuer that is used to address unique situations in which a participant, beneficiary, or enrollee requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

Participating health care facility means any health care facility described in this section that has a contractual relationship directly or indirectly with a group health plan or health insurance issuer offering group or individual health insurance coverage setting forth the terms and conditions on which a relevant item or service is provided to a participant, beneficiary, or enrollee under the plan or coverage, respectively. A single case agreement between a health care facility and a plan or issuer that is used to address unique situations in which a participant, beneficiary, or

enrollee requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

Participating provider means any physician or other health care provider who has a contractual relationship directly or indirectly with a group health plan or health insurance issuer offering group or individual health insurance coverage setting forth the terms and conditions on which a relevant item or service is provided to a participant, beneficiary, or enrollee under the plan or coverage, respectively.

Physician or health care provider means a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, but does not include a provider of air ambulance services.

Provider of air ambulance services means an entity that is licensed under applicable State and Federal law to provide air ambulance services.

Same or similar item or service has the meaning given the term in § 149.140(a)(13).

Service code has the meaning given the term in § 149.140(a)(14).

Qualifying payment amount has the meaning given the term in § 149.140(a)(16).

Recognized amount means, with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility—

(1) Subject to paragraph (3) of this definition, in a State that has in effect a specified State law, the amount determined in accordance with such law.

(2) Subject to paragraph (3) of this definition, in a State that does not have in effect a specified State law, the lesser of—

(i) The amount that is the qualifying payment amount (as determined in accordance with § 149.140); or

(ii) The amount billed by the provider or facility.

(3) In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies with respect to the plan or issuer; the nonparticipating provider or nonparticipating emergency facility; and the item or service, the amount that the State approves under the All-Payer Model Agreement for the item or service.

Specified State law means a State law that provides for a method for determining the total amount payable under a group health plan or group or individual health insurance coverage offered by a health insurance issuer to

the extent such State law applies for an item or service furnished by a nonparticipating provider or nonparticipating emergency facility (including where it applies because the State has allowed a plan that is not otherwise subject to applicable State law an opportunity to opt in, subject to section 514 of the Employee Retirement Income Security Act of 1974). A group health plan that opts in to such a specified State law must do so for all items and services to which the specified State law applies and in a manner determined by the applicable State authority, and must prominently display in its plan materials describing the coverage of out-of-network services a statement that the plan has opted into the specified State law, identify the relevant State (or States), and include a general description of the items and services provided by nonparticipating facilities and providers that are covered by the specified State law.

State means each of the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Treating provider is a physician or health care provider who has evaluated the individual.

Visit, with respect to items and services furnished to an individual at a health care facility, includes, in addition to items and services furnished by a provider at the facility, equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is at the facility.

Subpart B—Protections Against Balance Billing for the Group and Individual Health Insurance Markets

§ 149.110 Preventing surprise medical bills for emergency services.

(a) *In general.* If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department, the plan or issuer must cover emergency services, as defined in paragraph (c)(2) of this section, and this coverage must be provided in accordance with paragraph (b) of this section.

(b) *Coverage requirements.* A plan or issuer described in paragraph (a) of this section must provide coverage for emergency services in the following manner—

(1) Without the need for any prior authorization determination, even if the services are provided on an out-of-network basis.

(2) Without regard to whether the health care provider furnishing the emergency services is a participating provider or a participating emergency facility, as applicable, with respect to the services.

(3) If the emergency services are provided by a nonparticipating provider or a nonparticipating emergency facility—

(i) Without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities.

(ii) Without imposing cost-sharing requirements that are greater than the requirements that would apply if the services were provided by a participating provider or a participating emergency facility.

(iii) By calculating the cost-sharing requirement as if the total amount that would have been charged for the services by such participating provider or participating emergency facility were equal to the recognized amount for such services.

(iv) The plan or issuer—

(A) Not later than 30 calendar days after the bill for the services is transmitted by the provider or facility (or, in cases where the recognized amount is determined by a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement), determines whether the services are covered under the plan or coverage and, if the services are covered, sends to the provider or facility, as applicable, an initial payment or a notice of denial of payment. For purposes of this paragraph (b)(3)(iv)(A), the 30-calendar-day period begins on the date the plan or issuer receives the information necessary to decide a claim for payment for the services.

(B) Pays a total plan or coverage payment directly to the nonparticipating provider or nonparticipating facility that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services (as determined in accordance with paragraphs (b)(3)(ii) and (iii) of this section), less any initial payment amount made under paragraph (b)(3)(iv)(A) of this section. The total plan or coverage payment must be made in accordance with the timing requirement described in section

2799A–1(c)(6) of the PHS Act, or in cases where the out-of-network rate is determined under a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement.

(v) By counting any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to the emergency services toward any in-network deductible or in-network out-of-pocket maximums (including the annual limitation on cost sharing under section 2707(b) of the PHS Act) (as applicable) applied under the plan or coverage (and the in-network deductible and in-network out-of-pocket maximums must be applied) in the same manner as if the cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility.

(4) Without limiting what constitutes an emergency medical condition (as defined in paragraph (c)(1) of this section) solely on the basis of diagnosis codes.

(5) Without regard to any other term or condition of the coverage, other than—

(i) The exclusion or coordination of benefits (to the extent not inconsistent with benefits for an emergency medical condition, as defined in paragraph (c)(1) of this section).

(ii) An affiliation or waiting period (each as defined in § 144.103 of this subchapter).

(iii) Applicable cost sharing.

(c) *Definitions.* In this section—

(1) *Emergency medical condition* means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)

(2) *Emergency services* means, with respect to an emergency medical condition—

(i) *In general.* (A) An appropriate medical screening examination (as

required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

(ii) *Inclusion of additional services.*

(A) Subject to paragraph (c)(2)(ii)(B) of this section, items and services—

(1) For which benefits are provided or covered under the plan or coverage; and

(2) That are furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the participant, beneficiary, or enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in paragraph (c)(2)(i) of this section are furnished.

(B) Items and services described in paragraph (c)(2)(ii)(A) of this section are not included as emergency services if all of the conditions in § 149.410(b) are met.

(3) *To stabilize*, with respect to an emergency medical condition, has the meaning given such term in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(d) *Applicability date.* The provisions of this section are applicable with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022.

§ 149.120 Preventing surprise medical bills for non-emergency services performed by nonparticipating providers at certain participating facilities.

(a) *In general.* If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to items and

services described in paragraph (b) of this section, the plan or issuer must cover the items and services when furnished by a nonparticipating provider in accordance with paragraph (c) of this section.

(b) *Items and services described.* The items and services described in this paragraph (b) are items and services (other than emergency services) furnished to a participant, beneficiary, or enrollee by a nonparticipating provider with respect to a visit at a participating health care facility, unless the provider has satisfied the notice and consent criteria of § 149.420(c) through (i) with respect to such items and services.

(c) *Coverage requirements.* In the case of items and services described in paragraph (b) of this section, the plan or issuer—

(1) Must not impose a cost-sharing requirement for the items and services that is greater than the cost-sharing requirement that would apply if the items or services had been furnished by a participating provider.

(2) Must calculate the cost-sharing requirements as if the total amount that would have been charged for the items and services by such participating provider were equal to the recognized amount for the items and services.

(3) Not later than 30 calendar days after the bill for the items or services is transmitted by the provider (or in cases where the recognized amount is determined by a specified State law or All-Payer Model Agreement, such other timeframe as specified under the State law or All-Payer Model Agreement), must determine whether the items and services are covered under the plan or coverage and, if the items and services are covered, send to the provider an initial payment or a notice of denial of payment. For purposes of this paragraph (c)(3), the 30-calendar-day period begins on the date the plan or issuer receives the information necessary to decide a claim for payment for the items or services.

(4) Must pay a total plan or coverage payment directly to the nonparticipating provider that is equal to the amount by which the out-of-network rate for the items and services involved exceeds the cost-sharing amount for the items and services (as determined in accordance with paragraphs (c)(1) and (2) of this section), less any initial payment amount made under paragraph (c)(3) of this section. The total plan or coverage payment must be made in accordance with the timing requirement described in section 2799A-1(c)(6) of the PHS Act, or in cases where the out-of-network rate is determined under a specified

State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement.

(5) Must count any cost-sharing payments made by the participant, beneficiary, or enrollee toward any in-network deductible and in-network out-of-pocket maximums (including the annual limitation on cost sharing under section 2707(b) of the PHS Act) (as applicable) applied under the plan or coverage (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a participating provider.

(d) *Applicability date.* The provisions of this section are applicable with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022.

§ 149.130 Preventing surprise medical bills for air ambulance services.

(a) *In general.* If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits for air ambulance services, the plan or issuer must cover such services from a nonparticipating provider of air ambulance services in accordance with paragraph (b) of this section.

(b) *Coverage requirements.* A plan or issuer described in paragraph (a) of this section must provide coverage of air ambulance services in the following manner—

(1) The cost-sharing requirements with respect to the services must be the same requirements that would apply if the services were provided by a participating provider of air ambulance services.

(2) The cost-sharing requirement must be calculated as if the total amount that would have been charged for the services by a participating provider of air ambulance services were equal to the lesser of the qualifying payment amount (as determined in accordance with § 149.140) or the billed amount for the services.

(3) The cost-sharing amounts must be counted towards any in-network deductible and in-network out-of-pocket maximums (including the annual limitation on cost sharing under section 2707(b) of the PHS Act) (as applicable) applied under the plan or coverage (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if the cost-sharing payments were made with respect to services furnished by a participating provider of air ambulance services.

(4) The plan or issuer must—

(i) Not later than 30 calendar days after the bill for the services is transmitted by the provider of air ambulance services, determine whether the services are covered under the plan or coverage and, if the services are covered, send to the provider an initial payment or a notice of denial of payment. For purposes of this paragraph (b)(4)(i), the 30-calendar-day period begins on the date the plan or issuer receives the information necessary to decide a claim for payment for the services.

(ii) Pay a total plan or coverage payment directly to the nonparticipating provider furnishing such air ambulance services that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services (as determined in accordance with paragraphs (b)(1) and (2) of this section), less any initial payment amount made under paragraph (b)(4)(i) of this section. The total plan or coverage payment must be made in accordance with the timing requirement described in section 2799A-2(b)(6) of the PHS Act, or in cases where the out-of-network rate is determined under a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement.

(c) *Applicability date.* The provisions of this section are applicable with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022.

§ 149.140 Methodology for calculating qualifying payment amount.

(a) *Definitions.* For purposes of this section, the following definitions apply:

(1) *Contracted rate* means the total amount (including cost sharing) that a group health plan or health insurance issuer has contractually agreed to pay a participating provider, facility, or provider of air ambulance services for covered items and services, whether directly or indirectly, including through a third-party administrator or pharmacy benefit manager. Solely for purposes of this definition, a single case agreement, letter of agreement, or other similar arrangement between a provider, facility, or air ambulance provider and a plan or issuer, used to supplement the network of the plan or coverage for a specific participant, beneficiary, or enrollee in unique circumstances, does not constitute a contract.

(2) *Derived amount* has the meaning given the term in § 147.210 of this subchapter.

(3) *Eligible database* means—

(i) A State all-payer claims database; or

(ii) Any third-party database which—
(A) Is not affiliated with, or owned or controlled by, any health insurance issuer, or a health care provider, facility, or provider of air ambulance services (or any member of the same controlled group as, or under common control with, such an entity). For purposes of this paragraph (a)(3)(ii)(A), the term controlled group means a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended;

(B) Has sufficient information reflecting in-network amounts paid by group health plans or health insurance issuers offering group or individual health insurance coverage to providers, facilities, or providers of air ambulance services for relevant items and services furnished in the applicable geographic region; and

(C) Has the ability to distinguish amounts paid to participating providers and facilities by commercial payers, such as group health plans and health insurance issuers offering group or individual health insurance coverage, from all other claims data, such as amounts billed by nonparticipating providers or facilities and amounts paid by public payers, including the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of the Social Security Act (or a demonstration project under title XI of the Social Security Act), or the Children's Health Insurance Program under title XXI of the Social Security Act.

(4) *Facility of the same or similar facility type* means, with respect to emergency services, either—

(i) An emergency department of a hospital; or

(ii) An independent freestanding emergency department.

(5) *First coverage year* means, with respect to an item or service for which coverage is not offered in 2019 under a group health plan or group or individual health insurance coverage offered by a health insurance issuer, the first year after 2019 for which coverage for such item or service is offered under that plan or coverage.

(6) *First sufficient information year* means, with respect to a group health plan or group or individual health insurance coverage offered by a health insurance issuer—

(i) In the case of an item or service for which the plan or coverage does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section in 2019, the first year after 2022 for which the plan or issuer has

sufficient information to calculate the median of such contracted rates in the year immediately preceding that first year after 2022; and

(ii) In the case of a newly covered item or service, the first year after the first coverage year for such item or service with respect to such plan or coverage for which the plan or issuer has sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section in the year immediately preceding that first year.

(7) *Geographic region* means—

(i) For items and services other than air ambulance services—

(A) Subject to paragraphs (a)(7)(i)(B) and (C) of this section, one region for each metropolitan statistical area, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in a State, and one region consisting of all other portions of the State.

(B) If a plan or issuer does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an item or service provided in a geographic region described in paragraph (a)(7)(i)(A) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in the State, and one region consisting of all other portions of the State.

(C) If a plan or issuer does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an item or service provided in a geographic region described in paragraph (a)(7)(i)(B) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in each Census division and one region consisting of all other portions of the Census division, as described by the U.S. Census Bureau.

(ii) For air ambulance services—

(A) Subject to paragraph (a)(7)(ii)(B) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in the State, and one region consisting of all other portions of the State, determined based on the point of pick-up (as defined in 42 CFR 414.605).

(B) If a plan or issuer does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an air ambulance service provided in a

geographic region described in paragraph (a)(7)(ii)(A) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in each Census division and one region consisting of all other portions of the Census division, as described by the U.S. Census Bureau, determined based on the point of pick-up (as defined in 42 CFR 414.605).

(8) *Insurance market* is, irrespective of the State, one of the following:

(i) The individual market (other than short-term, limited-duration insurance or individual health insurance coverage that consists solely of excepted benefits).

(ii) The large group market (other than coverage that consists solely of excepted benefits).

(iii) The small group market (other than coverage that consists solely of excepted benefits).

(iv) In the case of a self-insured group health plan, all self-insured group health plans (other than account-based plans, as defined in § 147.126(d)(6)(i) of this subchapter, and plans that consist solely of excepted benefits) of the same plan sponsor, or at the option of the plan sponsor, all self-insured group health plans administered by the same entity (including a third-party administrator contracted by the plan), to the extent otherwise permitted by law, that is responsible for calculating the qualifying payment amount on behalf of the plan.

(9) *Modifiers* mean codes applied to the service code that provide a more specific description of the furnished item or service and that may adjust the payment rate or affect the processing or payment of the code billed.

(10) *Newly covered item or service* means an item or service for which coverage was not offered in 2019 under a group health plan or group or individual health insurance coverage offered by a health insurance issuer, but that is offered under the plan or coverage in a year after 2019.

(11) *New service code* means a service code that was created or substantially revised in a year after 2019.

(12) *Provider in the same or similar specialty* means the practice specialty of a provider, as identified by the plan or issuer consistent with the plan's or issuer's usual business practice, except that, with respect to air ambulance services, all providers of air ambulance services are considered to be a single provider specialty.

(13) *Same or similar item or service* means a health care item or service billed under the same service code, or

a comparable code under a different procedural code system.

(14) *Service code* means the code that describes an item or service using the Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS), or Diagnosis-Related Group (DRG) codes.

(15) *Sufficient information* means, for purposes of determining whether a group health plan or health insurance issuer offering group or individual health insurance coverage has sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section—

(i) The plan or issuer has at least three contracted rates on January 31, 2019, to calculate the median of the contracted rates in accordance with paragraph (b) of this section; or

(ii) For an item or service furnished during a year after 2022 that is used to determine the first sufficient information year—

(A) The plan or issuer has at least three contracted rates on January 31 of the year immediately preceding that year to calculate the median of the contracted rates in accordance with paragraph (b) of this section; and

(B) The contracted rates under paragraph (a)(15)(ii)(A) of this section account (or are reasonably expected to account) for at least 25 percent of the total number of claims paid for that item or service for that year with respect to all plans of the sponsor (or the administering entity as provided in paragraph (a)(8)(iv) of this section, if applicable) or all coverage offered by the issuer that are offered in the same insurance market.

(16) *Qualifying payment amount* means, with respect to a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage, the amount calculated using the methodology described in paragraph (c) of this section.

(17) *Underlying fee schedule rate* means the rate for a covered item or service from a particular participating provider, providers, or facility that a group health plan or health insurance issuer uses to determine a participant's, beneficiary's, or enrollee's cost-sharing liability for the item or service, when that rate is different from the contracted rate.

(b) *Methodology for calculation of median contracted rate*—(1) *In general.* The median contracted rate for an item or service is calculated by arranging in order from least to greatest the contracted rates of all group health plans of the plan sponsor (or the administering entity as provided in

paragraph (a)(8)(iv) of this section, if applicable) or all group or individual health insurance coverage offered by the issuer in the same insurance market for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the geographic region in which the item or service is furnished and selecting the middle number. If there are an even number of contracted rates, the median contracted rate is the average of the middle two contracted rates. In determining the median contracted rate, the amount negotiated under each contract is treated as a separate amount. If a plan or issuer has a contract with a provider group or facility, the rate negotiated with that provider group or facility under the contract is treated as a single contracted rate if the same amount applies with respect to all providers of such provider group or facility under the single contract. However, if a plan or issuer has a contract with multiple providers, with separate negotiated rates with each particular provider, each unique contracted rate with an individual provider constitutes a single contracted rate. Further, if a plan or issuer has separate contracts with individual providers, the contracted rate under each such contract constitutes a single contracted rate (even if the same amount is paid to multiple providers under separate contracts).

(2) *Calculation rules.* In calculating the median contracted rate, a plan or issuer must:

(i) Calculate the median contracted rate with respect to all plans of such sponsor (or the administering entity as provided in paragraph (a)(8)(iv) of this section, if applicable) or all coverage offered by such issuer that are offered in the same insurance market;

(ii) Calculate the median contracted rate using the full contracted rate applicable to the service code, except that the plan or issuer must—

(A) Calculate separate median contracted rates for CPT code modifiers “26” (professional component) and “TC” (technical component);

(B) For anesthesia services, calculate a median contracted rate for the anesthesia conversion factor for each service code;

(C) For air ambulance services, calculate a median contracted rate for the air mileage service codes (A0435 and A0436); and

(D) Where contracted rates otherwise vary based on applying a modifier code, calculate a separate median contracted rate for each such service code-modifier combination;

(iii) In the case of payments made by a plan or issuer that are not on a fee-for-service basis (such as bundled or capitation payments), calculate a median contracted rate for each item or service using the underlying fee schedule rates for the relevant items or services. If the plan or issuer does not have an underlying fee schedule rate for the item or service, it must use the derived amount to calculate the median contracted rate; and

(iv) Exclude risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments.

(3) *Provider specialties; facility types.*

(i) If a plan or issuer has contracted rates that vary based on provider specialty for a service code, the median contracted rate is calculated separately for each provider specialty, as applicable.

(ii) If a plan or issuer has contracted rates for emergency services that vary based on facility type for a service code, the median contracted rate is calculated separately for each facility of the same or similar facility type.

(c) *Methodology for calculation of the qualifying payment amount*—(1) *In general.* (i) For an item or service (other than items or services described in paragraphs (c)(1)(iii) through (vii) of this section) furnished during 2022, the plan or issuer must calculate the qualifying payment amount by increasing the median contracted rate (as determined in accordance with paragraph (b) of this section) for the same or similar item or service under such plans or coverage, respectively, on January 31, 2019, by the combined percentage increase as published by the Department of the Treasury and the Internal Revenue Service to reflect the percentage increase in the CPI-U over 2019, such percentage increase over 2020, and such percentage increase over 2021.

(A) The combined percentage increase for 2019, 2020, and 2021 will be published in guidance by the Internal Revenue Service. The Department of the Treasury and the Internal Revenue Service will calculate the percentage increase using the CPI-U published by the Bureau of Labor Statistics of the Department of Labor.

(B) For purposes of this paragraph (c)(1)(i), the CPI-U for each calendar year is the average of the CPI-U as of the close of the 12-month period ending on August 31 of the calendar year, rounded to 10 decimal places.

(C) The combined percentage increase for 2019, 2020, and 2021 will be calculated as:

$$(\text{CPI-U } 2019 / \text{CPI-U } 2018) \times (\text{CPI-U } 2020 / \text{CPI-U } 2019) \times (\text{CPI-U } 2021 / \text{CPI-U } 2020)$$

(ii) For an item or service (other than items or services described in paragraphs (c)(1)(iii) through (vii) of this section) furnished during 2023 or a subsequent year, the plan or issuer must calculate the qualifying payment amount by increasing the qualifying payment amount determined under paragraph (c)(1)(i) of this section, for such an item or service furnished in the immediately preceding year, by the percentage increase as published by the Department of the Treasury and the Internal Revenue Service.

(A) The percentage increase for any year after 2022 will be published in guidance by the Internal Revenue Service. The Department of the Treasury and Internal Revenue Service will calculate the percentage increase using the CPI-U published by the Bureau of Labor Statistics of the Department of Labor.

(B) For purposes of this paragraph (c)(1)(ii), the CPI-U for each calendar year is the average of the CPI-U as of the close of the 12-month period ending on August 31 of the calendar year, rounded to 10 decimal places.

(C) The combined percentage increase for any year will be calculated as CPI-U present year/CPI-U prior year.

(iii) For anesthesia services furnished during 2022, the plan or issuer must calculate the qualifying payment amount by first increasing the median contracted rate for the anesthesia conversion factor (as determined in accordance with paragraph (b) of this section) for the same or similar item or service under such plans or coverage, respectively, on January 31, 2019, in accordance with paragraph (c)(1)(i) of this section (referred to in this section as the indexed median contracted rate for the anesthesia conversion factor). The plan or issuer must then multiply the indexed median contracted rate for the anesthesia conversion factor by the sum of the base unit, time unit, and physical status modifier units of the participant, beneficiary, or enrollee to whom anesthesia services are furnished to determine the qualifying payment amount.

(A) The base units for an anesthesia service code are the base units for that service code specified in the most recent edition (as of the date of service) of the American Society of Anesthesiologists Relative Value Guide.

(B) The time unit is measured in 15-minute increments or a fraction thereof.

(C) The physical status modifier on a claim is a standard modifier describing the physical status of the patient and is used to distinguish between various levels of complexity of the anesthesia services provided, and is expressed as a

unit with a value between zero (0) and three (3).

(D) The anesthesia conversion factor is expressed in dollars per unit and is a contracted rate negotiated with the plan or issuer.

(iv) For anesthesia services furnished during 2023 or a subsequent year, the plan or issuer must calculate the qualifying payment amount by first increasing the indexed median contracted rate for the anesthesia conversion factor, determined under paragraph (c)(1)(iii) of this section for such services furnished in the immediately preceding year, in accordance with paragraph (c)(1)(ii) of this section. The plan or issuer must then multiply that amount by the sum of the base unit, time unit, and physical status modifier units for the participant, beneficiary, or enrollee to whom anesthesia services are furnished to determine the qualifying payment amount.

(v) For air ambulance services billed using the air mileage service codes (A0435 and A0436) that are furnished during 2022, the plan or issuer must calculate the qualifying payment amount for services billed using the air mileage service codes by first increasing the median contracted rate (as determined in accordance with paragraph (b) of this section), in accordance with paragraph (c)(1)(i) of this section (referred to in this section as the indexed median air mileage rate). The plan or issuer must then multiply the indexed median air mileage rate by the number of loaded miles provided to the participant, beneficiary, or enrollee to determine the qualifying payment amount.

(A) The air mileage rate is expressed in dollars per loaded mile flown, is expressed in statute miles (not nautical miles), and is a contracted rate negotiated with the plan or issuer.

(B) The number of loaded miles is the number of miles a patient is transported in the air ambulance vehicle.

(C) The qualifying payment amount for other service codes associated with air ambulance services is calculated in accordance with paragraphs (c)(1)(i) and (ii) of this section.

(vi) For air ambulance services billed using the air mileage service codes (A0435 and A0436) that are furnished during 2023 or a subsequent year, the plan or issuer must calculate the qualifying payment amount by first increasing the indexed median air mileage rate, determined under paragraph (c)(1)(v) of this section for such services furnished in the immediately preceding year, in accordance with paragraph (c)(1)(ii) of

this section. The plan or issuer must then multiply the indexed median air mileage rate by the number of loaded miles provided to the participant, beneficiary, or enrollee to determine the qualifying payment amount.

(vii) For any other items or services for which a plan or issuer generally determines payment for the same or similar items or services by multiplying a contracted rate by another unit value, the plan or issuer must calculate the qualifying payment amount using a methodology that is similar to the methodology required under paragraphs (c)(1)(iii) through (vi) of this section and reasonably reflects the payment methodology for same or similar items or services.

(2) *New plans and coverage.* With respect to a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage in a geographic region in which the sponsor or issuer, respectively, did not offer any group health plan or health insurance coverage during 2019—

(i) For the first year in which the group health plan, group health insurance coverage, or individual health insurance coverage, respectively, is offered in such region—

(A) If the plan or issuer has sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section, the plan or issuer must calculate the qualifying payment amount in accordance with paragraph (c)(1) of this section for items and services that are covered by the plan or coverage and furnished during the first year; and

(B) If the plan or issuer does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an item or service provided in a geographic region, the plan or issuer must determine the qualifying payment amount for the item or service in accordance with paragraph (c)(3)(i) of this section.

(ii) For each subsequent year the group health plan, group health insurance coverage, or individual health insurance coverage, respectively, is offered in the region, the plan or issuer must calculate the qualifying payment amount by increasing the qualifying payment amount determined under this paragraph (c)(2) for the items and services furnished in the immediately preceding year, in accordance with paragraph (c)(1)(ii), (iv), or (vi) of this section, as applicable.

(3) *Insufficient information; newly covered items and services.* In the case of a plan or issuer that does not have

sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section in 2019 (or, in the case of a newly covered item or service, in the first coverage year for such item or service with respect to such plan or coverage if the plan or issuer does not have sufficient information) for an item or service provided in a geographic region—

(i) For an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for the item or service with respect to the plan or coverage), the plan or issuer must calculate the qualifying payment amount by first identifying the rate that is equal to the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in the year immediately preceding the year in which the item or service is furnished (or, in the case of a newly covered item or service, the year immediately preceding such first coverage year) determined by the plan or issuer, respectively, through use of any eligible database, and then increasing that rate by the percentage increase in the CPI-U over such preceding year. For purposes of this section, in cases in which an eligible database is used to determine the qualifying payment amount with respect to an item or service furnished during a calendar year, the plan or issuer must use the same database for determining the qualifying payment amount for that item or service furnished through the last day of the calendar year, and if a different database is selected for some items or services, the basis for that selection must be one or more factors not directly related to the rate of those items or services (such as sufficiency of data for those items or services).

(ii) For an item or service furnished in a subsequent year (before the first sufficient information year for such item or service with respect to such plan or coverage), the plan or issuer must calculate the qualifying payment amount by increasing the qualifying payment amount determined under paragraph (c)(3)(i) of this section or this paragraph (c)(3)(ii), as applicable, for such item or service for the year immediately preceding such subsequent year, by the percentage increase in CPI-U over such preceding year;

(iii) For an item or service furnished in the first sufficient information year for such item or service with respect to such plan or coverage, the plan or issuer must calculate the qualifying payment amount in accordance with paragraph (c)(1)(i), (iii), or (v) of this section, as applicable, except that in applying such

paragraph to such item or service, the reference to ‘furnished during 2022’ is treated as a reference to furnished during such first sufficient information year, the reference to ‘in 2019’ is treated as a reference to such sufficient information year, and the increase described in such paragraph is not applied; and

(iv) For an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan or coverage, the plan or issuer must calculate the qualifying payment amount in accordance with paragraph (c)(1)(ii), (iv), or (vi) of this section, as applicable, except that in applying such paragraph to such item or service, the reference to ‘furnished during 2023 or a subsequent year’ is treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

(4) *New service codes.* In the case of a plan or issuer that does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section and determine the qualifying payment amount under paragraphs (c)(1) through (3) of this section because the item or service furnished is billed under a new service code—

(i) For an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for the item or service with respect to the plan or coverage), the plan or issuer must identify a reasonably related service code that existed in the immediately preceding year and—

(A) If the Centers for Medicare & Medicaid Services has established a Medicare payment rate for the item or service billed under the new service code, the plan or issuer must calculate the qualifying payment amount by first calculating the ratio of the rate that Medicare pays for the item or service billed under the new service code compared to the rate that Medicare pays for the item or service billed under the related service code, and then multiplying the ratio by the qualifying payment amount for an item or service billed under the related service code for the year in which the item or service is furnished.

(B) If the Centers for Medicare & Medicaid Services has not established a Medicare payment rate for the item or service billed under the new service code, the plan or issuer must calculate the qualifying payment amount by first calculating the ratio of the rate that the plan or issuer reimburses for the item or service billed under the new service

code compared to the rate that the plan or issuer reimburses for the item or service billed under the related service code, and then multiplying the ratio by the qualifying payment amount for an item or service billed under the related service code.

(ii) For an item or service furnished in a subsequent year (before the first sufficient information year for such item or service with respect to such plan or coverage or before the first year for which an eligible database has sufficient information to calculate a rate under paragraph (c)(3)(i) of this section in the immediately preceding year), the plan or issuer must calculate the qualifying payment amount by increasing the qualifying payment amount determined under paragraph (c)(4)(i) of this section or this paragraph (c)(4)(ii), as applicable, for such item or service for the year immediately preceding such subsequent year, by the percentage increase in CPI-U over such preceding year;

(iii) For an item or service furnished in the first sufficient information year for such item or service with respect to such plan or coverage or the first year for which an eligible database has sufficient information to calculate a rate under paragraph (c)(3)(i) of this section in the immediately preceding year, the plan or issuer must calculate the qualifying payment amount in accordance with paragraph (c)(3) of this section.

(d) *Information to be shared about qualifying payment amount.* In cases in which the recognized amount with respect to an item or service furnished by a nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services is the qualifying payment amount, the plan or issuer must provide in writing, in paper or electronic form, to the provider or facility, as applicable—

(1) With each initial payment or notice of denial of payment under § 149.110, § 149.120, or § 149.130:

(i) The qualifying payment amount for each item or service involved;

(ii) A statement to certify that, based on the determination of the plan or issuer—

(A) The qualifying payment amount applies for purposes of the recognized amount (or, in the case of air ambulance services, for calculating the participant's, beneficiary's, or enrollee's cost sharing); and

(B) Each qualifying payment amount shared with the provider or facility was determined in compliance with this section;

(iii) A statement that if the provider or facility, as applicable, wishes to

initiate a 30-day open negotiation period for purposes of determining the amount of total payment, the provider or facility may contact the appropriate person or office to initiate open negotiation, and that if the 30-day negotiation period does not result in a determination, generally, the provider or facility may initiate the independent dispute resolution process within 4 days after the end of the open negotiation period; and

(iv) Contact information, including a telephone number and email address, for the appropriate person or office to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service.

(2) In a timely manner upon request of the provider or facility:

(i) Information about whether the qualifying payment amount for items and services involved included contracted rates that were not on a fee-for-service basis for those specific items and services and whether the qualifying payment amount for those items and services was determined using underlying fee schedule rates or a derived amount;

(ii) If a plan or issuer uses an eligible database under paragraph (c)(3) of this section to determine the qualifying payment amount, information to identify which database was used; and

(iii) If a related service code was used to determine the qualifying payment amount for an item or service billed under a new service code under paragraph (c)(4)(i) or (ii) of this section, information to identify the related service code; and

(iv) If applicable, a statement that the plan's or issuer's contracted rates include risk-sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments for the items and services involved (as applicable) that were excluded for purposes of calculating the qualifying payment amount.

(e) *Certain access fees to databases.* In the case of a plan or issuer that, pursuant to this section, uses an eligible database to determine the qualifying payment amount for an item or service, the plan or issuer is responsible for any costs associated with accessing such database.

(f) *Audits.* The procedures described in part 150 of this subchapter apply with respect to ensuring that a plan or coverage is in compliance with the requirement of applying a qualifying payment amount under this subpart and ensuring that such amount so applied satisfies the requirements under this section, as applicable.

(g) *Applicability date.* The provisions of this section are applicable with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022.

§ 149.150 Complaints process for surprise medical bills regarding group health plans and group and individual health insurance coverage.

(a) *Scope and definitions*—(1) *Scope.* This section establishes a process to receive and resolve complaints regarding information that a specific group health plan or health insurance issuer offering group or individual health insurance coverage may be failing to meet the requirements under this subpart, which may warrant an investigation.

(2) *Definitions.* In this section—

(i) *Complaint* means a communication, written or oral, that indicates there has been a potential violation of the requirements under subpart B of this part, whether or not a violation actually occurred.

(ii) *Complainant* means any individual, or their authorized representative, who files a complaint as defined in paragraph (a)(2)(i) of this section.

(b) *Complaints process.* (1) HHS will consider the date a complaint is filed to be the date upon which HHS receives an oral or written statement that identifies information about the complaint sufficient to identify the parties involved and the action or inaction complained of.

(2) HHS will notify complainants, by oral or written means, of receipt of the complaint no later than 60 business days after the complaint is received. HHS will include a response acknowledging receipt of the complaint, notifying the complainant of their rights and obligations under the complaints process, and describing the next steps of the complaints resolution process. As part of the response, HHS may request additional information needed to process the complaint. Such additional information may include:

(i) Explanations of benefits;

(ii) Processed claims;

(iii) Information about the health care provider, facility, or provider of air ambulance services involved;

(iv) Information about the group health plan or health insurance issuer covering the individual;

(v) Information to support a determination regarding whether the service was an emergency service or non-emergency service;

(vi) The summary plan description, policy, certificate, contract of insurance, membership booklet, outline of

coverage, or other evidence of coverage the plan or issuer provides to participants, beneficiaries, or enrollees;

(vii) Documents regarding the facts in the complaint in the possession of, or otherwise attainable by, the complainant; or

(viii) Any other information HHS may need to make a determination of facts for an investigation.

(3) HHS will make reasonable efforts consistent with agency practices to notify the complainant of the outcome of the complaint after the submission is processed through appropriate methods as determined by HHS. A complaint is considered processed after HHS has reviewed the complaint and accompanying information and made an outcome determination. Based on the nature of the complaint and the plan or issuer involved, HHS may—

(i) Refer the complainant to another appropriate Federal or State resolution process;

(ii) Notify the complainant and make reasonable efforts to refer the complainant to the appropriate State or Federal regulatory authority if HHS receives a complaint where another entity has enforcement jurisdiction over the plan or issuer;

(iii) Refer the plan or issuer for an investigation for enforcement action under 45 CFR part 150; or

(iv) Provide the complainant with an explanation of the resolution of the complaint and any corrective action taken.

Subpart C—[Reserved]

Subpart D—Additional Patient Protections

§ 149.310 Choice of health care professional.

(a) *Choice of health care professional*—(1) *Designation of primary care provider*—(i) *In general.* If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer must permit each participant, beneficiary, or enrollee to designate any participating primary care provider who is available to accept the participant, beneficiary, or enrollee. In such a case, the plan or issuer must comply with the rules of paragraph (a)(4) of this section by informing each participant (in the individual market, primary subscriber) of the terms of the plan or health insurance coverage regarding designation of a primary care provider.

(ii) *Construction.* Nothing in paragraph (a)(1)(i) of this section is to be construed to prohibit the application of reasonable and appropriate geographic limitations with respect to the selection of primary care providers, in accordance with the terms of the plan or coverage, the underlying provider contracts, and applicable State law.

(iii) *Example.* The rules of this paragraph (a)(1) are illustrated by the following example:

(A) *Facts.* A group health plan requires individuals covered under the plan to designate a primary care provider. The plan permits each individual to designate any primary care provider participating in the plan's network who is available to accept the individual as the individual's primary care provider. If an individual has not designated a primary care provider, the plan designates one until the individual has made a designation. The plan provides a notice that satisfies the requirements of paragraph (a)(4) of this section regarding the ability to designate a primary care provider.

(B) *Conclusion.* In this *Example*, the plan has satisfied the requirements of paragraph (a) of this section.

(2) *Designation of pediatrician as primary care provider—(i) In general.* If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for the designation of a participating primary care provider for a child by a participant, beneficiary, or enrollee, the plan or issuer must permit the participant, beneficiary, or enrollee to designate a physician (allopathic or osteopathic) who specializes in pediatrics (including pediatric subspecialties, based on the scope of that provider's license under applicable State law) as the child's primary care provider if the provider participates in the network of the plan or issuer and is available to accept the child. In such a case, the plan or issuer must comply with the rules of paragraph (a)(4) of this section by informing each participant (in the individual market, primary subscriber) of the terms of the plan or health insurance coverage regarding designation of a pediatrician as the child's primary care provider.

(ii) *Construction.* Nothing in paragraph (a)(2)(i) of this section is to be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

(iii) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

(A) *Example 1—(1) Facts.* A group health plan's HMO designates for each participant a physician who specializes in internal medicine to serve as the primary care provider for the participant and any beneficiaries. Participant A requests that Pediatrician B be designated as the primary care provider for A's child. B is a participating provider in the HMO's network and is available to accept the child.

(2) *Conclusion.* In this *Example 1*, the HMO must permit A's designation of B as the primary care provider for A's child in order to comply with the requirements of this paragraph (a)(2).

(B) *Example 2—(1) Facts.* Same facts as *Example 1* (paragraph (a)(2)(iii)(A) of this section), except that A takes A's child to B for treatment of the child's severe shellfish allergies. B wishes to refer A's child to an allergist for treatment. The HMO, however, does not provide coverage for treatment of food allergies, nor does it have an allergist participating in its network, and it therefore refuses to authorize the referral.

(2) *Conclusion.* In this *Example 2*, the HMO has not violated the requirements of this paragraph (a)(2) because the exclusion of treatment for food allergies is in accordance with the terms of A's coverage.

(3) *Patient access to obstetrical and gynecological care—(i) General rights—*

(A) *Direct access.* A group health plan, or a health insurance issuer offering group or individual health insurance coverage, described in paragraph (a)(3)(ii) of this section, may not require authorization or referral by the plan, issuer, or any person (including a primary care provider) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. In such a case, the plan or issuer must comply with the rules of paragraph (a)(4) of this section by informing each participant (in the individual market, primary subscriber) that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology. The plan or issuer may require such a professional to agree to otherwise adhere to the plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer. For purposes of this paragraph (a)(3), a health care professional who specializes

in obstetrics or gynecology is any individual (including a person other than a physician) who is authorized under applicable State law to provide obstetrical or gynecological care.

(B) *Obstetrical and gynecological care.* A group health plan or health insurance issuer described in paragraph (a)(3)(ii) of this section must treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under paragraph (a)(3)(i)(A) of this section, by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(ii) *Application of paragraph.* A group health plan, or a health insurance issuer offering group or individual health insurance coverage, is described in this paragraph (a)(3) if the plan or issuer—

(A) Provides coverage for obstetrical or gynecological care; and

(B) Requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

(iii) *Construction.* Nothing in paragraph (a)(3)(i) of this section is to be construed to—

(A) Waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(B) Preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

(iv) *Examples.* The rules of this paragraph (a)(3) are illustrated by the following examples:

(A) *Example 1—(1) Facts.* A group health plan requires each participant to designate a physician to serve as the primary care provider for the participant and the participant's family. Participant A, a female, requests a gynecological exam with Physician B, an in-network physician specializing in gynecological care. The group health plan requires prior authorization from A's designated primary care provider for the gynecological exam.

(2) *Conclusion.* In this *Example 1*, the group health plan has violated the requirements of this paragraph (a)(3) because the plan requires prior authorization from A's primary care provider prior to obtaining gynecological services.

(B) *Example 2—(1) Facts.* Same facts as *Example 1* (paragraph (a)(3)(iv)(A) of this section) except that A seeks

gynecological services from *C*, an out-of-network provider.

(2) *Conclusion.* In this *Example 2*, the group health plan has not violated the requirements of this paragraph (a)(3) by requiring prior authorization because *C* is not a participating health care provider.

(C) *Example 3—(1) Facts.* Same facts as *Example 1* (paragraph (a)(3)(iv)(A) of this section) except that the group health plan only requires *B* to inform *A*'s designated primary care physician of treatment decisions.

(2) *Conclusion.* In this *Example 3*, the group health plan has not violated the requirements of this paragraph (a)(3) because *A* has direct access to *B* without prior authorization. The fact that the group health plan requires the designated primary care physician to be notified of treatment decisions does not violate this paragraph (a)(3).

(D) *Example 4—(1) Facts.* A group health plan requires each participant to designate a physician to serve as the primary care provider for the participant and the participant's family. The group health plan requires prior authorization before providing benefits for uterine fibroid embolization.

(2) *Conclusion.* In this *Example 4*, the plan requirement for prior authorization before providing benefits for uterine fibroid embolization does not violate the requirements of this paragraph (a)(3) because, though the prior authorization requirement applies to obstetrical services, it does not restrict access to any providers specializing in obstetrics or gynecology.

(4) *Notice of right to designate a primary care provider—(i) In general.* If a group health plan or health insurance issuer requires the designation by a participant, beneficiary, or enrollee of a primary care provider, the plan or issuer must provide a notice informing each participant (in the individual market, primary subscriber) of the terms of the plan or health insurance coverage regarding designation of a primary care provider and of the rights—

(A) Under paragraph (a)(1)(i) of this section, that any participating primary care provider who is available to accept the participant, beneficiary, or enrollee can be designated;

(B) Under paragraph (a)(2)(i) of this section, with respect to a child, that any participating physician who specializes in pediatrics can be designated as the primary care provider; and

(C) Under paragraph (a)(3)(i) of this section, that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology.

(ii) *Timing.* In the case of a group health plan or group health insurance coverage, the notice described in paragraph (a)(4)(i) of this section must be included whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage. In the case of individual health insurance coverage, the notice described in paragraph (a)(4)(i) of this section must be included whenever the issuer provides a primary subscriber with a policy, certificate, or contract of health insurance.

(iii) *Model language.* The following model language can be used to satisfy the notice requirement described in paragraph (a)(4)(i) of this section:

(A) For plans and issuers that require or allow for the designation of primary care providers by participants, beneficiaries, or enrollees, insert:

[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

(B) For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

For children, you may designate a pediatrician as the primary care provider.

(C) For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant, beneficiary, or enrollee of a primary care provider, add:

You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].

(b) *Applicability date.* The provisions of this section are applicable with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022.

Subpart E—Health Care Provider, Health Care Facility, and Air Ambulance Service Provider Requirements

§ 149.410 Balance billing in cases of emergency services.

(a) *In general.* In the case of a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished emergency services (for which benefits are provided under the plan or coverage) with respect to an emergency medical condition with respect to a visit at an emergency department of a hospital or an independent freestanding emergency department—

(1) A nonparticipating emergency facility must not bill, and must not hold liable, the participant, beneficiary, or enrollee for a payment amount for such emergency services (as defined in 26 CFR 54.9816–4T(c)(2), 29 CFR 2590.716–4(c)(2), and § 149.110(c)(2), as applicable) that exceeds the cost-sharing requirement for such services (as determined in accordance with 26 CFR 54.9816–4T(b)(3)(ii) and (iii), 29 CFR 2590.716–4(b)(3)(ii) and (iii), and § 149.110(b)(3)(ii) and (iii), as applicable).

(2) A nonparticipating provider must not bill, and must not hold liable, the participant, beneficiary, or enrollee for a payment amount for an emergency service (as defined in 26 CFR 54.9816–4T(c)(2), 29 CFR 2590.716–4(c)(2), and § 149.110(c)(2), as applicable) furnished to such individual by such provider with respect to such emergency medical condition and visit for which the individual receives emergency services at the hospital or independent freestanding emergency department that exceeds the cost-sharing requirement for such service (as determined in accordance with 26 CFR 54.9816–4T(b)(3)(ii) and (iii), 29 CFR 2590.716–4(b)(3)(ii) and (iii), and § 149.110(b)(3)(ii) and (iii), as applicable).

(b) *Notice and consent to be treated by a nonparticipating provider or nonparticipating emergency facility.* The requirements in paragraph (a) of this section do not apply with respect to items and services described in 26 CFR, 54.9816–4T(c)(2)(ii)(A), 29 CFR 2590.716–4(c)(2)(ii)(A), § 149.110(c)(2)(ii)(A), as applicable, and are not included as emergency services if all of the following conditions are met:

(1) The attending emergency physician or treating provider determines that the participant,

beneficiary, or enrollee is able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into account the individual's medical condition. The attending emergency physician's or treating provider's determination is binding on the facility for purposes of this requirement.

(2) The provider or facility furnishing such additional items and services satisfies the notice and consent criteria of § 149.420(c) through (g) with respect to such items and services, provided that the written notice additionally satisfies paragraphs (b)(2)(i) and (ii) of this section, as applicable. In applying this paragraph (b)(2), a reference in § 149.420 to a nonparticipating provider is deemed to include a nonparticipating emergency facility.

(i) In the case of a participating emergency facility and a nonparticipating provider, the written notice must also include a list of any participating providers at the facility who are able to furnish such items and services involved and notification that the participant, beneficiary, or enrollee may be referred, at their option, to such a participating provider.

(ii) In the case of a nonparticipating emergency facility, the written notice must include the good faith estimated amount that the participant, beneficiary, or enrollee may be charged for items or services furnished by the nonparticipating emergency facility or by nonparticipating providers with respect to the visit at such facility (including any item or service that is reasonably expected to be furnished by the nonparticipating emergency facility or nonparticipating providers in conjunction with such items or services).

(3) The participant, beneficiary, or enrollee (or an authorized representative of such individual) is in a condition to receive the information described in § 149.420, as determined by the attending emergency physician or treating provider using appropriate medical judgment, and to provide informed consent under such section, in accordance with applicable State law. For purposes of this section and § 149.420, an authorized representative is an individual authorized under State law to provide consent on behalf of the participant, beneficiary, or enrollee, provided that the individual is not a provider affiliated with the facility or an employee of the facility, unless such provider or employee is a family member of the participant, beneficiary, or enrollee.

(4) The provider or facility satisfies any additional requirements or prohibitions as may be imposed under State law.

(c) *Inapplicability of notice and consent exception to certain items and services.* A nonparticipating provider or nonparticipating facility specified in paragraph (a) of this section will always be subject to the prohibitions in paragraph (a) of this section, with respect to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider or nonparticipating emergency facility satisfied the notice and consent criteria in § 149.420(c) through (g).

(d) *Retention of certain documents.* A nonparticipating emergency facility (with respect to such facility or any nonparticipating provider at such facility) that obtains from a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage (or an authorized representative of such an individual) a written consent in accordance with § 149.420(e), with respect to furnishing an item or service to such an individual, must retain the written notice and consent for at least a 7-year period after the date on which the item or service is so furnished. If a nonparticipating provider obtains a signed consent from a participant, beneficiary, or enrollee, or such individual's authorized representative, the provider may either coordinate with the facility to retain the written notice and consent for a 7-year period, or the provider must retain the written notice and consent for a 7-year period.

(e) *Notification to plan or issuer.* In the case of a participant, beneficiary, or enrollee who is stabilized and furnished additional items and services described in § 149.110(c)(2)(ii), a nonparticipating provider or nonparticipating emergency facility must notify the plan or issuer, respectively, when transmitting the bill for such items and services, either on the bill or in a separate document, as to whether all of the conditions described in paragraph (b) of this section are met with respect to each of the items and services for which the bill is submitted, and if applicable, provide to the plan or issuer a copy of the signed written notice and consent document described in paragraph (b)(2) of this section.

(f) *Applicability date.* The provisions of this section are applicable with respect to emergency services furnished during a plan year (in the individual market, policy year) beginning on or after January 1, 2022.

§ 149.420 Balance billing in cases of non-emergency services performed by nonparticipating providers at certain participating health care facilities.

(a) *In general.* A nonparticipating provider of a group health plan or group or individual health insurance coverage who provides items or services (other than emergency services) for which benefits are provided under the plan or coverage at a participating health care facility must not bill, and must not hold liable, a participant, beneficiary, or enrollee of such plan or coverage for a payment amount for such an item or service furnished by such provider with respect to a visit at the facility that exceeds the cost-sharing requirement for such item or service (as determined in accordance with 26 CFR 54.9816–5T(c)(1) and (2), 29 CFR 2590.717–1(c)(1) and (2), and § 149.120(c)(1) and (2), as applicable), unless the provider (or the participating health care facility on behalf of the provider) satisfies the notice and consent criteria of paragraph (c) of this section.

(b) *Inapplicability of notice and consent exception to certain items and services.* The notice and consent criteria in paragraphs (c) through (i) of this section do not apply, and a nonparticipating provider specified in paragraph (a) of this section will always be subject to the prohibitions in paragraph (a) of this section, with respect to the following services:

- (1) Ancillary services, meaning—
 - (i) Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
 - (ii) Items and services provided by assistant surgeons, hospitalists, and intensivists;
 - (iii) Diagnostic services, including radiology and laboratory services; and
 - (iv) Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

(2) Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider satisfied the notice and consent criteria in paragraph (c) of this section.

(c) *Notice and consent to be treated by a nonparticipating provider.* Subject to paragraph (f) of this section, and unless prohibited by State law, a nonparticipating provider satisfies the notice and consent criteria of this paragraph (c) with respect to items or services furnished by the provider to a participant, beneficiary, or enrollee of a group health plan or group or individual

health insurance coverage, if the provider (or a participating health care facility on behalf of a nonparticipating provider)—

(1) Provides to the participant, beneficiary, or enrollee a written notice in paper or, as practicable, electronic form, as selected by the individual, that contains the information required under paragraph (d) of this section, provided such written notice is provided:

(i) In accordance with guidance issued by HHS, and in the form and manner specified in such guidance;

(ii) With the consent document, and is provided physically separate from other documents and not attached to or incorporated into any other document; and

(iii) To such participant, beneficiary, or enrollee—

(A) Not later than 72 hours prior to the date on which the individual is furnished such items or services, in the case where the appointment to be furnished such items or services is scheduled at least 72 hours prior to the date on which the individual is to be furnished such items and services; or

(B) On the date the appointment to be furnished such items or services is scheduled, in the case where the appointment is scheduled within 72 hours prior to the date on which such items or services are to be furnished. Where an individual is provided the notice on the same date that the items or services are to be furnished, providers and facilities are required to provide the notice no later than 3 hours prior to furnishing items or services to which the notice and consent requirements apply.

(2) Obtains from the participant, beneficiary, or enrollee the consent described in paragraph (e) of this section to be treated by the nonparticipating provider. An authorized representative may receive the notice on behalf of a participant, beneficiary, or enrollee, and may provide consent on behalf of the participant, beneficiary, or enrollee. For purposes of this section and § 149.410, an authorized representative is an individual authorized under State law to provide consent on behalf of the participant, beneficiary, or enrollee, provided that the individual is not a provider affiliated with the facility or an employee of the facility, unless such provider or employee is a family member of the participant, beneficiary, or enrollee. The consent must—

(i) Be provided voluntarily, meaning the individual is able to consent freely, without undue influence, fraud, or duress;

(ii) Be obtained in accordance with, and in the form and manner specified in, guidance issued by HHS; and

(iii) Not be revoked, in writing, by the participant, beneficiary, or enrollee prior to the receipt of items and services to which the consent applies.

(3) Provides a copy of the signed written notice and consent to the participant, beneficiary, or enrollee in person or through mail or email, as selected by the participant, beneficiary, or enrollee.

(d) *Information required under written notice.* The written notice described in paragraph (c)(1) of this section must be provided in the form and manner specified by HHS in guidance, and must—

(1) State that the health care provider is a nonparticipating provider, with respect to the health plan or coverage.

(2) Include the good faith estimated amount that such nonparticipating provider may charge the participant, beneficiary, or enrollee for the items and services involved (including any item or service that is reasonably expected to be furnished by the nonparticipating provider in conjunction with such items or services), including notification that the provision of the estimate or consent to be treated under paragraph (e) of this section does not constitute a contract with respect to the charges estimated for such items and services or a contract that binds the participant, beneficiary, or enrollee to be treated by that provider or facility.

(3) Provide a statement that prior authorization or other care management limitations may be required in advance of receiving such items or services at the facility.

(4) Clearly state that consent to receive such items and services from such nonparticipating provider is optional and that the participant, beneficiary, or enrollee may instead seek care from an available participating provider, with respect to the plan or coverage, as applicable, and that in such cases the cost-sharing responsibility of the participant, beneficiary, or enrollee would not exceed the responsibility that would apply with respect to such an item or service that is furnished by a participating provider, as applicable, with respect to such plan.

(e) *Consent described to be treated by a nonparticipating provider.* The consent described in this paragraph (e), with respect to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage who is to be furnished items or services by a nonparticipating provider, must be documented on a form specified by the

Secretary, in consultation with the Secretary of Labor, through guidance and provided in accordance with such guidance, that must be signed by the participant, beneficiary, or enrollee before such items and services are furnished and that—

(1) Acknowledges in clear and understandable language that the participant, beneficiary, or enrollee has been—

(i) Provided with the written notice under paragraph (c) of this section, in the form selected by the participant, beneficiary, or enrollee.

(ii) Informed that the payment of such charge by the participant, beneficiary, or enrollee might not accrue toward meeting any limitation that the plan or coverage places on cost sharing, including an explanation that such payment might not apply to an in-network deductible or out-of-pocket maximum applied under the plan or coverage.

(2) States that by signing the consent, the individual agrees to be treated by the nonparticipating provider and understands the individual may be balance billed and subject to cost-sharing requirements that apply to services furnished by the nonparticipating provider.

(3) Documents the time and date on which the participant, beneficiary, or enrollee received the written notice described in paragraph (c) of this section and the time and date on which the individual signed the consent to be furnished such items or services by such nonparticipating provider.

(f) *Language access.* (1) A nonparticipating provider (or the participating health care facility on behalf of the nonparticipating provider) must provide the individual with the choice to receive the written notice and consent document in any of the 15 most common languages in the State in which the applicable facility is located, except that the notice and consent document may instead be available in any of the 15 most common languages in a geographic region that reasonably reflects the geographic region served by the applicable facility; and

(2) If the individual's preferred language is not among the 15 most common languages in which the nonparticipating provider (or the participating health care facility on behalf of the nonparticipating provider) makes the notice and consent document available and the individual cannot understand the language in which the notice and consent document are provided, the notice and consent criteria in paragraph (c) of this section are not met unless the nonparticipating

provider (or the participating health care facility on behalf of the nonparticipating provider) has obtained the services of a qualified interpreter to assist the individual with understanding the information contained in the notice and consent document.

(g) *Scope of consent.* The consent described in paragraph (e) of this section will constitute consent only to the receipt of the information provided pursuant to this section and will not constitute a contractual agreement of the participant, beneficiary, or enrollee to any estimated charge or amount included in such information, or to be treated by that provider or facility.

(h) *Retention of certain documents.* A participating health care facility (with respect to nonparticipating providers at such facility) that obtains from a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage a written consent in accordance with paragraph (e) of this section, with respect to furnishing an item or service to such an individual, must retain the written notice and consent for at least a 7-year period after the date on which the item or service is so furnished. If a nonparticipating provider obtains a signed consent from a participant, beneficiary, or enrollee, where the facility does not otherwise obtain the consent on behalf of the provider, the provider may either coordinate with the facility to retain the written notice and consent for a 7-year period, or the provider must retain the written notice and consent for a 7-year period.

(i) *Notification to plan or issuer.* For each item or service furnished by a nonparticipating provider described in paragraph (a) of this section, the provider (or the participating facility on behalf of the nonparticipating provider) must timely notify the plan or issuer that the item or service was furnished during a visit at a participating health care facility, and, if applicable, provide to the plan or issuer a copy of the signed written notice and consent document described in paragraphs (c) and (e) of this section. In instances where, to the extent permitted by this section, the nonparticipating provider bills the participant, beneficiary, or enrollee directly, the provider may satisfy the requirement to notify the plan or issuer by including the notice with the bill to the participant, beneficiary, or enrollee.

(j) *Applicability date.* The provisions of this section are applicable with respect to items and services furnished during a plan year (in the individual market, policy year) beginning on or after January 1, 2022.

§ 149.430 Provider and facility disclosure requirements regarding patient protections against balance billing.

(a) *In general.* Each health care provider and health care facility (including an emergency department of a hospital and an independent freestanding emergency department) must make publicly available, post on a public website of such provider or facility (if applicable), and provide to any individual who is a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer and to whom the provider or facility furnishes items or services, the information described in paragraph (b) of this section regarding patient protections against balance billing, except as provided in paragraphs (e) and (f) of this section. A provider or facility must make the disclosures in accordance with the method and timing requirements set forth in paragraphs (c) and (d) of this section.

(b) *Content.* The disclosures required under this section must include, in clear and understandable language, all the information described in this paragraph (b) (and may include any additional information that does not conflict with that information).

(1) A statement that explains the requirements of and prohibitions applicable to the health care provider or health care facility under sections 2799B–1 and 2799B–2 of the PHS Act and their implementing regulations in §§ 149.410 and 149.420;

(2) If applicable, a statement that explains any State law requirements regarding the amounts such provider or facility may, with respect to an item or service, charge a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer with respect to which such provider or facility does not have a contractual relationship, after receiving payment, if any, from the plan or coverage, respectively, for such item or service and any applicable cost-sharing payment from such participant, beneficiary, or enrollee; and

(3) A statement providing contact information for the appropriate State and Federal agencies that an individual may contact if the individual believes the provider or facility has violated a requirement described in the notice.

(c) *Required methods for disclosing information.* Health care providers and health care facilities must provide the disclosure required under this section as follows:

(1) With respect to the required disclosure to be posted on a public website, the information described in paragraph (b) of this section, or a link to such information, must appear on a searchable homepage of the provider's or facility's website. A provider or facility that does not have its own website is not required to make a disclosure under this paragraph (c)(1).

(2) With respect to the required disclosure to the public, a provider or facility must make public the information described in paragraph (b) of this section on a sign posted prominently at the location of the provider or facility. A provider that does not have a publicly accessible location is not required to make a disclosure under this paragraph (c)(2).

(3) With respect to the required disclosure to individuals who are participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a provider or facility must provide the information described in paragraph (b) of this section in a one-page (double-sided) notice, using print no smaller than 12-point font. The notice must be provided in-person or through mail or email, as selected by the participant, beneficiary, or enrollee.

(d) *Timing of disclosure to individuals.* A health care provider or health care facility is required to provide the notice to individuals who are participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer no later than the date and time on which the provider or facility requests payment from the individual, or with respect to an individual from whom the provider or facility does not request payment, no later than the date on which the provider or facility submits a claim to the group health plan or health insurance issuer.

(e) *Exceptions.* A health care provider is not required to make the disclosures required under this section—

(1) If the provider does not furnish items or services at a health care facility, or in connection with visits at health care facilities; or

(2) To individuals to whom the provider furnishes items or services, if such items or services are not furnished at a health care facility, or in connection with a visit at a health care facility.

(f) *Special rule to prevent unnecessary duplication with respect to health care providers.* To the extent a provider furnishes an item or service covered under the plan or coverage at a health care facility (including an emergency

department of a hospital or independent freestanding emergency department), the provider satisfies the requirements of paragraphs (c)(2) and (3) of this section if the facility makes the information available, in the required form and manner, pursuant to a written agreement. Accordingly, if a provider and facility enter into a written agreement under which the facility agrees to make the information required under this section available on a sign posted prominently at the facility and to provide the one-page notice to individuals in compliance with this section, and the facility fails to do so, then the facility, but not the provider, violates the disclosure requirements of this section.

(g) *Applicability date.* The provisions of this section are applicable beginning on January 1, 2022.

§ 149.440 Balance billing in cases of air ambulance services.

(a) *In general.* In the case of a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer who is furnished air ambulance services (for which benefits are available under such plan or coverage) from a nonparticipating provider of air ambulance services, with respect to such plan or coverage, the provider must not bill, and must not hold liable, the participant, beneficiary, or enrollee for a payment amount for the air ambulance services furnished by the provider that is more than the cost-sharing amount for such service (as determined in accordance with 26 CFR 54.9817–1T(b)(1) and (2), 29 CFR 2590.717–1(b)(1) and (2), and § 149.130(b)(1) and (2), as applicable).

(b) *Applicability date.* The provisions of this section are applicable with respect to air ambulance services furnished during a plan year (in the individual market, policy year) beginning on or after January 1, 2022.

§ 149.450 Complaint process for balance billing regarding providers and facilities.

(a) *Scope and definitions.*—(1) *Scope.* This section establishes a process for HHS to receive and resolve complaints regarding information that a health care provider, provider of air ambulance services, or health care facility may be failing to meet the requirements under subpart E of this part, which may warrant an investigation.

(2) *Definitions.* In this section—

(i) *Complaint* means a communication, written, or oral, that

indicates there has been a potential violation of the requirements under this subpart, whether or not a violation actually occurred.

(ii) *Complainant* means any individual, or their authorized representative, who files a complaint as defined in paragraph (a)(2)(i) of this section.

(b) *Complaints process.* (1) HHS will consider the date a complaint is filed to be the date upon which HHS receives an oral, written, or electronic statement that identifies information about the complaint sufficient to identify the parties involved and the action or inaction complained of.

(2) HHS will notify complainants, by oral or written means, of receipt of the complaint no later than 60 business days after the complaint is received. HHS will include a response acknowledging receipt of the complaint, notifying the complainant of their rights and obligations under the complaints process, and describing the next steps of the complaints resolution process. HHS may request additional information that may be needed to process the complaint as part of the response. Such additional information may include:

(i) Health care provider, air ambulance provider, or health care facility bills;

(ii) Health care provider, air ambulance provider, or health care facility network status;

(iii) Information regarding the participant's, beneficiary's, or enrollee's health care plan or health insurance coverage;

(iv) Information to support a determination regarding whether the service was an emergency service or non-emergency service;

(v) Documents regarding the facts in the complaint in the possession of, or otherwise attainable by, the complainant; or

(vi) Any other information HHS needs to make a determination of facts for an investigation.

(3) HHS will make reasonable efforts consistent with agency practices to notify the complainant of the outcome of the complaint after the submission is processed through appropriate methods as determined by HHS. A complaint is considered processed after HHS has reviewed the complaint and accompanying information and made an outcome determination. Based on the nature of the complaint, HHS may—

(i) Refer the complainant to another appropriate Federal or State resolution process;

(ii) Notify the complainant and make reasonable efforts to refer the complainant to the appropriate State or Federal regulatory authority if HHS receives a complaint where another entity has enforcement jurisdiction over the health care provider, air ambulance provider or health care facility;

(iii) Refer the health care provider, air ambulance provider or health care facility for an investigation for enforcement action under 45 CFR part 150; or

(iv) Provide the complainant with an explanation of resolution and any corrective action taken.

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

■ 19. The authority citation for part 156 continues to read as follows:

Authority: 42 U.S.C. 18021–18024, 18031–18032, 18041–18042, 18044, 18054, 18061, 18063, 18071, 18082, and 26 U.S.C. 36B.

■ 20. Section 156.155 is amended by:

■ a. Revising paragraph (a)(3);

■ b. Redesignating paragraph (c) as paragraph (d); and

■ c. Adding a new paragraph (c).

The revision and addition read as follows:

§ 156.155 Enrollment in catastrophic plans.

(a) * * *

(3) Provides coverage of the essential health benefits under section 1302(b) of the Affordable Care Act, except that the plan provides no benefits for any plan year (except as provided in paragraphs (a)(4), (b), and (c) of this section) until the annual limitation on cost sharing in section 1302(c)(1) of the Affordable Care Act is reached.

* * * * *

(c) *Coverage to prevent surprise medical bills.* A catastrophic plan must provide benefits as required under sections 2799A–1 and 2799A–2 of the Public Health Service Act and their implementing regulations in §§ 149.110, 149.120, and 149.130 or any applicable State law providing similar protections to individuals, and will not violate paragraph (a)(3) of this section solely because of the provision of such benefits before the annual limitation on cost sharing is reached.

* * * * *

[FR Doc. 2021–14379 Filed 7–6–21; 4:15 pm]

BILLING CODE 6523–63–P; 4830–01–P; 4510–29–P; 4120–01–P

PUBLIC SUBMISSION

As of: September 08, 2021 Received: September 07, 2021 Status: Draft Category: Health Care Professional/Association - Physician Tracking No. kta-fxoo-ov0d Comments Due: September 07, 2021 Submission Type: API

Docket: CMS-2021-0117

Requirements Related to Surprise Billing; Part I CMS-9909-IFC Dispay

Comment On: CMS-2021-0117-0002

Requirements Related to Surprise Billing; Part I

Document: CMS-2021-0117-DRAFT-7445

Comment on CMS-2021-0117-0002

Submitter Information

Email: kelly.walla@texmed.org

Organization: Texas Medical Association (and others as listed in the comment letter)

General Comment

Dear Secretary Becerra, Secretary Walsh, Secretary Yellen, and Administrator Brooks-LaSure:

Please find attached comments of the Texas Medical Association, Texas Orthopaedic Association, Texas College of Emergency Physicians, Texas Radiological Society, Texas Society of Pathologists, and Texas Society of Anesthesiologists (hereinafter the “Associations”) on the interim final rules on the Requirements Related to Surprise Billing; Part I, as published in the July 13, 2021 edition of the Federal Register (File code: CMS–9909–IFC)

Attachments

9 7 2021 TMA and Association comments on NSA Part 1 final



September 7, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, D.C. 20210

The Honorable Chiquita Brooks-LaSure
Administrator
Center for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-9909-IFC; Requirements Related to Surprise billing; Part I

Submitted via *Federal eRulemaking Portal* at www.regulations.gov

Dear Secretary Becerra, Secretary Walsh, Secretary Yellen, and Administrator Brooks-LaSure:

On behalf of our collectively more than 55,000 physician and medical student members, the Texas Medical Association (TMA), Texas Orthopaedic Association, Texas College of Emergency Physicians, Texas Radiological Society, Texas Society of Pathologists, and Texas Society of Anesthesiologists (hereinafter the “Associations”) appreciate this opportunity to comment on the [interim final rules](#) on the Requirements Related to Surprise Billing; Part I, as published in the July 13, 2021 edition of the *Federal Register*.

Our organizations have a keen interest in legislative and regulatory efforts relating to “surprise” out-of-network balance bills. The Associations supported surprise billing legislation in Texas (i.e., [SB 1264](#), 86th Regular Session), as passed, due to our commitment to helping patients address “surprise” out-of-network balance bills.

The Associations also support many of the patient protection measures included in the No Surprises Act and the interim final rules (such as protections reinforcing the prudent layperson standard for emergency care and the application of cost-sharing amounts to the in-network deductible and out-of-pocket maximum); however, we have grave concerns with others portions of the rule, such as the “qualifying payment amount” definition in the context of the independent dispute resolution (IDR) process. Our specific comments are set forth in more detail, below.

I. Definitions

A. “Health care facility” and “Independent freestanding emergency department”

1. “Health care facility”

The definition of “health care facility” in the interim final rules is as follows in the context of nonemergency services: (1) a hospital (as defined in section 1861(e) of the Social Security Act; (2) a hospital outpatient department; (3) a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act; and (4) an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

The Departments solicit feedback on whether additional facilities should be included in this definition and request feedback related to urgent care centers and retail health clinics. As the preamble states,

[t]he Departments recognize that state regulation of urgent care centers varies significantly, as does the type of services they are permitted to provide under state law. Under these interim final rules, emergency services provided at urgent care centers that are licensed in a manner that brings them within the definition of independent freestanding emergency department would be subject to cost-sharing and balance billing protections, among others. However, given significant variation in state law definitions, urgent care centers are not included within the definition of health care facilities, in the context of nonemergency services.¹

The Associations strongly agree with not including urgent care centers in the definition of a “health care facility.” As acknowledged by the Departments, state regulation of urgent care centers varies widely (as do the services provided at urgent care centers). Some states license urgent care centers and treat them as a facility. Others, like Texas, do not license urgent care centers and regulate them not as facilities but as physician practices (focusing on physician licensure and oversight by the state medical board). It is imperative that the Departments not interfere with these existing and long-standing state regulatory frameworks.

The risk of surprise billing is not the same at an urgent care center as it is as at a hospital or other traditional health care facility for multiple reasons, including that (1) a facility fee is not charged; and (2) urgent care centers typically perform a wide variety of services that are lower acuity than emergency care (where surprise billing scenarios are more likely to occur). In contrast to a freestanding emergency care facility (which in Texas are licensed to provide emergency care),

¹ Federal Register Vol. 86, No. 131 at 36882 (July 13, 2021).

urgent care centers often function as walk-in or after-hours care for patients with nonemergent conditions. Since care provided at urgent care centers is lower acuity, there is more of an opportunity to shop for care and avoid a surprise out-of-network bill.

Notably, the Texas Legislature did not include urgent care centers in its definition of a “health care facility” under Texas’ comprehensive surprise billing legislation (i.e., SB 1264, Texas Legislature, 86th Regular Session), thereby recognizing that: (1) surprise billing legislation should be focused on scenarios where surprise billing is most likely to occur (i.e., certain licensed facilities) and (2) urgent care centers in Texas are not those facilities. **We urge the Departments to do the same and refrain from broadening the definition of a “health care facility” to encompass urgent care centers.**

The Associations also oppose any proposed inclusion of retail health clinics in the definition of a “health care facility” for purposes of surprise billing legislation. Retail health clinics are not licensed as health care facilities in Texas and should not be performing emergency services; thus, there is not the same risk for surprise bills in these locations (which may schedule care and provide a smaller range of services than in licensed facilities) as in the facilities encompassed in the Departments’ current definition of a “health care facility.” Surprise billing legislation and regulation is typically directed at avoiding scenarios where patients are likely to be surprised that care is out-of-network, not in circumstances under which patients choose care at a particular location or with a particular provider for convenience.

In summary, the Associations contend that the itemized list in the interim final rule definition of “health care facility” encompasses sufficient facilities for the purposes of implementing the law’s surprise billing protections. Thus, the Associations oppose any proposed inclusion of urgent care centers or retail health clinics in the definition of a “health care facility.”

2. Independent freestanding emergency department

Next, the Departments define an “independent freestanding emergency department” as “a health care facility (not limited to those described in the definition of health care facility with respect to non-emergency services) that—(1) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and (2) provides any emergency services described in §54.9816-4T(c)(2)(i).”

For consistency with the underlying statutory language in the No Surprises Act and to aid physicians and providers in assessing which facilities fall within the definition, the Associations recommend that the rules be amended to refer solely to facilities licensed as independent freestanding emergency departments under state law. However, should the Departments move forward with a more expansive definition (as currently reflected in the interim final rules), the Associations agree with not expressly including urgent care centers in this definition, because (as noted above) the services provided at urgent care centers and the regulation of urgent care centers varies widely under state laws. The Associations also support the separate licensure requirement contained in the current definition of “independent freestanding emergency department.” As noted, above, Texas does not license urgent care centers and thus, our understanding is that Texas urgent care centers, therefore, would not fall within the definition of an independent freestanding

emergency department under the interim final rules. This approach would be consistent with Texas law, which exempts physician offices and clinics from the freestanding emergency medical care facility licensure requirements.

B. “Participating Health Care Facility” and “Participating Emergency Facility”

Next, in the definition of “participating facility,” the interim final rules provide that “a single case agreement between a health care facility and a plan or issuer, used to address unique situations in which a participant, beneficiary, or enrollee requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement with respect to the particular individual involved.” The practical effect of including this language in the “participating health care facility” definition is that when nonparticipating physicians or other providers provide nonemergency care at a facility that has a single case agreement, the nonparticipating physician or provider would be subject to the surprise billing provisions of the interim final rules for that particular individual’s care.

While the Associations understand the Departments’ rationale for inclusion of this language as stated in the preamble (i.e., to address instances where the patient might expect the other providers to be in-network), we are concerned that this expansive definition of “participating facilities,” will have two negative effects on patients and physicians. First, inclusion of this language will create compliance challenges for nonparticipating physicians and other providers. It will be more difficult for a physician or provider who is providing services at a facility to know whether such a single case agreement (to which they are not a party) is in place (and, therefore, whether the physician or provider is subject to the balance billing prohibitions and other requirements under the law). Given the steep penalties applicable for violations of the law, this compliance challenge could ensnare well-intentioned physicians and providers who, despite good faith efforts, may violate the law based upon a lack of knowledge of these single-case agreements.

Additionally, the single case agreement language essentially permits health benefit plan issuers and health care facilities to determine on a case-by-case basis whether an individual will fall within the No Surprises Act (for nonparticipating physicians or providers providing services at the facilities). This allowance may disincentivize health plans from developing robust networks (by giving them assurances that they can rely on these single case agreements with facilities as a backstop). **Thus, while inclusion of the single case agreement in the definition might benefit the individual whose care is affected by the agreement, it may seriously harm the composition of the network on a broader scale (resulting in patients having fewer choices of in-network physicians and other providers overall).**

The Associations, therefore, recommend that the Departments strike the last sentence regarding single case agreements from the interim final rules. Should the Departments move forward with the single case agreement language, over the Associations’ objection, the Associations ask that the Department include language stating that the single case agreement must be in advance of the provision of services (to make it abundantly clear that an agreement after services have been rendered does not affect the application of the No Surprises Act to nonparticipating physicians or providers providing services at the single case agreement facility).

The Associations note that the same language regarding single case agreement is included in the interim final rules for “participating emergency facility.” The Associations offer the same comments, as stated above, with regard to the “participating emergency facility” definition. The single case agreement language in both definitions goes beyond the language of the underlying law and is problematic for the reasons stated herein.

C. “Specified State Law”

Next, the rules define a “specified state law” as follows:

a state Law that provides a method for determining the total amount payable under a group health plan to the extent such State law applies for an item or service furnished by a nonparticipating provider or nonparticipating emergency facility (including where it applies because the State has allowed a plan that is not otherwise subject to applicable State law an opportunity to opt in, subject to section 514 of the Employee Retirement Income Security Act of 1974). A group health plan that opts into such a specified State law must do so for all items and services to which the specified State law applies and in a manner determined by the applicable State authority, and must prominently display in its plan materials describing the coverage of out-of-network services a statement that the plan has opted into the specified State law, identify the relevant State (or States), and include a general description of the items and services provided by nonparticipating facilities and providers that are covered by the specified State law).

1. Comments on “a method for determining the total amount payable”

The Associations appreciate the Departments’ consistency with underlying statutory language in the first portion of the definition of “specified state law” in the interim final rules and the explanatory language in the preamble on that portion of the definition; however, the Associations have some remaining concerns with the ERISA language and believe that additional guidance likely will be needed on the interaction between state and federal law (particularly for physicians and providers who are licensed and practicing in multiple states with surprise billing laws).

Determining whether a particular state law addressing surprise billing qualifies as a “specified state law” under the No Surprises Act and regulations will be critical for compliance efforts by the regulated community (as it is clear from the federal law and the rules that the cost-sharing amount, payment, and independent dispute resolution provisions of “specified state laws” are not preempted). Varying interpretations of the application of state and federal law may result in enforcement efforts taken against providers who are making good faith attempts to navigate the interaction between state and federal law.

For this reason, we are particularly appreciative of the Departments’ guidance in the preamble, which states as follows:

The Departments interpret the statutory phrase ‘a State law that provides for a method for determining the total amount payable under such a plan, coverage, or

issuer, respectively’ broadly as referring not only to state laws that set a mathematical formula for determining the out-of-network rate, or that set a predetermined amount for an out-of-network item or service. Rather the Departments interpret that language to also include, for example, state laws that require or permit a plan or issuer and a provider or facility to negotiate and then to engage in a state arbitration process to determine the out-of-network rate. Such state laws provide a process for determining the total amount payable, and in such instances, the timeframes and processes under such a state law related to negotiations and arbitration would apply, as opposed to the timeframes and IDR processes under the No Surprises Act.²

The Associations **strongly agree** that the statutory language should be interpreted broadly to effectuate Congress’ intent of not preempting state surprise billing laws. In particular, we strongly agree that state laws, such as Texas’ law (i.e., SB 1264, 86th Regular Session) that require or permit a plan or issuer and provider or facility to negotiate and then engage in a state arbitration process to determine the out-of-network rate qualify as a “specified state law.” Clearly by using language that references a “method for determining,” Congress did not intend the “specified state law” language to be limited to state laws that set a fee schedule or mathematical formula for assessing the total out-of-network payment. This is the only rational reading of the statutory language.

Further, state laws that have an arbitration process like Texas’ arbitration process do set forth “a method for determining the total payment amount.” In Texas, there is a defined method for determining the enrollee’s cost sharing (which is based upon the amount initially determined payable by the plan or if applicable, a modified amount determined under the plan’s internal appeal process) and there is a defined method of determining the total payment amount (with the arbitrator limited to selecting between certain amounts in baseball style arbitration after determining the reasonable amount for the services or supplies). Thus, a surprise billing law that is similar to Texas’ should (very clearly) qualify as a “specified state law” under the No Surprises Act.

Some [law articles](#) have raised questions as to whether the “total payment amount” language in the statute requires the arbitration under a state law to be binding. The Associations note that the arbitration determination under Texas’s surprise billing law is, in fact, “binding.” Thus, such a distinction should not affect the qualification of Texas’ law as a “specified state law.” As reflected in SB 1264, the Texas Legislature used the word “binding” **seven** different times in the statute to describe the arbitration determination. Most expressly, the Texas Legislature states in Section 1467.089 that “[a]n arbitrator’s decision under Section 1467.088 is binding.” Texas law does permit a narrow window of 45 days for a party not satisfied with the decision to file an action to determine the payment due to an out-of-network provider, but this is a very limited review under a substantial evidence standard of review. Thus, this review should not be construed as altering the binding nature of the award for purposes of the specified state law analysis.³

² *Id.* at 36887.

³ Anecdotally, the Texas Medical Association has also been told that when a provider has won under the substantial evidence standard of review, the court has stated their recourse was to go back through arbitration to determine the award.

In any event, the Associations also contend that the “total payment amount” determination should not be dependent upon whether an arbitration decision is “binding” or not, because a non-binding arbitration determination would still be a process for determining the total payment amount (thus strictly complying with the language of the No Surprises Act). The No Surprises Act statutory language does not state that any arbitration process has to be “binding” in order to fall within the “specified state law” provision nor does the Departments’ explanatory language in the preamble. Such an additional requirement should not be read into the statutory language, thereby altering the plain meaning of the statute. Furthermore, the Associations agree with the Departments that the language should be broadly construed to effectuate Congress’ intended deference to the states with surprise billing legislation.

The Associations note that [some analyses](#) have viewed 16 state laws as having comprehensive surprise billing laws and several more as having partial surprise billing laws. Yet, the preamble references 14 (unidentified) states as having established a method for determining payment for nonparticipating emergency and nonemergency services. This disconnect has caused some to raise concern as to whether their particular state’s surprise billing law would qualify as a “specified state law.” Thus, additional clarification could be beneficial to prevent any confusion among the regulated community as physicians and providers attempt to navigate state and federal law (particularly those who provide services physically in multiple states or via telemedicine). However, in issuing any such further guidance, the Associations urge the Departments, again, to be mindful of the interim final rule statement regarding broad construction of the statutory language and to avoid narrowing the scope of the “specified state law” definition. Specified state laws (including laws that apply comparable or additional requirements on plans), like Texas’ clearly were not intended to be preempted by the No Surprises Act. The Departments should not alter this statutory intent.

The Associations also recommend that, given the risk for potential confusion over which law (state versus federal) applies in a particular scenario, the Departments provide for an opportunity for physicians and other providers acting in good faith who use the wrong process to correct the mistake without penalty. Furthermore, any timelines under state or federal law for initiating arbitration should also be deemed to have been satisfied if arbitration was initiated in the wrong forum (i.e., state versus federal). For example, if a provider initiates an arbitration under federal law within 90 days of receipt of initial payment (i.e., the timeframe applicable for initiating arbitration in Texas), but the arbitration should have been initiated under Texas’ arbitration process, Texas should permit that arbitration to proceed in Texas even if the arbitration is shifted to Texas after the expiration of the 90-day arbitration initiation period. The same should apply with any deadlines applicable at the federal level for initiating arbitration.

2. Comments on the ERISA-Opt-In Component of the “Specified State Law” Definition

Next, the Departments add a statement in the definition of “specified state law” providing that a specified state law “includes where the state law applies because the State has allowed a plan that is not otherwise subject to applicable State law an opportunity to opt in, subject to section 514 of the Employee Retirement Income Security Act of 1974).”

The rules further specify that “a group health plan that opts into such a specified State law must do so for all items and services to which the specified State law applies and in a manner determined by the applicable State authority, and must prominently display in its plan materials describing the coverage of out-of-network services a statement that the plan has opted into the specified State law, identify the relevant State (or States), and include a general description of the items and services provided by nonparticipating facilities and providers that are covered by the specified State law).”

Although Texas’ surprise billing law does not currently have an ERISA opt-in, the Associations **strongly agree** that for states that do have an ERISA opt-in a self-funded plan that chooses to opt-in should be required to opt in for all items and services to which the specified state law applies (in order to protect against the self-insured plan cherry picking the application of state law). It must be wholesale opt-in, not piecemeal or episodic opt-ins. Furthermore, health plan issuers should not be able to opt-in on a product-specific basis. Again, it should be wholesale or not at all.

We also agree that if ERISA opt-ins are permitted by self-funded plans, the ERISA opt-in must be in the manner determined by applicable state law. It is important for states to have the latitude (if granting ERISA opt-ins) to set the terms of those opt-ins (e.g., requiring plans to voluntarily agree to more than just the process for surprise billing, but also to the enforcement provisions and other attendant regulations (e.g., network adequacy requirements) under state law). Presumably, compliance with any additional requirements under state opt-in laws is part of what is contemplated by the interim final rule’s statement regarding “in the manner determined by the applicable State authority.” The Associations also contend that a self-funded plan should not be able to unilaterally dictate whether a physician or other provider is subject to a self-funded plan’s opt-in.

3. Opt-Ins to State Law for Providers

Next in the interim final rules, the Departments expressly seek comment on whether the rules should provide flexibility for health plan issuers, physicians or providers to opt-in to a particular state’s program when the issuer, physician or provider is not otherwise subject to a specified state law that provides a method for determining the total amount payable under a group health plan or group or individual health insurance coverage with respect to an item or service furnished by the nonparticipating provider.

The Associations contend that health plan issuers should not be able to unilaterally decide (or cherry pick) which claims go through federal versus state law (or which particular state law applies to particular items or services). However, there are circumstances where it makes sense for physicians and providers to have the **option** to have expanded access to a specified state law’s process (rather than having to go through the federal law process). For example, it makes sense if there are services provided by a particular physician or provider on a single claim or for a single episode of care that are split between a specified state law and federal law arbitration process for the physician or provider to have the ability to opt-in to the state law for the items or services that would otherwise be subject to the federal process in order to avoid the administrative hassle of two separate processes (and the expense of two separate arbitrations).

To illustrate this point, this would make sense in the scenario described in Example 3 in the preamble on page 36886 of the interim final rules where a specified state law covers emergency care but does not cover post-stabilization care. Under most state surprise billing laws, post-stabilization services are not included in the definition of emergency services. Thus, if a patient has both emergency services and post-stabilization services, the provider would have to use two separate processes for these claims with the current drafting of the interim final rule. This split process adds additional and unnecessary expense and compliance burden for physicians and other providers.

Furthermore, it makes sense if a physician or provider is subject to a state surprise billing law for fully-insured plans for a particular item or service (e.g., provided on an emergency basis out-of-network in an in-network facility), for the physician or provider to have the option to use the same state surprising billing law for those items and services under the same circumstances when those items or services are covered by a self-insured plan. Using one state independent dispute resolution (IDR) program may be much less administratively burdensome and costly for a physician than having to parse out which claims go through a state law IDR process and which go through the federal IDR process. Most physicians in Texas have historically practiced in small groups. It will be challenging for physicians in practices of all sizes (but especially in small practices) to navigate separating out each claim based upon the particular plan type. Thus, allowing physicians the flexibility to choose to utilize a single state-based process that would otherwise apply to them for fully-insured plans would accomplish the desired goals of the federal legislation while reducing costs and expenses to physician and provider practices. The Associations recommend that the Departments provide the physicians and other providers with this option. Health plans operate on a much larger scale and face fewer difficulties navigating multiple laws, **thus the state-only pathway should be at the physician or provider's choice.**

In Texas, the relevant stakeholders (physicians, hospitals, health plans, and consumer groups) all ultimately supported SB 1264, as passed. Texas' legislation was carefully crafted to provide a means of protecting patients from "surprise" out-of-network balance bills while providing physicians and providers with an IDR process to seek reasonable payment (thereby deterring plans from terminating long-standing physician contracts). The Texas system, which also includes network adequacy examinations conducted by the Texas Department of Insurance (TDI) at least each three years for state-regulated plans, has been working. If a state has an established program (and is consistent with the underlying goals of the No Surprises Act as is Texas' law), a physician or provider should be able to utilize that system more fully, if desired.

D. "Qualifying Payment Amount"

Under the No Surprises Act, the Departments are directed to establish through rulemaking the methodology that group health plans and health insurance issuers are required to use to determine the "qualifying payment amount" (QPA). The methodology is critical, because the QPA is used for two important purposes under the law: (1) (in circumstances when an All Payer Model Agreement or specified state law does not apply) to determine the recognized amount for patient cost-sharing responsibilities; and (2) for consideration by IDR entities when selecting between the plan and facility or provider's offer and determining the total payment for emergency services

furnished by a nonparticipating emergency facility or nonparticipating provider, or non-emergency services performed by a nonparticipating providers at participating facilities that are subject to the federal IDR process.

While the Associations support low cost-sharing for patients out-of-network (and appreciate the Departments efforts to this end), we have grave concerns with the current methodology used to establish QPA to the extent that it is considered in the IDR process (and represented as reflective of the market), because the methodology does not accurately reflect median contracted rates or the market. Our concerns with some of the specific elements of the QPA are detailed, below.

1. Median Contracted Rate

Under the law, the “qualifying payment amount” (QPA) for a particular item or service is the median of the contracted rates recognized by the plan or issuer on January 31, 2019 for the same or similar item or service that is provided by a provider in the same or similar specialty and provided in a geographic region in which the item or service is furnished, increased for inflation. The median contracted rate is determined with respect to all group health plans of the plan sponsor or all group or individual health insurance coverage offered by the health insurance issuer that are offered in the same insurance market, consistent with the methodology established by the Departments.

Under the methodology in the rule, the median contracted rate for an item or service is determined by arranging the contract rates in order from highest to lowest and selecting the middle number (or when there is an even number of rates, the average of the middle two rates). The rules further provide that “[i]n determining the median contracted rate, the amount negotiated under each contract is treated as a separate amount.” Thus, each contracted rate for a particular item or service will be treated as a single data point when calculating the median contracted rate (so that group contracts are treated as a single data point and have the same weight as a single contract with an individual physician).

The Associations are very concerned with this approach as it is not reflective of market rates under typical contract negotiations and will artificially deflate the median contract rate. In the health insurance market, negotiations are entered into with a variety of physician practices of varying sizes (from solo practitioners to large group practices). In Texas, most physicians have historically practiced in small groups. But regardless of the size of a physician practice, each physician is a part of the market and affects market rates (even if the physician is part of a group contract).

Yet, the interim final rules fail to acknowledge the role each physician in the market and create a scenario wherein the median contract rate may discount contracts that are representative of a majority of physicians in the area (e.g., if three contracts are considered with the contracts representing a group practice of 50, a group practice of 5 and a solo practitioner, and the group practice of 5 is the median rate). While we understand that as a practical matter, large group practices may, in some instances have greater bargaining power (and more favorable rates) than solo practitioners, this is a part of normal market functioning. To weigh group contracts the same

as a single physician contract significantly distorts the market to skew it in favor of smaller contracts wherein physicians presumably have less bargaining power.

The rules also provide that the number of claims or services provided under the contract for the particular item or service will not be considered in determining the median contracted rate. The Associations note that as part of contract negotiations, physicians or providers may negotiate differently for particular services dependent upon the number of times they expect to perform that service. For low volume services, they may find lower rates more acceptable (knowing that they can make up the loss in fees for other services that are provided more frequently). For higher volume services, they may spend more time negotiating the rate because it has a greater impact on their practice's viability. Thus, failure to consider the volume of claims and weight contracted claims by frequency may also significantly distort the median contract rate determination.

2. Insurance Market

Under the interim final rules, the insurance market is defined as the individual market, small group market, or large group market (each as defined under section 2791(e) of the PHS Act (and are defined irrespective of state). The preamble to the rules further expounds on the definition of an insurance market.

The Associations appreciate the Departments' clarification in the preamble that Medicare Advantage and Medicaid managed care plans must not be included in any insurance market for purposes of determining the QPA. We strongly agree that Medicare Advantage and Medicaid managed care (as well as Medicaid fee-for-service and Medicare) should be *excluded* from calculating the median contracted rates. Inclusion of these products (which are not commercial products) is not contemplated by the No Surprises Act and would inappropriately distort the QPA determination.

We are concerned, however, that the interim final rules “permit sponsors of self-insured group health plans to allow their third-party administrators to determine the QPA for the sponsor by calculating the median contracted rate using the contracted rates recognize by all self-insured group health plans administered by the third-party administrator (not only those of the particular plan sponsor.)”⁴

While we understand the stated rationale for this decision (i.e., to reduce the burden imposed on the sponsors and to have fewer instances of insufficient information to calculate a median contracted rate for a given item or service), we are very concerned that this flexibility will permit TPAs to calculate the QPA in a manner that is most advantageous for them (i.e. creates the lowest QPA) and is not reflective of the plan sponsor or the relevant network.

3. Same or Similar Item or Service

Next, in the interim final rules, the Departments define “same or similar item service” for purposes of the QPA as a health care item or service billed under the same service code, or comparable code

⁴ *Id.* at 36890.

under a different procedural code system. The interim final rules include specific requirements concerning modifiers. For example, the rules provide that:

... plans and issuers must calculate separate median contracted rates for CPT code modifiers that distinguish the professional services component (“26”) from the technical component (“TC”). This will result in separate median contracted rates being calculated for services when billed by a facility versus a provider. In addition, where a plan or issuer’s contracted rates otherwise vary based on applying a modifier, the plan or issuer must calculate a separate median contracted rate for each such service code-modifier combination.⁵

The Associations are concerned that the interim final rules’ language on determining same or similar service does not appear to account for the effect of downcoding by health plans on the QPA. If plans are permitted to calculate median contracted rates on the downcoded claims rather than on the level of claim submitted for payment, they can reduce the median contract rate through their own initiative (thereby deflating the appropriate contracted rate for QPA purposes). We also agree with the AMA’s [prior comments](#) stating that: (1) the contracted rates used to calculate a median rate should not incorporate modifiers that reduce payments and (2) the departments “should consider using an outlier methodology that excludes \$0 paid on claims, as well as inappropriately low payments, that may result in inappropriate skewing of the median.”

4. Same or similar specialty provider

Next, the interim final rules provide that the median contracted rate must be calculated separately for each provider specialty if a plan or issuer has contracted rates for a service code that vary based on provider specialty. Under the rules, “provider in the same or similar specialty” is defined as “the practice specialty of a provider, as identified by the plan or issuer consistent with the plan’s or issuer’s usual business practice” If the plan or issuer uses separate identifications of specialty for contracting purposes and other business needs, the plan is supposed to be required (as stated in the preamble) to use the specialty classification that the plan uses for contracting purposes.

The Associations are concerned that the definition and explanatory language in the preamble appear to defer significantly to the plan’s classification of the physician or provider’s specialty. The plan’s classification also should have to accurately reflect the physician or provider’s self-designation of specialty (and not unilaterally be determined by the plan in order to prevent plans from skewing the results of the applicable rates); otherwise, this could negatively affect the QPA determination. We also note that for a truly apples-to-apples comparison, it is vital for the same or similar specialty provider to be the same or similar specialty provider with the same licensure type (i.e., physicians of the same or similar specialty should be compared to other physicians of the same or similar specialty). The education, training, and experience of a provider affects negotiated contract rates.

5. Geographic Regions

⁵ *Id.* at 36891.

In order to narrow and more accurately reflect the markets, the No Surprises Act requires plans to calculate the median contracted rate for an item or service using contracted rates for the similar item or service provided in the geographic region where the item is furnished. The Associations are concerned that under the interim final rules, geographic areas are defined very broadly as one region for each metropolitan statistical area in a state and one region for all other portions of the state.

We agree with [prior comments from the AMA](#) that geozips are the most appropriate tool to define the geographic area. Under Texas law (SB 1264, 86th Regular Session), geozips are the relevant market for consideration in the IDR process. The Associations understand that this may result in more instances of insufficient data for each calculation, but it would be more appropriately tailored data that is reflective of the local market, which could also be beneficial for calculating cost-sharing in the QPA computation. Furthermore, under the current rules the threshold for having sufficient information to calculate the median contracted rates is not high (i.e., it is currently if the plan or issuer has at least three contracted rates on January 31, 2019).

6. Non-Fee-For-Service Contractual Arrangements

In the interim final rules, the Departments acknowledge that there are many arrangements that are non-fee-for-service (e.g., bundled payments or capitation arrangements). The Departments state that when a plan or issuer uses an alternative payment model that isn't fully fee-for-service, the plan or issuer is required to calculate a median contracted rate for a given item or service using the underlying fee schedule rates that the plan uses for cost-sharing for the relevant items or services, if such a schedule is available. If such a schedule isn't available, the plan or issuer must use a derived amount (which the plan or issuer assigns for the purpose of internal accounting reconciliation as set forth in the rules). The rules further specify that "when calculating median contracted rates, plans and issuers must exclude risk sharing, bonus, or penalty, and other incentive-based and retrospective payments or payment adjustments." The Associations are concerned that failure to include bonus or other incentive-based payments distorts the median contracted rate and makes it not reflective of the market.

7. Eligible Databases

The No Surprises Act sets forth that in cases of "insufficient information," the QPA is determined through the use of any database determined by the Departments rule to not have conflicts of interest and to have information sufficient to reflect allowed amounts paid to a health care provider or facility for the particular service in the relevant geographic region. The interim final rules provide criteria for these databases under the definition of "eligible databases." The Associations have numerous concerns with this definition.

i. State all-payer claim databases

First, the interim final rules provide that state all-payer claims databases are categorically eligible databases. While the Associations have been supportive of all-payer claims databases (and supported recent Texas legislation to create an all-payer claims database in our state), we are concerned with the categorical eligibility language. Some states may not have a robust set of data

in their all-payer claims databases or have data that has not been properly audited and verified and those states' databases, therefore, may not have sufficient information or sufficiently valid information for the median contracted rate calculation. Also, many states may not have self-funded data (due to ERISA preemption issues). Thus, the data taken from these databases may not be reflective of the market.

The Associations, therefore, strongly recommend that the Departments establish minimum requirements for all-payer claims databases to qualify as "eligible databases." These requirements should include the following: include commercial plans only; include in-network claims only; exclude zero and negative allowable rates; and include only facility claims (based on revenue code). For anesthesia services, it is important that data in the all-payer claims database includes the time units involved and that claims reflect 15-minute increments for all observations. It also will be important for all-payer claims databases to include self-funded claims as much as possible. All-payer claim databases need to truly be reflective of market data if they are to be used to calculate median contracted rates and the Associations strongly contend that the Departments need be more involved in assessing all-payer claims databases to ensure their use is appropriate.

ii. Other databases

For other databases that may be used, the interim final rules establish three basic criteria. First, the database or organization maintaining the database must be not affiliated with or owned or controlled by any health insurance issuer or health care provider, facility, or air ambulance provider (or any member of the same controlled group as, or under common control). While the Associations appreciate the Departments' effort to place some guardrails on this provision from a conflict-of-interest perspective, we are concerned that the rules do not go far enough and that databases that have other conflicts might be used under the rules. We also are concerned that, in order to avoid a conflict of interest, the interim final rules do not currently prohibit use of databases that are affiliated with, or controlled or owned by, plan sponsors or third-party administrators.

Precisely defining a conflict of interest is a difficult task, because it will likely be fact specific. Thus in Texas, the Legislature prohibited affiliations with certain entities but also included a more general statutory prohibition on any other conflict of interest for the database selected by the Texas Department of Insurance for purposes of calculating certain amounts (50th percentile of rates paid to participating providers and 80th percentile of billed charges) considered in Texas' arbitration process for surprise bills. We recommend that the Departments not limit their conflict analysis to the conflicts specifically identified in current rules.

The second criterion for the database under the current rules is that it must have sufficient information to reflect the in-network amounts paid by group or individual health coverage to providers, facilities, or air ambulance providers for the relevant items or services furnished in the geographic region. However, the interim final rules do not provide a particular definition for when that threshold for sufficient information is satisfied. We are concerned that the lack of guidance on this issue will result in databases that are not reflective of the market being used.

The third criterion is that the database must have the ability to distinguish amounts paid to participating providers by commercial payers from other claims data (such as nonparticipating

providers and amounts paid by government payors – e.g., Medicare). While this is an important component, we are concerned that this criterion (in conjunction with the other two criteria) remains insufficient to prevent inappropriate databases from being used by payers and third-party administrators.

Given the foregoing concerns with the “eligible database” criteria, the Associations contend that payers should not be given such wide discretion to use any database that is determined to meet these basic criteria. **Instead, we strongly recommend that the Department engage in a vetting and selection process for eligible databases (allowing for stakeholder input) to ensure that an appropriate database is used (and that it truly has no conflicts of interest), as well as to prevent a plan from choosing the database that has the most favorable rate from the plan’s perspective.**

We note that the Departments include some language regarding consistent use of a selected database and that choosing another database cannot be related to rates (but for other reasons such as sufficiency of data), but we are still concerned with potential cherry picking in this area. Further action, as suggested herein, is needed on the Departments’ part to prevent payer abuse of the current eligible database criteria.

iii. Recommendations for Addressing the QPA in the IDR process

Based upon all of the foregoing, it is clear that the QPA (while useful for limiting patient cost-sharing) will not be reflective of the actual median of contracted rates in the commercial market for the geographic area of the particular items or services at issue. And misrepresenting the QPA as reflecting the market in the IDR process is likely to have a very detrimental impact on physician practice viability and patient access to care.

More specifically, outsized IDR consideration of a skewed QPA is likely to result in health plans exerting more pressure to lower in-network rates (effectively creating a race to the bottom) and health plan termination of long-standing physician contracts. This will compromise patient access to *in-network* care and is likely to lead to forced consolidation of physician practices to survive the payment cuts. Physician practices in Texas are already facing practice viability challenges in the midst of the COVID-19 pandemic. According to [TMA’s COVID-19 Practice Viability Survey of Texas Physicians](#), 63% of physician respondents reported their revenue had decreased 51% to 100% during the pandemic. Many small practices may simply be unable to keep their doors open under this added strain.

Both Congress and the Texas Legislature have expressed concerns regarding health care consolidation, as consolidation can lead to increased costs. In recognition of consolidation concerns, the Texas Legislature included measures in its surprise billing legislation (and other legislation passed that same legislative session) that were designed to help create a more balanced process to settle payment disputes and promote network adequacy. More specifically, under SB 1264 (86th Regular Session), the Texas Legislature established ten exclusive factors that must be considered in determining the “reasonable amount” for services in its arbitration process.

While one of those ten factors is the 50th percentile of rates for the service or supply paid to participating providers in the same or similar specialty and provided in the same geozip area as reported in a nonconflicted database selected by the Texas Department of Insurance (TDI), the Texas Legislature balanced that factor by also requiring consideration, among other things, of the 80th percentile of all billed charges for the service or supply performed by a health care provider in the same or similar specialty and provided in the same geozip as reported in the TDI selected database. **Thus, the Texas Legislature took into consideration amounts primarily set by the plan (i.e., contract rates) and amounts primarily set by the physician or provider (billed charges). Inclusion of billed charges was a critical factor to a fair process under the Texas bill.**

The federal legislation does not have the critical counterbalance of the 80th percentile of billed charges for QPA in the arbitration process (nor did the federal legislation include network adequacy examinations by the Departments as is required under Texas law by TDI at least once every three years); thus, a very skewed calculation of QPA is likely to have an even greater impact on the outcomes of federal IDR (causing physicians and other providers to lose more frequently). The QPA has great potential to negatively impact network adequacy, practice viability, consolidation, and health care costs.

Given all the foregoing, the Associations, therefore, urges the Departments to take measures to address concerns related to the QPA methodology and to ensure that a skewed QPA is not given an outsized role in decisionmaking by the IDR entity.

The Associations understand that, under the No Surprises Act, the QPA must be provided to the IDR entity; however, it is imperative that the QPA be provided in context so that is not inappropriately weighted by the IDR entity. **More specifically, the Associations strongly recommend that the Departments take the following three steps (without the physician or provider having to request the steps to be taken).**

- 1. Require the IDR entity (and the physician or provider) to be provided with direction that the IDR entity is *not* to weigh the QPA more than any other submitted information when picking a party's offer.**

Congressional intent, as reflected in [this June 17, 2021 letter](#) was “to ensur[e] a balanced process to settle payment disputes between health plans and providers.” As the letter continues to state:

Providers and payors are able to bring relevant information with the exception of billed charges and public payor information for consideration, and the certified IDR entity shall consider:

- Median in-network rates
- Provider training and quality of outcomes
- Market share of parties
- Patient acuity or complexity of services
- Teaching status, case mix, and scope of services of the facility
- Demonstrations of previous good faith efforts to negotiate in-network rates

- Prior contract history between the two parties over the previous four years

The No Surprises Act instructs the certified IDR entity to consider each of these listed factors, as well as any allowable information brought by either party or requested by the certified IDR entity. **To match Congressional intent, your implementation of the law should ensure an IDR process that captures the unique circumstances of each billing dispute and does not cause any single piece of information to be the default one considered.**

The Associations concur with the above assessment regarding the weighing of QPA and believe that it is important for this information to be properly communicated to the IDR decision-maker.

2. **Provide the IDR entity (and the physician or provider) with a clear and conspicuous disclaimer that: (a) the QPA was calculated primarily for the purpose of determining/limiting patient cost-sharing amounts, and (b) that the Departments recognize that the QPA is *not* necessarily reflective of a true median of contracted commercial rates in that market for that item or service.**

Given all the aforementioned concerns related to the QPA, it also is critical that an express and standard disclaimer be provided to the IDR entity to properly explain the purpose of the QPA (which is focused on limiting patient cost-sharing responsibility) and to inform the IDR entity of the limitations of the QPA. The QPA will not reflect actual market conditions or rates and this fact needs to be conveyed to the IDR decision-maker.

3. **Require Payers to Provide the IDR entity (and the physician or provider) with additional information relevant to the calculation of the QPA.**

In the interest of transparency and to properly place the QPA in context, the IDR entity (and the physician or provider) also should be provided with additional information from the payer regarding the computation of the QPA, including:

- the type of specialties and subspecialties of the physicians or providers that have contracted rates included in the dataset used to determine the QPA;
- the number of contracts used to determine the median contracted rate (including the number of physicians or providers represented by those contracts);
- if the QPA is based on a claim that has been downcoded by the payer, an explanation of why it was downcoded and what the QPA would have been for the item or service if it were not downcoded;
- information pertaining to the use of any modifier in calculating the QPA and what modifiers were used, if any; and
- information regarding the use of alternative payment models, bonuses and other supplemental payments paid to providers within the payers' networks; and
- if the claim is denied, what the QPA would have been based on the original claim.

While the Associations appreciate the other information that is required to be provided to physicians by issuers and plans related to the QPA under the interim final rules, we assert that the above-listed additional information is also important to the open negotiation and IDR processes and should be provided without the physician or provider having to request the information.

II. Initial Payments

A. Initial Payment Amounts

Next, the Departments solicit information on whether they should set a payment standard for the health plan's initial payment. **The Associations are opposed to the Departments setting an initial payment amount or standard (particularly any payment standard based on Medicare or in-network rates), because: (1) we are concerned that such a standard will have a negative impact on physician contracting and financial viability; and (2) the No Surprises Act does not establish an initial payment amount or contemplate the Departments setting an initial payment amount.**

As has been noted by physician stakeholders repeatedly, Medicare rates are not reflective of rates in the commercial market, do not reflect the cost of providing care, and have not kept pace with inflation. Medicare rates are based on political and budgetary considerations. And, in-network rates are significantly discounted rates that reflect other considerations (e.g., patient steerage and prompt payment) that are not present in out-of-network scenarios. Thus, neither of these amounts is an appropriate basis for setting an initial payment amount.

In the interim final rules, the Departments noted that an initial payment “does not refer to a first installment” and “should be an amount the plan or issuer reasonably intends to be payment in full based on the relevant facts and circumstances and as required under the terms of the plan or coverage [.]” We appreciate the Departments’ statement of intent and agree that, in order to have IDR be the backstop (and not the default), it is imperative that health plans act consistently with this stated intent.

To ensure that this occurs, the Associations recommend that the Departments require the plan’s initial payment be considered the plan’s final offer in the IDR. This will encourage health plans to provide reasonable initial payments and prevent health plans from providing “low ball” initial payments only to subsequently shift their conduct in the IDR. The IDR process will entail time and expenses for physicians and other providers to pursue. It is important that health plans not drive all payment resolutions to IDR (and ultimately add wasteful, unnecessary costs to the healthcare system). Physicians should not have to engage the IDR process to obtain a fair payment.

In the alternative, should the Departments not accept our recommendation for the plan’s initial payment to be considered the plan’s final offer in the IDR, we recommend *at the very least* that the Departments require the plan’s last offer in negotiation be considered their final offer in the IDR. This measure will help ensure that the plans use the negotiation period in good faith, moving towards a payment resolution.

B. Other Initial Payment Issues

In the interim final rules, the Departments provide that if a plan or issuer knows or reasonably should know that the notice and consent (required to exercise the exception to the balance billing prohibition) were not properly and timely given and received (despite the provider's assertions to the contrary), the plan or issuer "should apply the cost-sharing and other requirements set forth in these interim final rules and applicable state law by, among other actions, reprocessing any claims that were not processed consistently with those requirements."⁶

The Associations are concerned that the rules appear to permit the plans to make a unilateral assessment as to the appropriateness of the notice and consent. Moreover, the rules do not set forth any requirement for the plan to inform the provider or enrollee of this determination or for the physician to challenge or appeal this determination. The Associations oppose the Departments providing this delegation of authority to the plans.

Next, the Departments provide that 30 calendar-day period for the initial payment generally begins on the day the plan or issuer receives information necessary to decide a claim for payment for such services (i.e., a clean claim). It is not clear, however, under the interim final rules what information will be needed to decide a claim for payment (and there may be variations in plan requirements). Thus, to avoid delays in payment and potential health plan abuses of this timeframe, it is critical that, if the claim is rejected, the Departments require the plans to clearly communicate the precise information needed to correct the claim. This clear communication from the plans needs to occur on the first rejection (with all the relevant information to enable the provider to address any purported deficiencies and move the claim along).

III. Notice and Consent

Next, the Associations appreciate the Departments' language in the preamble, which provides further information as to the intended functioning of the notice and consent provisions. However, we agree with the comments made by the American Medical Association (AMA) regarding the need for additional clarification of certain components of the notice and consent process.

More specifically, we agree that the requirement for plans and issuers to pay physicians and providers directly should extend to scenarios in which notice and consent are provided and received (when the patients seeks coverage for out-of-network care). Health plan practices of sending out-of-network payment to the patient and requiring the patient to remit full payment to the provider often creates confusion and additional burden for the patient and results in payment delays for the provider. Removing this unnecessary step in the process would be beneficial to patients and providers alike.

The Associations also agree with AMA's expressed concerns regarding the interim final rule's language in the "ancillary" services provision, which states that the notice and consent exception is not available for "items and services provided by a nonparticipating provider if there is no participating provider who can furnish the item or service at such facility."

⁶ *Id.* at 36900.

Although the Texas Department of Insurance (TDI) included a similar requirement for Texas' notice and disclosure process (i.e., that "the enrollee [have] a meaningful choice between a participating provider for a health benefit plan issuer or administrator and an out-of-network provider,") the TMA and other physician organizations opposed this requirement, which we believe goes beyond the statutory language of Texas' surprise billing legislation.

In our comments to TDI, the TMA and other physician organizations stated that we opposed the language because it makes the out-of-network provider's satisfaction of the exception dependent upon third parties over whom the out-of-network provider has no control, namely health plans and health facilities. More specifically, the language effectively shifts responsibility for health plan network inadequacies from the plans to the out-of-network providers (which was not the Legislature's intent). The out-of-network provider cannot control whether there is choice between an in-network provider and out-of-network provider in any given scenario. In striking contrast, the health plan can. Yet, the out-of-network provider would be the one that is forced to forego collecting his or her full fee in this scenario. The burden (and additional financial responsibility) should be placed on the health plan in this scenario. And, the enrollee should be complaining to the health plan regarding its inadequate network (asking the health plan to make him or her whole).

Also as the TMA and other physician organizations stated to TDI when the Texas rules were proposed, for services performed in a facility, whether there is a choice between a participating provider and an out-of-network provider will be dependent upon the facility (in addition to the health plan), not the out-of-network provider. The out-of-network provider does not control the scheduling or assignment of procedures, the credentialing of providers at the facility, or the contracting practices of the facility; yet, all of these factors may impact whether there is a participating provider available to furnish an item or service at the facility. For these same reasons, the Associations are concerned with this provision in the Departments' interim final rule.

Finally, the Associations recommend that the Departments clarify that pain management services (including when furnished by anesthesiologists) qualify for participation in the notice and consent exception to the balance billing prohibition. Although the statute excludes from the notice and consent exception items and services related to certain "ancillary" services, including anesthesiology, pain management services (including when performed by anesthesiologists) should not be subject to this exclusion, the Associations agree with the American Society of Anesthesiologists that pain management services provided in non-urgent scenarios where a patient selects an anesthesiologist in advance (and otherwise satisfies the notice and consent provisions) should be distinguishable from "anesthesiology" in this context. Making this distinction would encourage patient choice and access to pain management care.

IV. Prudent Layperson

Finally, the Associations are generally supportive of the Departments' efforts to reinforce the prudent layperson standard. We note that in the preamble, the Departments states the following:

These interim final rules make clear that if a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers

any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department, the plan or issuer must cover emergency services without limiting what constitutes an emergency medical condition (as defined in these interim final rules) **solely** on the basis of diagnosis codes. When a plan or issuer denies coverage, in whole or in part, for a claim for payment of a service rendered in the emergency department of a hospital or independent freestanding emergency department, including services rendered during observation or surgical services, the determination of whether the prudent layperson standard has been met must be based on all pertinent documentation and be focused on the presenting symptoms (and not **solely** on the final diagnosis). This determination must take into account that the legal standard regarding the decision to seek emergency services is based on whether a prudent layperson (rather than a medical professional) would reasonably consider the situation to be an emergency. (emphasis added).⁷

We are concerned, however, that plans may misconstrue and misapply the “solely” language in the rule. We strongly contend that presenting symptoms, not final diagnosis codes, should be the focal point of any review and urge the Departments to monitor for any abuses of this language.

V. Delayed Implementation

Finally, while the Associations greatly appreciate the Departments’ efforts to quickly publish Part 1 of the rules implementing the No Surprises Act, we are concerned that there are still two other parts of the rules that need to be published before the end of the year. Thus, there will be a very short turnaround for physicians and other providers to implement changes to their policies and procedures. The Associations, therefore, respectfully request a one-year delay in implementation to enable more time for compliance efforts.

The Associations thank the Departments for the opportunity to comment. If you have any questions, please do not hesitate to contact Kelly Walla, Associate Vice President and Deputy General Counsel of the Texas Medical Association, at kelly.walla@texmed.org.

Sincerely,



E. Linda Villarreal, MD
President
Texas Medical Association

⁷ *Id.* at 36879.



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ASSOCIATION OF AIR MEDICAL SERVICES



December 6th, 2021

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

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

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

Dear Secretaries Becerra, Walsh and Yellen:

I write to offer the views of the Association of Air Medical Services (AAMS) on the tri-departmental Interim Final Rule ("IFR"), *Requirements Related to Surprise Billing; Part II*, as prescribed by the No Surprises Act, Pub. L. No. 116-260 (2020) (the "Act"). AAMS is the international trade association that represents over 93 percent of air ambulance providers in the U.S. Together, our over 300 members operate nearly 1,000 helicopter air ambulances and 200 fixed wing air ambulance services across the U.S. AAMS represents every emergency air ambulance care model, including aircraft based at hospitals, independent aircraft at bases in rural areas far from hospitals, and many hybrid variations.

AAMS strongly supports the purpose of the Act, which is removing patients from payment disputes between healthcare providers and payers, through an independent dispute resolution ("IDR") process, while maintaining patient cost sharing at participating levels. However, we are gravely concerned about the negative consequences that will result from the implementation timeline, cost sharing and payment methodologies, and IDR process, as currently drafted.

We believe the IFR threatens the sustainability of air ambulance services and places traditionally underserved communities at risk of reduced access to care. The qualifying payment amount (“QPA”) methodology and the Departments’ presumption that the QPA is the appropriate out-of-network rate to be selected in IDR will create a race to the bottom in which existing contracts are destabilized and reimbursement drops to an unsustainable level. Instead of simply removing patients from payer-provider payment disputes, the Departments have put patients at risk by making it harder for air ambulance providers to sustain operations and deliver life-saving care. Air ambulance providers can only operate if they receive fair, adequate payments that cover the costs of delivering services. Fair payments are essential to preserving the emergency medical system that saves American lives every day.

Without adequate reimbursement, air ambulance providers may be forced to exit the market or reduce services, leaving patients in emergent situations with few options. This is not the outcome Congress intended when it passed the Act. We urge the Departments to consider the negative impacts the regulations will have on underserved communities and, instead, take a more equitable approach to ensure that access to care is possible, regardless of location.

In this comment letter, we offer several considerations that the Departments should take into account as you revise the regulation, including recommendations in the following key areas:

- I. Navigating Implementation
- II. Qualifying Payment Amount
- III. Weighting of Factors in IDR
- IV. Transparency in IDR
- V. IDR Entity Certification
- VI. Batching of Claims

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I. Navigating Implementation

We appreciate the ambitious timeline that Congress prescribed in the Act and the Departments’ efforts to achieve those milestones to protect consumers from surprise bills. However, the IFRs involve significant, industry-wide changes to day-to-day practices that require time, resources, and careful attention to implement correctly. These changes were initiated and adopted without notice and comment. And, where we engaged with Congressional Members during the design and passage of the Act, we have not seen the intent and vision of those Members, nor our discussions, carried through in the Departments’ regulations.

We believe the Departments can achieve the goal of the Act if they provide stakeholders more time to understand, test, and provide thoughtful recommendations on the policies. We have just begun to identify the barriers to implementation and are anticipating many more hurdles ahead. To that end, the Departments should engage more deeply with the air ambulance provider community, so that concerns and solutions can be openly shared and addressed.

The Departments should also exercise enforcement discretion as stakeholders work to become compliant with the new requirements, which are far-ranging and complex (e.g., data reporting,

and more). The Departments have demonstrated a willingness to exercise enforcement discretion for group health plans and issuers. They should extend comparable regulatory relief to air ambulance providers that are making good faith, reasonable efforts to implement the Act. We urge the Departments to use their enforcement discretion as the IFRs are implemented; to work with the air ambulance provider community as obstacles are identified; and to provide reasonable and timely clarification, when needed.

II. Qualifying Payment Amount

The QPA methodology described in IFR Part I and reinforced in IFR Part II will have unintended consequences for access to emergency air ambulance services, especially in rural America. The Departments posit that the QPA is a median contracted rate that “generally reflect[s] market rates.”¹ The QPA methodology, however, arbitrarily excludes from the median calculation certain types of contracts, like single case agreements and alternative payment arrangements (collectively, “SCAs”), that are commonplace in the air ambulance industry. The magnitude of the exclusion is material; AAMS members representing 236 air bases (approx. 25% of the national air bases) report that, in 2019, 38%-56% of out-of-network claims were resolved through SCAs. The result is that under the QPA methodology, the QPA does not reflect market rates.

The QPA methodology also treats all types of air ambulance providers the same – lumping together in the same category those providers that negotiate with insurers as part of a larger hospital system and those providers that negotiate independently. Plus, if there is an insufficient number of contracted rates at the state level to determine a median, then IFR Part I requires the QPA to be determined using all metropolitan statistical areas (“MSAs”) in a Census division or all other areas in the Census division. This means that an air ambulance provider’s reimbursement may derive from amounts paid several states, or even an ocean, away.

This methodology will depress reimbursement. Congress tasked the Departments with implementing a framework that would remove patients from payment disputes and allow for the swift resolution of disagreements. Instead, the Departments have distorted the statutory framework to reduce payment on a national scale – something Congress considered and rejected. This is not a theoretical problem. We were alarmed to see a now widely-circulated letter by BlueCross BlueShield of North Carolina, which uses the QPA as a lever to immediately terminate and renegotiate provider contracts.² We are concerned that this is only the start of contract terminations and that, in straying from Congress’s intent, the Departments have put patient access to care at risk. As payers terminate contracts and drive reimbursement to levels at or below the administratively depressed QPA, air ambulance providers will be forced to make difficult, but necessary, business decisions. Our members simply cannot operate where expenses exceed reimbursement. This means that transports may be reduced, including in rural, underserved areas. This is not what Congress intended in implementing the Act.

¹ 86 Fed. Reg. 55,980, 56,060.

² See e.g. J. Lagasse, *American Society of Anesthesiologists Accuses BCBSNC of Abusing No Surprises Act*, Healthcare Finance (Nov. 23, 2021). Accessible at: <https://www.healthcarefinancenews.com/news/american-society-anesthesiologists-accuses-bcbs-north-carolina-abusing-no-surprises-act>.

For these reasons and more, we ask that the Departments fix the QPA methodology and we discuss each of the fundamental flaws below.

The QPA Methodology Arbitrarily Excludes Relevant Data: The QPA methodology excludes contracted rates from a wide range of contracts, including SCAs, letters of agreement, arrangements used to supplement a payer's network, incentive-based and retrospective arrangements. Given these broad exclusions, the methodology will not produce QPAs that reflect all contracted rates, nor will it account for the cost of services. Rather, the QPA will reflect the comparatively smaller number of rates from in-network contracts, including contracts that were accepted without vigorous negotiation (as described below). This will exacerbate the historic market conditions that prompted the need for the Act in the first place.

Instead, all contracted rates should be included in the QPA calculation, especially since no reliable database presently exists to determine a median contracted rate for air ambulance services in the case of "insufficient information." There is no existing database that contains a representative number of the air ambulance transports in a given state. AAMS is interested in working with the Departments to create such a database. However, in the interim, the only avenue for generating a fair, reliable QPA is to include all contracted rates in the methodology.

The QPA Methodology Should Differentiate Between Air Ambulance Provider Types: The QPA is the median contracted rate for the "same or similar item or service" rendered by a provider in "the same or similar specialty" in the geographic region. The Departments lump all air ambulance providers into "the same or similar specialty," and fail to draw critical distinctions between those that bill for services through a hospital system and those that do not, emergency rotor-wing and emergency and non-emergency fixed wing providers, and active and shuttered providers. Each of these distinctions can drive the costs of delivering the service, as well as any contracted rate negotiated between the provider and the payer.

This is an unreliable approach because it does not account for critical differences in an entity's structure and contracting practices. For example, a hospital may enter into an agreement with a payer based on a broad range of services, including rates for air ambulance services. In some instances, a hospital may agree to rates for air ambulance services without actually offering the services. Such rates may be far below market, and may be included in the contract without any negotiation because the hospital will never seek payment.

In contrast, providers of air ambulance services who only bill for air ambulance services must ensure that rates are sufficient to maintain services. Otherwise, they cannot cover their costs. It is not rational for the Departments to treat independent rates negotiated at arm's length the same as below-market, ghost rates that are passively accepted by hospitals because they will never be charged to payers.

The Departments acknowledge legitimate differences between independent and hospital providers elsewhere in IFR Part I. Notably, the Departments recognize that standalone emergency departments may have a different relationship to payers when compared to

emergency departments that bill through a hospital system.³ The Departments should similarly recognize the distinctions between air ambulance providers.

The Use of Census Divisions Will Produce Absurd Results: While we appreciate the Departments' efforts to base the QPA on sufficient information, the use of Census divisions in the context of air ambulance services means that a rate from Hawaii or Alaska may dictate the QPA for a pick-up in California. We believe this approach, again, reflects a misunderstanding of the unique nature of air ambulance services. Congress tied payment rates to geography because it understood that healthcare is local or regional and that the unique features of a market varies by geography and economy. The circumstances of a rural county in Alaska should not dictate payments for services in Los Angeles, California. There are better approaches to reaching a sufficient number of rates – such as including SCAs and historic payment rates established in the same market – that do not involve comparing markets that are thousands of miles apart.

The Departments Should Mitigate the QPA's Unintended Consequences: Regardless of whether the Departments address flaws in the QPA methodology, the Departments should, at a minimum, work to mitigate the unintended consequences of the methodology. As a first step, payers should be required to disclose additional information about the limitations of the QPA to providers. As drafted, payers are required to communicate very little information about the QPA to providers and there is no opportunity for providers, or the Departments, to confirm that payers have taken the necessary and correct steps to reach the final amount. The Departments have placed a significant amount of trust in payers to understand and calculate this complex sum, with hardly any oversight or checks and balances.

To promote transparency and confidence in the QPA, payers should disclose: the number of contracts used to calculate the QPA; the rates, types of air ambulance providers, and volumes of claims in the QPA; out-of-network volume and payment amounts; volume and payment amounts for all other arrangements (e.g., SCAs); and a description of each contract omitted from the QPA methodology and the reasons for the omission. Disclosure of this information will allow providers to assess whether payers' calculations were performed correctly and will better equip both parties to evaluate the reasonableness of their positions. If providers have assurance that the amount is accurate and based on a sufficient number and range of contracts, the number of claims brought to IDR will likely be reduced.

In addition, the Departments should instruct IDR entities on the limitations of the QPA. IDR entities should evaluate payments to air ambulance providers with an open mind and with a clear-eyed understanding of what the QPA does and does not represent. The IDR entity should be able to consider the QPA in context and, based on all of the circumstances Congress articulated in the statute, make a sound selection of the appropriate out-of-network rate.

³ 86 Fed. Reg. 36,872, 36,892 (July 13, 2021) (“[W]here a plan or issuer has established contracts with both hospital emergency departments and independent freestanding emergency departments, and its contracts vary the payment rate based on the facility type, the median contracted rate is to be calculated separately for each facility type. The Departments are of the view that this approach will maintain the ability of plans and issuers to develop QPAs that are appropriate to the different types of emergency facilities specified by statute.”)

III. Weighting of Factors in IDR

IDR Entities Should be Free to Weigh the Circumstances that Congress Mandated for Payment Determinations: The Act establishes certain criteria that an IDR entity must weigh when determining which payment offer to select, including the QPA, the provider or facility's level of training, experience, and quality and outcomes measurements, and more. The IFR, however, ignores these factors and instead requires arbiters to "select the offer closest to the QPA, unless credible information presented by the parties rebuts that presumption and clearly demonstrates the QPA is materially different from the appropriate out-of-network rate [.]"⁴ This approach directly conflicts with the process Congress designed.

The Act states that the IDR entity "shall consider" the list of circumstances enumerated, and the QPA is but one of those factors.⁵ Congress likely designed the IDR process to consider multiple circumstances because no two patients are alike. The cost of services may vary from case to case based on the severity of the condition, the expertise of the provider/s involved, the patient's underlying conditions, and more. The presumption that the QPA is the appropriate out-of-network rate ignores these realities to the detriment of providers and their patients.

The Departments also add qualifying terms (i.e., "credible information" and "materially different") that are not included in the Act, further diminishing the relevance of the additional circumstances that Congress directed the IDR entities to consider. These qualifiers create a much higher bar for providers to meet and impose an additional step in the resolution process.

The result is that the Departments have transformed the IDR process enacted by Congress into a perfunctory rubber stamp for an administratively depressed QPA. Instead of considering all circumstances mandated by Congress, evaluating the parties' arguments, and reaching an independent conclusion, IDR entities must award the QPA in all but the most exceptional cases. This approach is inconsistent with the statute. If Congress had meant for the QPA to be the appropriate out-of-network rate, then it would have said so. Instead, Congress created an IDR in which the QPA is one of many factors that IDR entities must consider when determining the appropriate out-of-network rate.

Congress's design was to encourage payers and air ambulance providers to resolve their monetary disputes through negotiations between each other to avoid having to risk it all in an IDR determination with little guidance as to what a particular IDR entity would view as the reasonable payment amount. And, even if the parties could not reach an agreement through negotiations, final-offer dispute resolution creates strong incentives for both sides to put forth their most reasonable offer and then for the certified IDR entity to choose the one that it deems most reasonable. The need to make a reasonable offer is reinforced by the statute's obligation on the losing party to bear the costs of the IDR process.

Congress' design is effective because it offers a dispute resolution process that is *unpredictable*. Despite this design, the Departments concluded that "emphasizing the QPA will allow for

⁴ 86 Fed. Reg. 55,980, 55,984.

⁵ Public Health Service Act (PHSA) § 2799A-2(b)(5)(C).

predictability.”⁶ The IFR states “[t]his certainty will encourage plans, issuers, providers, and facilities to make offers that are closer to the QPA, and to the extent another factor could support deviation from the QPA, to focus on evidence concerning that factor” and “may also encourage parties to avoid the Federal IDR process altogether and reach an agreement during the open negotiation period.”⁷ Therefore the express purpose of IFR Part II is to destabilize the foundation on which the dispute resolution is built and to render the process effectively meaningless. Congress created an independent dispute resolution process because it wanted an *independent* dispute resolution process, not one in which outcomes were predetermined.

The Departments should revise their regulations to align with the process Congress intended. IDR entities should have the discretion to weigh all of the circumstances mandated by Congress, consider the parties’ arguments, and make independent decisions.

IV. Transparency in IDR

The Departments Should Encourage Transparency in IDR: The Departments should make the information that the parties disclose to one another in open negotiations admissible in IDR, require the parties to share their submissions to the IDR entity with one another, and make clear that the only mandatory exemptions of those materials from public disclosure are the ones established by the Freedom of Information Act (“FOIA”). Anything less than maximum transparency in the IDR process will permit parties to game the IDR system by withholding information from both the IDR entity and the public that is material to the decision-making process and integral to a fair resolution on the merits.

Fairness also requires an opportunity to respond to new information that a party withheld during open negotiations, and disclosed for the first time in its submission to the IDR entity. The Act imposes a 10-day statutory deadline for both sides to submit claims and supporting information to the IDR entity. But the Act authorizes the Secretary to modify that deadline for “extenuating circumstances.” The Departments should define “extenuating circumstances” to include a submitting party’s presentation of information that was not disclosed during open negotiations, and that requires the IDR entity to grant the receiving party at least 5 days to respond to such information. A procedural right to respond to new information will encourage transparency during open negotiations and prevent unfair surprise.

V. IDR Entity Certification

The Departments Should Require that IDR Entities Request Average Non-Contracted Paid Claims Amounts From the Parties: The IFR outlines a process for certifying IDR entities to ensure they carry out their responsibilities. The Act authorizes the Departments to revoke an IDR entity’s certification if it demonstrates a pattern or practice of noncompliance. Separately, the Act requires the parties to submit to the IDR entity (i) an offer for a payment amount, and (ii) “such information as requested by the certified IDR entity.” Together, these provisions authorize the Departments to require IDR entities to request specific information from parties in IDR as a

⁶ 86 Fed. Reg. 55,980, 56,061.

⁷ *Id.*

condition of IDR certification.

We recommend that the Departments require IDR entities to request that, with respect to a dispute regarding calendar year 2022, the provider submit the average non-contracted paid claims amount during calendar year 2019 (to be updated by an inflation factor with respect to a dispute regarding a future calendar year). This information is important because it reflects the amounts that payers were willing to offer before the Act was implemented. The information will provide the parties and the IDR entity with a more complete and transparent factual basis for assessing the dispute. The failure to request this information should result in decertification of the IDR entity.

VI. Batching of Claims

The Departments Should Clarify the Definitions Associated with the Batching of Claims; Allow Air Ambulance Providers to Batch Base and Mileage Rates: The Act allows multiple qualified IDR dispute items and services to be considered jointly in one determination if they are: (i) furnished by the same provider or facility; (ii) payment is made by the same health plan or issuer; (iii) items or services rendered are related to the treatment of a similar condition; and (iv) items or services were furnished during the same 30-day period or an alternative period as determined by the Secretary. The IFR refines the definition of “same provider or facility” to include entities that bill with the same National Provider Identifier (“NPI”) or Taxpayer Identification Number (“TIN”).

However, the Act and IFR do not define “same health plan or issuer.” We believe that the Departments intend to refer to a specific health plan in the market and not to a payer’s parent organization, which may operate on a regional or national basis. If the Departments were to interpret the definition as applying at the parent organization level, it would create a significant backlog as every claim associated with a national payer is forced to wait out the cooling off period. This would be contrary to Congress’s vision of establishing an “efficient” resolution process. We request confirmation of this understanding.

Next, the IFR adds a conflicting definition of “items or services.” While the Act defines items or services as related to the treatment of a similar condition, the IFR defines items or services as “billed under the same service code, or a comparable code under a different procedural code systems [.]”⁸ Service codes are defined according to CPT, HCPCS, or DRG codes. We believe that the Departments should apply the Act’s broader definition, with the aim of enabling the batching of claims to the fullest extent (and thereby reducing the number of IDR proceedings).

Similarly, we request that the Departments clarify the ability to bundle air ambulance base rates and mileage rates in one payment determination. Every air ambulance flight is billed with a base rate and loaded miles. Under the current structure, it is not clear whether these amounts may be batched in one resolution. It appears that payers may issue separate QPAs for the base rate and mileage and that these amounts will then be deemed separate items or services. This means that for each air transport, an air ambulance provider might need to initiate two IDR processes for: (i) base rates involving the same NPI, same payer, and in the same 30-day window; and (ii)

⁸ 86 Fed. Reg. 55,980, 55,994.

milage rates involving the same NPI, same payer, and in the same 30-day window.

This approach would create tremendous inefficiencies and essentially double the IDR disputes involving air ambulance providers. Rather, the Departments should clarify that, given the nature of air ambulance services, base and mileage rates go hand-in-hand and should be considered in the same determination.

Thank you for the opportunity to provide comments on the IFR. We believe it is critical to protect patients' use of air ambulance services, both in emergency and nonemergency situations. Air ambulance services are essential to our healthcare system and there must be a reliable mechanism in place to financially support these operations. We are concerned that the IFR will have serious, unintended consequences, particularly for underserved and rural communities, and we urge the Departments to consider our recommendations. If you have any questions, please contact AAMS Vice President of Public Affairs Christopher Eastlee at ceastlee@aams.org.

Sincerely,



Cameron Curtis, CMM, CAE
President & CEO
Association of Air Medical
Services



Deborah Boudreaux, MSN, RN, CCRN, C-NPT, LP,
CMTE
Chairman and Region IV Director, AAMS
Teddy Bear Transport, Cooks Children Medical
Center

November 17, 2021

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

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

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

Re: Concerns with Interim Final Rule Requirements Related to Surprise Billing: Part II implementing the No Surprises Act (NSA)

Dear Secretaries, Becerra, Walsh, and Yellen:

On behalf of the undersigned organizations representing physicians across the country, we write to urge you to reconsider the requirements in the Interim Final Rule (IFR), entitled “Requirements Related to Surprise Billing; Part II,” 86 Fed. Reg. 55,980 (Oct. 7, 2021), implementing the No Surprises Act (NSA) that directs Independent Dispute Resolution (IDR) entities to consider the qualifying payment amount (QPA) a rebuttable presumptive reasonable payment for out-of-network physicians engaging in the IDR process and, in turn, places a thumb on the scale in favor of health insurers in contract negotiations.

The American Medical Association, state medical associations, and national medical specialty societies strongly support protecting patients from surprise medical bills and continue to support the patient protections in the NSA that do just that. To be clear, our request is not to unravel the NSA or delay implementation of any of its patient protections. Instead, **we ask that you revise the most recent IFR to conform with the NSA’s statutory language to allow an IDR entity the discretion to consider all the relevant information submitted by the parties to determine a fair out-of-network payment to physicians, without creating a rebuttable presumption that directs an IDR entity to consider the offer closest to the QPA as the appropriate payment amount.**

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With patients protected, we acknowledge that our concerns are now centered on ensuring fair payments to physicians and a balanced IDR process. This is, of course, relevant at an individual physician level, as physicians should be able to negotiate reasonable payment for their services. But more importantly, a skewed IDR process that restricts physicians' ability to make their case for a reasonable out-of-network payment removes a critical remaining incentive for insurers to negotiate fair contracts with physicians.

As the NSA is implemented, a remaining force pushing health insurers to negotiate with physicians—the demands of patients and employers for in-network care—is being significantly reduced. While we strongly support removing patients from the middle, we also appreciate that Congress recognized an additional check on health plans was needed to replace this market force—a meaningful IDR process. While none of our organizations anticipated a high volume of claims going all the way through the dispute process to IDR when the NSA was enacted, we knew that the possibility of a physician successfully making the case for a fair out-of-network payment to an IDR entity could help influence a health insurer to come to the negotiating table in the first place, offer a reasonable initial payment when a surprise bill happens, and settle most disputes in the open negotiations process.

But, in implementing the IDR process in a way that essentially predetermines the outcome to be at the 50th percentile of contract rates, that important check on negotiating incentives established by Congress has largely been stripped away.

We agree with the analysis that *insurers* will likely pay many in-network physicians much less in the coming years as they negotiate contracts (and renegotiate current contracts) under the QPA's ceiling. Whether that will translate to a reduction in health care premiums for patients is not known, but it is certain to put an additional financial strain on many independent practices that are working to make ends meet and pay their staff, many just regaining their footing lost over the last 18 months due to the pandemic. While financial strain often forces independent practices to close, others make tough decisions to accept outside funding, join hospital systems, or consolidate with other provider groups. We suggest none of these options necessarily increase access to quality, lower-cost care.

We also anticipate a significant reduction in contracts being offered to many physicians in the coming years, especially those hospital-based physicians targeted by the NSA's surprise billing provisions. Without the existing lack of pressure of network adequacy enforcement, and now the reduced demand for in-network hospital care from patients and employers, insurers are not likely to expand their networks or renew those contracts with payment rates above the QPA. While protections from surprise billing that results from these network inadequacies will shield patients from some of the financial impact, we believe that a long-term reduction in network breadth is not good for patients who still benefit from in-network coverage when it falls outside of the NSA protections. Additionally, meaningful negotiations that lead to contracting create efficiencies in

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the health care system including, but not limited to, reduced administrative waste, value-based arrangements, billing efficiencies, and, importantly for this effort, reduced use of the dispute resolution process including the IDR process.

In conclusion, we believe that the NSA was drafted in a purposeful way to meaningfully protect patients from surprise billing while ensuring important checks and balances on the provider-insurer contracting process. We urge you to correct the IFR's deviation from that congressional balance and issue a final rule that does not include a rebuttable presumption that directs an IDR entity to consider the offer closest to the QPA as the appropriate payment amount, and confirms that an IDR entity has the discretion to consider all the relevant information submitted by the parties, as provided in the statute, to determine a fair out-of-network payment to physicians.

Thank you for your consideration,

American Medical Association
AMDA – The Society for PALTC Medicine
American Academy of Allergy, Asthma & Immunology
American Academy of Dermatology Association
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology- Head and Neck Surgery
American Academy of Physical Medicine & Rehabilitation
American Association of Clinical Endocrinology
American Association of Clinical Urologists
American Association of Neurological Surgeons
American College of Allergy, Asthma and Immunology
American College of Cardiology
American College of Emergency Physicians
American College of Gastroenterology
American College of Obstetricians and Gynecologists
American College of Osteopathic Internists
American College of Osteopathic Surgeons
American College of Radiology
American Gastroenterological Association
American Geriatrics Society
American Medical Group Association
American Orthopaedic Foot & Ankle Society
American Osteopathic Association
American Psychiatric Association

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American Society for Clinical Pathology
American Society for Dermatologic Surgery Association
American Society for Gastrointestinal Endoscopy
American Society for Laser Medicine and Surgery
American Society for Surgery of the Hand
American Society of Addiction Medicine
American Society of Anesthesiologists
American Society of Cataract & Refractive Surgery
American Society of Dermatopathology
American Society of Echocardiography
American Society of Hematology
American Society of Neuroradiology
American Urological Association
American Venous Forum
Association for Clinical Oncology
College of American Pathologists
Congress of Neurological Surgeons
International Society for the Advancement of Spine Surgery
Medical Group Management Association
Renal Physicians Association
Society for Vascular Surgery
Society of Interventional Radiology
Society of Thoracic Surgeons
Spine Intervention Society

Medical Association of the State of Alabama
Alaska State Medical Association
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association Inc
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society

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Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society
Wyoming Medical Society



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November 19, 2021

Via Electronic Submission

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

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

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

Dear Secretaries Becerra, Walsh and Yellen:

On behalf of our physicians and the patients and communities we serve, Mednax is providing these comments on the *Requirements Related to Surprise Billing; Part II* Interim Final Rule (IFR).

Mednax is a national medical group, comprised of the nation's leading providers of prenatal, neonatal, and pediatric services. Mednax, through its affiliated professional entities, provides services through a network of more than 2,300 physicians in 39 states and Puerto Rico. Twenty-five percent of premature babies in the U.S. are born in our NICUs.

While we applaud the Departments' goal of putting patient care first, we offer a number of recommendations below to facilitate implementation of the surprise billing protections. Specifically, we urge the Departments to fix the Qualifying Payment Amount (QPA) methodology, which is currently based on in-network contracts alone and a myriad of physicians, regardless of whether a physician ever bills for services under a CPT code. This issue of "ghost contracting" frequently occurs in the subspecialty of neonatology. Rather, the QPA should be determined based on a weighted methodology of CPT codes actually used that will allow the IDR entity to have better understanding of prior contracted rates, good-faith negotiations, specialists' medical experience, acuity of patients seen and market share.



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We are gravely concerned about the impact the IFR will have on underserved communities. The IFR as written will have a broad, discriminatory impact and harm patients who reside in traditionally underserved communities, including many rural areas. This will happen very quickly.

Today, Mednax provides highly specialized neonatology care in urban and rural areas alike. In some urban and suburban areas, high patient volume enables us to spread the costs of staffing obstetrics units 24/7 across many cases and sustain reasonable margins. These margins then enable us to provide care in traditionally underserved areas, like rural communities, where because of lower case volumes, professional service reimbursements alone typically do not sustain sophisticated high-cost neonatal care. We also operate in hospitals with high volume, but that are overwhelmingly dependent on Medicaid. We subsidize these services because we are committed to providing broad access to high-quality neonatal care. By subsidizing these services, we are able to deliver the same level of high-quality care where it could not possibly otherwise exist.

We are already hearing from payers who, in anticipation of the power-shift created by this rule, are leveraging the rules to renegotiate contracts. Many of these are contracts that are otherwise not up for renewal at this time. These payers are unilaterally terminating contracts and seeking substantial payment reductions to renew because they expect to be able to pay significantly less for services in 2022 as a result of the manner in which the Departments intend for plans to calculate the QPA, and the outsized role that the Departments envision for the QPA in dispute resolution processes. They are weaponizing the QPA and patient care in many places will be severely compromised or will end.

If payments for our services are wildly reduced, as we expect they may be as a result of these regulations, Mednax, like so many other providers, will need to make quick economic decisions about where we are able to provide services, and where it is no longer economically viable to do so. We will make hard, swift, but necessary business decisions to maintain operations, and these decisions will undoubtedly involve cutting some services, like the services we provide in underserved areas.

The effect of this ruling will also end our many vital support services. We provide enormous clinical oversight, and we are the leading neonatology research organization in the U.S. with the largest neonatal database anywhere.

With this in mind, we urge the Departments to reconsider several critical policy choices. We offer specific recommendations below.

Needless to say, we at Mednax are available to discuss any aspect of these concerns and our comments. If you have any questions, please contact me at any time.

Secretaries Becerra, Walsh and Yellen
November 19, 2021
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Sincerely,

/s/ Mark Ordan

Chief Executive Officer
Mednax Services, Inc,

Cc: David Kanter, MD, MBA, CPC
SVP, Medical Administrative Services, Mednax
Member, American Academy of Pediatrics Committee on Coding and Nomenclature
Member, American Academy of Pediatrics Editorial Advisory Board
Member, American Medical Association CPT Editorial Panel
Member, American Medical Association Digital Medicine Payment Advisory Group

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Urgent Areas for Consideration

- I. Fixing the QPA Methodology
- II. Independent Dispute Resolution Factors
- III. Batching Neonatology Claims to Support the IDR Process
- IV. Clarifying Application of the Cooling Off Period
- V. Good Faith Estimates
- VI. All-Payer Claims Databases

I. Fixing the QPA Methodology

We are already seeing payers engage in bad behaviors in anticipation of the No Surprises Act's (the "Act") January 1st effective date. For example, one payer with an existing, multi-year contract contacted us – outside the course of regular negotiations – to renegotiate their contract in light of the Act. We have been unable to resolve these discussions, to date. We have experienced an increasing number of contracts being terminated, with payers explicitly citing the Act as the reason for initiating terminations and pausing negotiations until January 2022. It is clear that payers have become emboldened by the Act and are increasingly displaying an unwillingness to negotiate.

i. The Departments should fix the QPA methodology. The methodology for calculating the QPA is built on broad generalizations that fail to account for the market dynamics that dictate rates. For example, the QPA does not use a weighted median nor does it incorporate critical differences between sub-specialties. Most of our physicians are board certified in Pediatrics, but are also board certified in at least one sub-specialty, like Neonatology, Cardiology or Neurology, among others. The median contracted rates for a pediatric cardiologist or neonatologist can vary significantly compared to a traditional primary care pediatrician. The training, experience, and settings in which these professionals practice can also be quite different. For example, while the majority of pediatricians primarily furnish services in an office setting, our specialists primarily furnish services in facility settings, like hospital emergency departments, NICUs and PICUs. Combining all sub-specialties into one median amount at the specialty level dilutes the weight of a specialist's experience (*i.e.*, because there are considerably more contracted rates for payment for pediatric services than there are for neonatal intensive care services, for example).

The Departments begin with a faulty assumption: that the QPA "represents a reasonable market-based payment for relevant items and services."¹ This assumption is not accurate. By definition, the QPA is *not* a market-based rate because it excludes all out-of-network payments, alternative payment arrangements, single case agreements, and more. It reflects only contracted rates as recognized by one payer, thereby discounting and underrepresenting a significant portion of the market. Moreover, the Departments acknowledge the market dynamic that occurs in payer-provider contracts: "Joining a plan's ... network assures providers of patient

¹ 86 Fed. Reg. 55980, 55,996.

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volume in exchange for lower reimbursements.”² That is the arm’s length transaction that underlies payer-provider contracts. If an out-of-network provider is more or less made to accept the QPA – which is the median rate under plan-provider contracts – as payment in full for out-of-network services, the provider is taking the discounted rate for nothing in exchange, e.g., patient volume. As such, the QPA as written, cannot be a credible proxy for out-of-network payments. By nature, an out-of-network payment indicates a failure or breakdown of in-network status, generally because the proposed rates are financially unsustainable or there is an inability to reach agreement on other considerations. Therefore, simply assigning a payer-recognized amount to a provider disparages the contracting process.

For these reasons and more, the QPA does *not* represent a market-based rate. Rather, the Departments have selected a subset of the market and applied it to the industry as a whole, often with the effect of artificially deflating rates. We urge the Departments to fix the QPA methodology so that it more accurately reflects what payers have been willing to offer and providers willing to accept. Accordingly, we urge the Departments to base the QPA on actual payments issued to individually contracted physicians.

ii. The Departments should base the median contracted rate on service codes that a provider has actually billed. The median contracted rate for an item or service is calculated based on care rendered by a provider in the same or similar specialty or facility in the same or similar facility type provided in a particular geographic region. This median includes rates that a provider may have accepted as part of a broader network agreement, even though the provider itself may not render or bill for select services. Such agreements may include rates that are folded into a larger contract without negotiation or discussion and are, therefore, lower than the true cost of providing care. For example, a provider may contract for hundreds of services, even though it does not offer and does not plan to offer a subset of those services. It has no incentive to fight for a fair payment rate on the subset and will generally accept the amounts the payer establishes, even if the rates are inadequate to cover the cost of care. Yet, under the Departments’ methodology, rates established via this “ghost contracting” approach would be incorporated in the median, thereby devaluing the rates for services actually delivered.

Given the significant role the median rate plays in establishing the QPA and, evidently, in directing the final payment amount, the median rate should not be influenced by rates that a provider has accepted but not used. Instead, the Departments should base the median on codes that providers bill. If the Departments do not modify this methodology, the independent dispute resolution (IDR) entity should, at a minimum, be informed that the median is based on amounts that were not thoroughly negotiated and the entity should be required to consider this discrepancy as one factor in its consideration.

II. Independent Dispute Resolution Factors

The Act requires arbiters to consider a number of factors in selecting the final payment amount in IDR, including the QPA, the provider’s level of training and experience, the parties’ market shares, patient’s level of acuity, and

² 86 Fed. Reg. 55980, 56,046.

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more. The Act deliberately and clearly specified that the arbiter shall consider all factors equally. Specifically, the statute noted that the IDR entity “shall consider” the QPA *and* “information on any circumstance” described in the statute as requested by the IDR entity or submitted by a party.³ However, the Departments add new restrictions in the IFR, which require arbiters to “select the offer closest to the QPA, unless credible information presented by the parties rebuts that presumption and clearly demonstrates the QPA is materially different from the appropriate out-of-network rate [.]” This approach is inconsistent with the process Congress designed and could have the unintended consequence of diminishing the value of this dispute resolution process, and worse, disrupting existing payer-provider contracts and future negotiations.

i. The Departments should allow arbiters to freely assess information submitted to IDR. In designing the dispute resolution process, Congress sought to create a fair and efficient process that would incentivize providers and payers to resolve payment disputes or otherwise accept the selection of a reasonable offer. Congress outlined the elements it believed to be critical in reaching this final amount and then it provided a catchall for parties to submit additional information relevant to the unique circumstances of the dispute. In this way, Congress acknowledged the complexities often involved in reaching a final payment and created the opportunity for payers and providers alike to make their case to an independent dispute resolution body.

Instead of implementing Congress’s vision, the Departments have redesigned the IDR process to, in most cases, reach a predetermined outcome solely recognized by the payer. Rather than considering all of the factors and information submitted, the IFR requires arbiters to select the offer closest to the QPA, unless a party can overcome the high bar of demonstrating that the QPA is materially different from the out-of-network rate. This requires parties to expend additional effort and incur additional costs in gathering materials and building their argument before they even get in the door. Only once parties’ successfully demonstrate that the out-of-network rate *is* materially different from the QPA, may they then engage in the full IDR process where the IDR entity will weigh that “credible information.” The Departments have, therefore, created an additional step (i.e., requiring parties to prove their information is credible) that Congress did not call for when it established a two-part resolution (i.e., negotiation and IDR).

The requirement that arbiters place primary weight on the QPA also ignores Congress’s directive for multiple factors to be considered. By favoring the QPA and making it difficult to introduce other evidence, the Departments have essentially discarded the factors Congress intended to be part of the consideration, and changed the nature of IDR. Instead of being an independent, deliberative process where a trained entity must wrestle with the evidence and reach a balanced decision, the Departments seek to implement a process where the QPA is dispositive in most instances. Before parties even initiate IDR, they now know that the outcome will most likely reflect the QPA, and they face an uphill battle of convincing the arbiter to rule otherwise.

This approach is inconsistent with aspects of the IFR itself. For example, the IFR establishes extensive requirements related to IDR entity selection and certification, yet, under the Departments’ proposal, these

³ Pub. L. No. 116-260, tit. I, div. BB.

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standards are largely unnecessary if the IDR entity's only function in the vast majority of instances is to select the amount that most resembles the QPA. If IDR entities are not going to engage in traditional dispute resolution procedures, it is not clear why parties must pay IDR fees or why the Departments would spend resources vetting applicants.

If Congress had wanted to resolve payer-provider disputes based on one factor, it would not have gone through the trouble of creating an IDR process and could have simply mandated that all payment disputes end with the QPA. Congress did not take that approach. It designed a comprehensive process to remove patients from disputes and to provide an avenue for swift resolution taking into account a variety of factors. The Departments have dramatically strayed from this framework. The Departments' qualifying terms (i.e., "credible information" and "materially different") were not included in the statute and diminish the role of the other factors that Congress clearly viewed as relevant in the payment determination. The Departments should revise this approach and allow arbiters to freely assess the evidence submitted.

ii. Providers should have a better understanding of how the QPA is derived and greater scrutiny of the QPA is required. The IFRs provide little oversight of the QPA, including how it is derived, reported, and efforts to safeguard against manipulation. This is a departure from regulators' generally careful approach to rate review. When a payer establishes its annual premium rates for the commercial market, those rates are closely scrutinized by State Departments of Insurance, including robust documentation justifying the amounts and any meaningful year-over-year increases. Similarly, Medicare Advantage plans must submit annual bids that estimate the cost of providing Parts A and B benefits, which are then compared to a benchmark established by the Centers for Medicare and Medicaid Services. Determining what Medicare Advantage plans will be paid involves a complex methodology, close analysis of the bids submitted, and back-and-forth communication with the agency. Yet, under the IFRs, the Departments have established a reimbursement methodology that payers alone calculate and apply, with little independent scrutiny or transparency. Like premium rates in the commercial and Medicare Advantage markets, QPAs should be submitted for review and approval before they are eligible for use and the Departments should play a role in overseeing how these amounts are reached.

The Departments have encouraged providers to monitor for and report instances of payers' bad behaviors related to the QPA, but this responsibility should not fall on providers alone. Documenting payers' bad behaviors requires additional time and resources and it is not clear how providers will be able to identify these accounts when hardly any information on the QPA is made available. Payers should be required to disclose considerably more information about the QPA methodology, including the number of contracts that contributed to the median, the specialty and subspecialties included, and the states in which the contracted rates are derived. At present, providers have no access to this data or the ability to confirm that calculations were performed accurately. To ensure that providers have confidence in the QPA and to ensure fairness, the methodology the payer used should be transparent and disclosed in the communication of the initial payment or notice of denial of payment. The Departments should not allow QPAs to be used until they are certified as accurate.

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iii. Assigning the QPA primary weight in IDR determinations will disrupt payer-provider contract negotiations and create an unlevelled playing field, which will negatively impact patient access to specialized care. In re-designing the IDR process, the Departments have not only tilted the scale in favor of payers, but have actually made it more difficult for providers to maintain and form fair in-network agreements with payers. Payers hold all the information because the QPA is based on their own contracted rates. If payers believe that the maximum they will ever have to pay in a dispute is the QPA, they have every incentive to only contract with providers who are willing to accept *less* than the QPA. Over time, this will drive down median contracted rates and compromise fair negotiations. The Departments have effectively eliminated providers' ability to engage in payment discussions: providers will, most often, have to accept QPA-like rates – which will deteriorate over time – or will likely be placed out-of-network; and any payment dispute providers pursue will likely settle near the QPA. Thus, it will be difficult for providers to ever move beyond the QPA.

We believe the IFR's structure harms the ability to form new agreements and also threatens the contracts that payers and providers have worked hard to secure, by incentivizing payers to abandon these existing agreements and seek artificially lower rates. As discussed earlier, patients will ultimately suffer through diminished access. If provider payments decline, subsidized outreach arrangements, like staffing rural facilities with specialized care, will be difficult to sustain. Patients may find it harder to find specialized neonatology services anywhere but large urban medical centers. The Departments should clarify that while the QPA is one data point for determining payment, it is not the overriding factor and should not be viewed as a benchmark for setting future rates. The Departments should also clarify that where parties had a prior contractual relationship, the arbiter should give deference to the parties' prior negotiated rates in IDR. If the QPA for the item or service does not align with the parties' prior contracted rates, then it should not be used as the determining factor in a dispute.

iv. Arbiters should not be biased or pressured to select one party over the other. The Act directed the Departments to create an unbiased process for settling disputes and it established certain guardrails to achieve this, including standards related to conflicts of interest and IDR certification. However, the Departments have now created a process where arbiters may only deviate from the QPA in rare instances and must explain any deviation from that amount. Whereas certified IDR entities must submit their decisions and underlying rationale through the Federal IDR portal in a form and manner specified by the Departments, the IFR suggests that an IDR entity that strays from the QPA must go a step further. The IFR states that "[i]f a certified IDR entity does not choose the offer closest to the QPA, the written decision's rationale must include a detailed explanation of the additional conditions relied upon, whether the information about those considerations submitted by the parties was credible, and the basis upon which the certified IDR entity determined that the credible information demonstrated that the QPA is materially different from the appropriate out-of-network rate."⁴

The IDR entity must, therefore, do considerably more work to select a final amount that differs from the QPA. This approach is not practical. When an arbiter is managing hundreds of disputes and has been directed to presume that the QPA is accurate, we believe the vast majority of arbiters will do as directed and select the

⁴ 86 Fed. Reg. 55,980, 56,000.

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offer closest to the QPA, with no further consideration. Even if they are willing to undertake the work, an IDR entity may hesitate to stray from the QPA out of concern that its decision may be challenged or subject to scrutiny. Entities that select the offer closest to the QPA are less likely to be reviewed, to have their decision overturned, or to be cast out of the Federal IDR system. This creates a disincentive for arbiters to consider evidence submitted by providers and pressures arbiters to default to the payer-driven QPA.

Arbiters should not be biased and pressured to select one party over the other. The Departments should allow arbiters greater flexibility to consider the information submitted and reduce any barriers that might prevent an arbiter from selecting a party.

III. Batching Neonatology Claims to Support the IDR Process

Claims should be eligible for batching based on an episode of care and at the sub-specialty level. The Act provides that multiple qualified IDR items or services may be considered jointly as part of a single determination when certain criteria are met. Such “batching” of services will only be permitted if such items or services are: (i) furnished by the same provider or facility; (ii) paid by the same group health plan or health insurance issuer; (iii) related to the treatment of a similar condition; and (iv) furnished within the 30-day period following the date on which the first item or service was furnished “or an alternative period as determined by the Secretary [.]” The IFR adds that if items or services are billed by a provider as part of a bundled arrangement, or where a payer makes an initial payment as a bundled payment, those qualified items or services may be submitted and considered as part of one payment determination.

We appreciate the Departments’ thoughtful consideration of the batching process and the flexibility provided in IFR Part II related to bundled arrangements. We endorse the opportunity to batch multiple claims in a single determination and agree, as the IFR recognizes, that there are instances where items or services should be considered at the same time as part of a bundled arrangement. We believe the Departments should expand this approach to allow for claims to be batched based on an episode of care at the sub-specialty level. An episode of care should include any claims incurred during the period of time the patient is under care (e.g., an entire stay in a NICU, or at least a continuous 30-day period of care within the NICU stay inclusive of all services rendered by the same group of subspecialists). NICU care often involves continuous, consecutive days of service within and beyond 30 days, with treatment sometimes continuing for two or three months for preterm newborns and complex cases. To better support the IDR process, neonatologists should be able to batch all of the services performed during these consecutive days, at least for the full 30-day period, if not also extending through the entire hospital course. Neonatology is unique in this sense, because care involves consistent treatment over the course of days and weeks to manage the hospitalization of preterm babies. During this time, the number of CPT codes relevant to neonatology is not extensive, but the assignment of those codes can vary from day to day or week to week depending on the patient’s status. The ability to batch the full hospitalization (or at least, the full 30-day period) in one determination at the specialty and subspecialty level across multiple service types (as reflected by different CPT codes) will reduce the administrative burden for the physician and IDR entity. It will also allow the IDR entity to better assess variations in the cost of care based on the relative differences in

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reported codes, which reflect clinical condition. Therefore, the Secretaries should use their authority to allow for claims to be batched where care is delivered in a coordinated fashion; the batching of multiple items or services should not be limited by the reimbursement structure.

IV. Clarifying Application of the Cooling Off Period

The Departments should clarify that the “cooling off” period applies at the plan level. Once the IDR entity renders a final determination, the law requires a 90-day “cooling off” period for the party that submitted the initial IDR request. During this time, the party may not submit a subsequent request involving the same opposing party and same item or service. While the IFR clarifies some aspects of the IDR process, it still does not answer whether the cooling off period applies at the payer or plan level. We believe the Departments intend to apply this standard at the plan level, since pending all disputes against a payer would significantly slow the resolution process and require both parties to undertake the burdensome task of tracking all disputes. Mednax requests clarification on the meaning of “opposing party,” as well as what providers will be paid during the 90-day period and what procedural rules apply. We recommend that the Departments consider flexibilities to implementing this 90-day period and request that all eligible disputes have timely access to the IDR process.

V. Good Faith Estimates

The Departments should delay implementation of the good faith estimate requirement to give providers more time to identify and prepare resources on the estimates. The IFR requires providers to inquire about an individual’s insurance status and provide a notification that the individual may receive a good faith estimate of the expected charges, including the expected billing and diagnostic codes for any such item or service. On August 20, 2021, the Departments released an FAQ deferring enforcement of this requirement on behalf of insured individuals until rulemaking is adopted and applicable. The Departments noted that “given the complexities of developing the technical infrastructure for transmission of the necessary data from providers and facilities to plans and issuers, [the Department of Health and Human Services] recognizes that compliance with this section related to individuals who are enrolled in a health plan or coverage and are seeking to have a claim from the scheduled items and services submitted to the plan or coverage is likely not possible by January 1, 2022.”⁵ The Departments did not defer enforcement of the requirement for uninsured individuals.

While Mednax appreciates the Departments’ commitment to greater transparency and patient education, the IFR contains complex requirements that will take time for providers to understand and implement. For example, it is not clear how providers are to exchange this information and coordinate to reach a reasonable estimate. Does the convening entity need to provide an individual’s entire medical record to all providers involved? How are providers to calculate the estimate if an individual has multiple co-morbidities or co-morbidities are not yet known? Do providers have only one day to evaluate the patient’s record and model and report an estimated

⁵ FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (Aug. 20, 2021). Accessible at: <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf>.

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amount? One approach would be for providers to calculate an average cost based on the average patient's profile. This would likely require a disclaimer that the good faith estimate is based on a patient with low or high needs. Will this approach satisfy the good faith standard?

If the charged amount ultimately exceeds the estimate by \$400 or more, patients may bring a claim through the patient-provider dispute resolution process. In the context of highly specialized services, like neonatology, \$400 is a very small margin in which to get the estimate correct. Despite providers' best efforts, there are many circumstances in which the billed amount may exceed this threshold. For instance, a patient may schedule services for a standard procedure, like a mole removal, but it will be difficult to predict up-front whether a specialist may need to be involved or if further testing will be required. Given the number of outstanding questions and the need for more guidance on how these estimates should be calculated and issued, we recommend that the Departments delay implementation of this requirement, similar to the delay of good faith estimates for insured individuals. A delay would give providers more time to identify and prepare resources on the estimates and train staff on how to comply with the requirements. This time may allow providers to give consumers better estimates that are well-aligned with the expected charges, based on data modeling and collaboration with our downstream providers.

Congress intended for consumers to have insight into the costs of care and we believe that with more time we can achieve this goal by providing estimates that are data-driven and thoughtful, rather than compiled on a compressed timeline, as the Departments themselves have acknowledged.

VI. All-Payer Claims Databases (APCDs)

APCDs should not be relied on until the Departments have established minimum standards for use and have verified that the databases are reliable for QPA calculations. The IFR places significant reliance on APCDs. When there is insufficient information to calculate the median contracted rate, payers must determine the QPA by using an eligible database. APCDs are considered "categorically eligible" to serve in this role because they are identified as not having any conflicts of interest and as having sufficient information reflecting the allowed amounts. This is not an accurate assumption.

HHS's Agency for Healthcare Research and Quality (AHRQ) has noted that APCDs tend to omit a large number of claims and populations, including uninsured patients and some substance abuse, mental health, and HIV populations.⁶ States may not compel data collection from non-governmental self-insured health plans, which represent approximately one-third of all insured people, leaving a large gap in the data APCDs can collect.⁷ States then apply different rules regarding which patients to include in the databases, making it difficult to

⁶ See Agency for Healthcare Research and Quality, *All-Payer Claims Databases* (Feb. 2018). Accessible at: <https://www.ahrq.gov/data/apcd/index.html>.

⁷ See M. Fiedler and C. Linke Young, *Federal Policy Options to Realize the Potential of APCDs*, USC-Brookings Schaeffer Initiative for Health Policy (Oct. 2020). Accessible at: <https://www.brookings.edu/wp-content/uploads/2020/10/APCD-Final-1.pdf/>

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compare data state-to-state.⁸ There are also several concerns with data quality, including that claims data does not consistently contain information on patient outcomes, bundled payments, or details from electronic health record data.⁹ AHRQ reports that data submitters do not always provide complete or clean data in a timely manner, which results in additional claims being omitted.¹⁰ And, where quality measures *are* included, these measures have not been thoroughly tested for validity.¹¹ As RAND most recently reported to HHS, “APCDs cannot be assumed to be representative of state populations or health care.”¹²

Given this evidence, we urge the Departments to consider the existing research on APCDs and adjust the presumption that they are “categorically eligible” for QPA calculations. Once an APCD has demonstrated the minimum requirements and the Departments have found it to be a reliable source, there should be transparency regarding the underlying data, including but not limited to, who submits to a state’s APCD, how many allowable amounts are included, whether workers’ compensation is included, what constitutes a “product,” and what percentage of the market is reflected in the data. In addition to promoting transparency, the Departments should engage in ongoing validation and verification of the data.

⁸ Agency for Healthcare Research and Quality, *All-Payer Claims Databases* (Feb. 2018).

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

¹² See K. Grace Carman, M. Dworsky, S. Heins, D. Schwam, S. Shelton, and C. Whaley, *The History, Promise and Challenges of State All Payer Claims Databases* (June 2021), prepared for the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Accessible at: <https://aspe.hhs.gov/sites/default/files/private/pdf/265666/apcd-background-report.pdf>.



December 3, 2021

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS - 9908-IFC
P.O. Box 8016
Baltimore, MD. 21244-8016

Re: RIN 1210-AB00: Requirements Related to Surprise Billing, Part II: Interim
Final Rule on Independent Dispute Resolution.
CMS: RIN 0938-AU62
EBSA: RIN 1210-AC00
IRS: RIN 1545:BQ05

Dear Ms. Brooks-LaSure:

On October 7, 2021, the Department of Health and Human Services, on behalf of itself and the Departments of Labor and the Treasury (hereinafter the "Departments") published in the Federal Register the Interim Final Rule ("IFR") for the Independent Dispute Resolution ("IDR") process required by Section 102 and the relevant portions of Section 105, specific to air ambulances, as required by the No Surprises Act ("NSA"), Consolidated Appropriations Act, 2021 (Pub. L. 116-260). PHI Health, LLC ("PHI") recognizes the hard work of the staff of the Centers for Medicare and Medicaid Services and each of the Departments in implementing the No Surprises Act, thereby providing greater clarity for air ambulance providers in the future. Today, I am writing on behalf of the 1,156 medical and aviation professionals serving PHI Health's patients nationwide to discuss the IDR IFR, and how the IDR IFR must be improved to ensure the sustainability of essential air medical services throughout the United States.

Summary

PHI, as one of the leading air ambulance providers in the United States, states in the strongest possible terms that the IDR IFR, when combined with Part I's misguided definition of the qualified payment amount ("QPA"), will lead to diminished capacity for providing air ambulance services nationwide, jeopardizing patient access to emergency air ambulance services, especially in rural and underserved areas. The IDR IFR fails to provide a balanced, independent, and

quasi-judicial proceeding for the resolution of payment disputes because it requires the IDR Entity to select the proposed payment amount closest to the QPA in a mechanical process, and establishes a presumption that the QPA is correct without regard to the additional circumstances that the IDR Entity is required to consider under the NSA. To prevent erosion of the nation's air ambulance capabilities to provide emergency care because of an IDR process biased in favor of insurers, PHI calls upon the Departments to revise the IDR IFR, and thus to ensure that critically ill patients do not suffer from the lack of air ambulance services.

This comment discusses the IDR IFR in two sections: first, how the IDR IFR fails to provide a balanced, independent, and quasi-judicial proceeding for the resolution of payment disputes, and second, it responds to the Departments' requests for specific comments on provisions of the IFR.

Background

Through our PHI Air Medical business line, PHI provides the highest level of patient care and the highest quality of safe air ambulance transportation for both insured and uninsured patients throughout the United States. We (along with our fellow air ambulance services) have a legal and ethical Duty to Act when called upon for emergent care, and we must do so regardless of a patient's insurance status or ability to pay. A significant number of commercially insured patients discover after needing our services that PHI and other air ambulance services are not in their health insurer's provider network, especially if they are injured while traveling away from their home state. However, commercial health insurers have been unwilling to expand their networks and negotiate fair payment amounts for our services. Instead, they have acted to terminate existing network contracts for air ambulance services or end ongoing contract negotiations. As noted in our September 3, 2021 comment on Part One of the IDR, this is not for lack of money. See CMS-2021-0117-6398. Health insurers remain immensely profitable, but they put those profits ahead of emergent patient care by leaving air ambulances out of network and undercompensating air ambulance providers for their services.

PHI's comment on Part One explains how the QPA fails to be an appropriate measure for reimbursement for air ambulance services. It states that Part One of the NSA IFR:

- fails to recognize that the median contracted rate can be manipulated by health insurers to drive the qualified payment amount down, thus lowering health insurers' reimbursements;
- fails to include single contract agreements in determining a median contracted rate, despite such contracts representing what air ambulances and insurers have historically agreed upon for payment of air ambulance services, thereby expanding the available data for accurate pricing of reimbursements; and
- fails to account for the fact that air ambulance services are provided by for-profit and non-profit organizations, and the degree to which a provider may be subsidized by health system cost allocations, charitable contributions, or tax support. The presence of these subsidies allows such subsidized providers to charge lower prices and accept lower contracted reimbursement amounts, thus skewing the data for the median contracted rate down.

These misguided parameters for the QPA in IFR Part One are compounded by the IDR IFR's over-reliance on the QPA to the exclusion of other statutory requirements, as discussed below. Moreover, since PHI filed its comment on September 3, 2021, new developments have occurred showing that PHI's statements regarding manipulation of the QPA are not speculative. On November 5, 2021, Blue Cross Blue Shield of North Carolina issued a model letter for health care providers in North Carolina that informs their in-network healthcare providers that these contracts are subject to renegotiation, with the intent of BCBS NC to decrease contracted rates. In this letter, BCBS NC seeks to deflate contracts by forcing in-network providers to agree to lower payments or have their network agreements terminated. BCBS NC's model letter states:

- "The QPA paid by health plan to the out-of-network provider constitutes payment in full unless certain limited exceptions apply for a given QPA."
- "Where previous state law could result in an obligation to pay at full charges if no contract is in place, the new law sets reasonable limits on payment at the median-in-network rate."
- "If we are unable to establish in-network rates more in line with a reasonable, market rate, our plan is to terminate agreements where the resulting out-of-network QPA would reduce medical expenses . . ."

BCBS NC misstates the terms of the NSA. The QPA in the NSA is a reference price to be considered by the IDR Entity among other factors, not a cap on payments. Nor does the NSA apply to most in-network providers. Yet BCBS NC is seeking to use it as a bludgeon to force in-network providers to accept lower payment amounts or be forced out of network. By lowering their prices under duress, BCBS NC forces one of two outcomes:

1. Deflated contracts are used to populate any eligible data base used by plans when “insufficient information” is available to determine a QPA based on a median of contracted rates.
2. Newly out-of-network providers will be forced into a pathway of leveraged negotiation, or a biased IDR process that forces the IDR entity to choose the offer closest to QPA (which disregards single case agreements).

For as long as “insufficient data” exists within a state (or a Census division), plans can rely on a flawed database of deflated contracts. Once sufficient data exists within a state or Census division, in the form of enough newly negotiated contracts to derive a median of in-network rates, the plan will have to use that median. However, at that point, the deflated rates will lower the median and, subsequently, the QPA, to the benefit of the plan. This bad faith action is precisely the manipulation by health insurers that PHI Health warned about in its prior comment and shows why IFR Part One needs to be revised to refine the definition of the QPA, and why revising the IDR IFR to ensure that full consideration of all factors by the IDR Entity is essential.

Part A: The IDR IFR Fails to Provide Fair Dispute Resolution

PHI Health sincerely appreciates the actions by Congress to remove patients from the middle of payment disputes. After enduring a life-threatening injury, patients should not have to endure protracted payment disputes or be held financially responsible for insurers' unwillingness to cover air medical transportation to enhance their profits. While the Departments have issued two interim final regulations which have aspects that may serve to support the ability of air ambulances to provide emergency air ambulance services, and a data disclosure Notice of Proposed Rulemaking, the Departments have included other aspects in the IFRs that will jeopardize the ability of air ambulances to continue to serve the public, especially in rural and underserved areas that already experience inequities in healthcare.

PHI Health has significant concerns about the following aspects of the IDR IFR, which far outweigh the limited aspects that promote sustainability of emergency air ambulance services:

1. The IDR IFR Creates a Presumption that Excludes Information From Consideration in IDR

The IDR IFR creates a presumption of correctness of the Qualifying Payment Amount (the “QPA”), contrary to the intent of Congress that an IDR Entity consider all factors equally. The statute states:

(C) CONSIDERATIONS IN DETERMINATION.--

(i) IN GENERAL.-- In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR service **shall consider--**

(I) the qualifying payment amounts (as defined in section 2799A-1(a)(3)(E)) for the applicable year for items or services that are comparable to the qualified IDR air ambulance service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR air ambulance service; **and**

(II) subject to subparagraph (iii), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), **and** any additional information provided in subparagraph (B)(ii). Consolidated Appropriations Act, 2021, Division BB, Section 105(b)(5)(C), 134 STAT. 2834 (Pub. L. 116-260, December 27, 2020) (emphasis added).

As the Departments are aware, subparagraph (C)(ii) provides a list of additional circumstances for consideration, including

- the quality and outcome measurements of the provider;
- the acuity of the patient and the complexity of the patient's case;
- the training and experience of the medical personnel;
- the population density of the pickup location; and
- demonstrations of good faith efforts made by provider, in this case the air ambulance service, to enter into network agreements.

Each of these factors may provide important information to the IDR Entity in reaching a payment determination. (As the Departments are also aware, subparagraph (C)(iii) prohibits certain other information from being considered, such as the amounts of usual and customary charges for services or reimbursements under government programs such as Medicare and Medicaid).

Thus, the statute is exceedingly clear by using the word "and" that ***both the QPA and the additional circumstances shall be considered by the IDR Entity*** in arriving at a payment determination. In contrast, the IDR IFR provides:

[T]he certified IDR entity should only consider this information to the extent the certified IDR entity determines that either party submitted credible information that clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate. Section III.D.4.iii., 86 Fed. Reg. 55998 (October 7, 2021).

The No Surprises Act clearly states that the IDR Entity shall consider the QPA, and "information on any circumstance" in the additional circumstances list, and any information relating to such offer submitted by either party. See section 105(b)(5)(C). The statute does not say the IDR Entity should consider additional information *only if* the hurdle of the presumption is overcome; instead, it clearly says "and." Thus, Congress did not include in the NSA any presumption of correctness rule which could be interpreted by the Departments as Congress favoring the QPA over additional circumstances information, nor does a general rule excluding information exist (beyond the specific list of prohibited information such as usual and customary charges and government payor rates). Moreover, Congress specified that the parties also may submit additional information not on the list of additional circumstances by stating "and any additional information provided in subparagraph (B)(ii)." *Id.* Clearly Congress viewed more information as beneficial for an informed, fair decision by the IDR Entity, rather than requiring that information would be excluded unless a presumption cannot be met.

But under the IDR IFR, the IDR Entity is instructed to consider additional information only to the extent that it is deemed "materially different" from the appropriate out-of-network rate, i.e., different enough to overcome the presumption that the QPA is correct, and thus demonstrate through the additional circumstances that the other offer (i.e., the offer not closest to QPA) should be the prevailing offer. See section III.D.4.iii., 86 Fed. Reg. 55998. There is no rational basis for an assumption that the QPA is correct and that the additional factors that Congress included in the No Surprises Act should be de-emphasized, or worse, wholly discarded. Moreover,

errors in the QPA methodology under IFR Part One are magnified by the mandate to follow the QPA in the IDR IFR. The reliance on a QPA methodology that disregards key data like single case agreements (which reflect historic payments agreed upon by payers and providers) and does not take into account the unique aspects of air ambulance services (which is the purpose of the additional factors listed in the statute) prevents the IDR Entity from making a fully informed and fair decision based on the totality of circumstances for each unique case. And as has already been shown, health insurers such as BCBS NC are seeking to exploit the NSA's narrow definition of QPA to the detriment of health care providers. Taken together, IFR Part One and the IDR IFR are a formula for serious harm to the provision of health care services.

The law of statutory interpretation is clear that where the statute is unambiguous, there is no basis to change a word's meaning. When the Supreme Court is asked to determine a question of statutory interpretation, its analysis begins "with the language of the statute." Kingdomware Techs., Inc. v. United States, 136 S. Ct. 1969, 1976 (2016) (quoting *Barnhart v. Sigmon Coal Co.*, 534 U.S. 438, 450 (2002)). And when the language of that statute is clear, the Court's inquiry "ends there as well." *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 438 (1999). The word in question here is "and" which means both, not if. It does not mean that the following requirement -- in this case, the IDR IFR's additional circumstances -- can be considered only if a presumption is overcome. Thus, the presumption in the IDR IFR should be stricken as exceeding the express terms of the NSA.

If the insurer can be certain that it will have to pay no more than the QPA in dispute resolution, it has no incentive to negotiate a fair payment.

2. Members of Congress Agree the IDR IFR Fails to Follow the No Surprises Act

PHI is not alone in its objection to the IDR IFR's failure to follow the law of the No Surprises Act. Congress agrees that the IDR IFR does not follow the statute. On October 4, 2021, Richard Neal, the Chairman of the House Committee on Ways & Means, and the Ways & Means Committee's former Chairman, Ranking Republican Kevin Brady, wrote on behalf of all medical providers to the three secretaries of the Departments and stated: "we are concerned that the regulation . . . [does] not reflect the law that Congress passed" (emphasis in the original). Their letter continues:

Despite the careful balance Congress designed for the IDR process, the September 30, 2021 interim final rule with comment strays from the No Surprises Act in favor of an approach that Congress *did not* enact in the final law and does so in a very concerning manner. The rule crafts a process that essentially tips the scale for the median contracted rate being the default appropriate payment amount. Under the interim final rule, the IDR Entity is only allowed to deviate from the median amount where the parties present "credible information about additional circumstances [that] clearly demonstrates that the [median in-network rate] is materially different from the appropriate out-of-network rate." Such a standard affronts the provisions enacted in law, and we are concerned that this approach biases the IDR Entity toward one factor (a median rate) as opposed to evaluating all factors equally as Congress intended.

On November 5, 2021, Chairmen Neal and Brady were joined by 152 of their colleagues in a separate letter to the Departments. This second bipartisan letter, written by Representatives Thomas Suozzi, Brad Wenstrup, D.P.M., Raul Ruiz, M.D., and Larry Bucshon, M.D., states that:

Unfortunately, the parameters of the IDR process in the IFR released on September 30 do not reflect the way the law was written, do not reflect a policy that could have passed Congress, and do not create a balanced process to settle the payment disputes. The IFR directs the IDR entities to begin with the assumption that the median in-network rate is the appropriate payment amount prior to considering other factors. This directive establishes a de-facto benchmark rate, making the median in-network rate the default factor considered in the IDR process. This approach is contrary to statute and could incentivize insurance companies to set artificially low payment rates, which would narrow provider networks and jeopardize patient access to care -- the exact opposite of the goal of the law.

After this overwhelming message from Congress, the Departments cannot fail to act to correct the IDR IFR. The IDR IFR must be revised to follow the No Surprises Act, and to avoid harm to medical providers, including air ambulance services, and thereby avoid diminishing the availability of patient care and transportation.

3. Additional Issues with the IDR IFR

There are additional troubling provisions in the IDR IFR, including the methodology for resolution of payment disputes between providers and payers (for commercially insured patients) and between providers and patients (for uninsured patients). The IFR instructs the IDR Entity to begin with the assumption that the offer closest to the QPA is the correct offer and should be chosen as the prevailing offer. See section III.D.4.iii., 86 Fed. Reg. 55999. This provision rejects the fundamental *independence* required by the Independent Dispute Resolution Entity, forcing the IDR Entity into a mechanical result that precludes the essential objective examination of all facts necessary to support fully informed decision-making in each unique case. The IDR IFR requires a mechanical approach that removes discretion from the IDR Entity's authority and will likely lead to inequitable results and the erosion of payments for air ambulance services. What is paramount is that because the QPA can be manipulated by insurers, it will likely result in payment amounts for air ambulance services that are insufficient to cover the costs of providing such services. If an insurer can be certain that it will have to pay no more than the QPA in dispute resolution, it has no incentive to negotiate a fair payment. A mechanical IDR based on a flawed QPA will lead to unsustainable results that will leave some communities without air ambulance services.

The IFR states in reference to non-air ambulance services that it is "not the role of the IDR Entity to determine whether the QPA has been calculated correctly, to make determinations of medical necessity, or review denials of coverage." See section III.D.4.iii., 86 Fed. Reg. 55996. Presumably the IDR must follow the same limitations on its role for resolving disputes over air ambulance services. However, by virtue of its name the IDR Entity was intended by Congress to be an *independent* certified professional acting as an arbitrator to examine the facts as presented, and to make a decision based on that examination. Rules that prevent inquiries into the accuracy of the QPA and equitable consideration of all factors destroy the IDR Entity's independence and nullify its ability to ensure a fully informed result. Similarly, a truly independent IDR Entity should be able to look behind the numbers in batches where coverage is repeatedly denied as a means of delaying payment for the benefit of the float. The IDR IFR's formulaic approach rends the use of arbitration as a means to resolve a dispute and will prevent air ambulance providers from addressing the issues of a correct QPA, medical necessity, and denials of coverage in the most efficient and readily accessible forum for the parties.

Although it is in the section of the preamble devoted to the selection of offers for qualified IDR services that are not air ambulance services, the provision regarding good faith efforts to enter into network agreements also covers air ambulance services by its terms. See section III.D.4.ii., 86 Fed. Reg. 55998. It states:

Fifth, to the extent credible information is submitted by a party, the certified IDR entity must also consider whether the credible information about any demonstrations of good faith efforts (or lack thereof) made by the nonparticipating provider, nonparticipating facility, or nonparticipating provider of air ambulance services or the plan or issuer, as applicable, to enter into network agreements, and if applicable, contracted rates between the provider or facility and the plan or issuer, as applicable during the previous 4 plan years, clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate for the qualified IDR item or service. For example, a certified IDR entity must consider what the contracted rate might have been had the good faith negotiations resulted in the nonparticipating provider, facility, or provider of air ambulance services being in-network, if a party is able to provide related credible information of good faith efforts or lack thereof.¹

This complex sentence appears to be saying that 1) if the presumption can be overcome and 2) if an out-of-network air ambulance provider can show good faith efforts to negotiate network agreement rates over the past four years, then the IDR Entity must consider what the contracted rate would have been had the negotiations been successful. Because PHI and other air ambulance providers have repeatedly attempted to negotiate network agreements with insurers, this second condition can be met. However, the IDR IFR should not condition the arrival of a reasonable payment amount upon overcoming a presumption that such amount is materially different than the QPA, because, as stated herein, the QPA is not a legitimate measure of a fair payment for air ambulance services. Moreover, if the IDR Entity is going to be charged with predicting what the contracted rate would have been had the good faith negotiations been successful, the IDR IFR should expressly provide regulatory factors for the IDR Entity to consider in making such a determination, such as the additional circumstances listed in section 105(b)(5)(C)(ii) of the No Surprises Act.

¹ A similar provision is also stated in the section regarding the selection of offer for qualified IDR services that are air ambulance services, but without the explanatory example.

* * * * *

PHI Health urges the Departments to reconsider and correct these deficiencies in the IDR IFR, so that all factors in the IDR process are considered equally in a balanced, fair and independent arbitration process, as Congress intended and the statute plainly requires, and without a presumption that must be overcome before such factors can be considered. In doing so, the Departments will act to sustain the provision of emergency air ambulance services for the protection of the health of rural and underserved populations throughout the United States.

Part B. Responses to the Departments Specific Requests for Comments

PHI welcomes the opportunity to respond to the Departments requests for comments on certain provisions of the IDR IFR, as follows:²

Page 41, Part III.D.1.

Based upon this information and any additional information requested by the selected certified IDR entity, the selected certified IDR entity will determine whether the Federal IDR process is applicable. The Departments seek comment on this approach and whether any challenges exist in relying solely upon electronic notifications.

It is important that the "courthouse door" of arbitration be held wide open for all parties, and that decisions be based on the merits of a claim rather than procedural hurdles. Electronic notification is acceptable but should have acknowledgement and verification processes in place to prevent disqualification of a claim due to miscommunication.

Page 41, Part III.D.1.

The Departments will make available on the Federal IDR portal a list of certified IDR entities among which parties to the Federal IDR process may select, including basic information about the certified IDR entities, such as contact information, certified IDR entity numbers (unique identification numbers assigned to each certified IDR entity by the Departments), websites, and service areas. The Departments seek comment on this

² References in Part B are to the September 30, 2021 pre-publication release of the IFR for ease in locating the exact question raised by the Departments.

approach, including whether additional information about the certified IDR entities should be made public, and whether any challenges exist in relying solely upon electronic notifications.

The additional information about certified IDR entities that should be made public over time is the individual and aggregate percentages of decisions in favor of providers and in favor of insurers, so that to the extent certain IDR Entities deviate from the aggregate norm in favor of insurers or providers, it is known by the public.

Page 49, Part III.D.3.

The Departments also seek comment on how frequently nonparticipating providers, nonparticipating emergency facilities, or nonparticipating providers of air ambulance services will be reimbursed through a bundled payment and whether allowing items or services included in a bundled payment by a provider or facility to be treated as one payment determination could be used to circumvent the batching requirements by not requiring precise consideration of what specific claims within the batch should be arbitrated and which claims should not, thereby resulting in potential overuse of the Federal IDR process in a manner that creates inefficiencies.

The batching of claims and bundling of payments should be distinct processes, whereby similar claims may be made and arbitrated in batches, and payments aggregated into a single payment bundle to settle accounts between providers and insurers. One process should not impact the other.

Page 60, Part III.D.4.ii.

The Departments seek comment on whether additional requirements should be considered to address any potentially abusive scenarios, including scenarios in which parties could potentially distort information that informs the enumerated considerations, such as overestimating the teaching experience of providers at the facility or upcoding the costs for items or services, and seek comment on the potential for gaming of the Federal IDR process.

While this request for comment is for general medical providers rather than air ambulances, it is ironic that the Departments are concerned and seek comment on the potential gaming of the Federal IDR process. Under IFR Parts One and Two, the IFR IDR is based upon the QPA, which in itself can be, and in fact is already being gamed by insurers, as discussed above in reference to BCBS NC. Such gaming includes excluding air ambulances from in-network agreements. Further

distortion results from excluding single contracts from consideration, and including median contracted rates that are agreed to by hospitals trading loss-leader air ambulance services for more lucrative in-hospital services, such as cardiac services and cancer treatments.

The IDR IFR is a house built on the sand of the QPA. If the Departments are sincerely concerned about gaming of the IDR process, they should start by ensuring that all circumstances are included in the information available to the IDR Entity so that the IDR Entity can make an equitable decision without being biased by a manipulated QPA.

Page 61, Part III.D.4.ii.

The Departments intend to provide additional guidance to certified IDR entities as necessary to clarify how the allowable factors should be considered and seek comment on this approach, including the appropriateness and scope of the factors previously discussed.

This request for comment is confusing. The IDR IFR states that additional circumstances will not be considered unless the presumption of a material difference is met. Does this request for comment indicate that the Departments are not fully committed to this approach? If so, they should abandon the presumption immediately as exceeding the bounds of the statute, as discussed herein.

Page 74, Part III.D.5.

The Departments seek comment on whether IDR entities should be required to have air space law knowledge for IDR entity certification to make determinations for air ambulance cases.

PHI does not believe knowledge of air space law is a required qualification for IDR Entities.

Page 74, Part III.D.5.

The Departments seek comment on whether any additional accreditation or training standards would meet this requirement, including whether additional flexibility is needed to help encourage innovation in the provision of IDR services and new entrants as IDR entities that may be certified for the Federal IDR process.

The Departments have already stated sufficient standards for IDR Entities; in fact, they may be biased in favor of large organizations with advanced technology capabilities rather than retired jurists and doctors that have traditionally performed arbitration roles with distinction. No additional requirements for IDR Entities should be added.

Page 83, Part III.D.5.

The Departments will also consider factors such as the anticipated volume of payment determinations under the Federal IDR process and adequacy of the Federal IDR process capacity to efficiently handle the volume of IDR initiations and payment determinations. The Departments will review and update the allowable fee range annually based on these factors and the impact of inflation and other cost increases. The Departments seek comment on these factors and any additional factors that should be considered when determining the range for allowable certified IDR entity fees.

PHI is concerned that in the Departments' efforts to promote efficiency in the IDR process the Departments have moved the dispute resolution process from an arbitration process handled by experienced experts, such as retired jurists and medical doctors, to a mechanical process that will be handled by clerks and computer programs. Because of the expense of air ambulance services, air ambulance bills are substantial and the circumstances behind them are complex. The complexity of the case, the time necessary to review the file thoroughly, and the required sophistication of the arbitrator demand that fees be sufficient for fair compensation of the arbitrator. Otherwise, the arbitrator will likely follow the path of least effort and the quality of analysis and decision making will suffer.

The Departments state in the IDR IFR that they have determined to regulate the price of arbitration to avoid shifting costs to consumers by annually setting a price range, and cite IDR entity fees of \$300 to \$600 per payment determination in state-run arbitration programs as representative. Combined with the QPA methodology established in IFR Part 1, this approach disincentivizes a thorough and thoughtful review of competing offers. First, the QPA is biased towards the payors in its disregard of historical payment, such as single contract payments, agreed to by air ambulances and insurers. Second, IFR Part 2 directs the IDR entity to choose the offer closest to the QPA. Third, the Departments choice in IFR Part 2 to limit compensation for the work required by an IDR entity virtually ensures that the IDR entity will not put in the necessary work to fully evaluate the information behind the

competing offers. The economics are plain: low compensation for the IDR entity yields low effort by the IDR entity.

The Departments' plan to constrain the IDR entity and process is misguided. First, to protect consumers the Departments should instead look to excessive insurer profits generated through mistreatment of their customers and of medical providers. United Healthcare reported \$15.4 billion in profits in the last twelve months alone.³ The largest five health insurers reported \$91 billion in profits over the last five years. Attempting to protect consumers through price regulation of dispute resolution through arbitration costs in the hundreds of dollars while allowing insurers to abuse their providers and customers in total amounts in the billions of dollars through low provider payment rates, excessive premiums, a multitude of cost-sharing and co-insurance techniques, and arbitrary, self-serving claim denials is locking the barn door after the horse has run off.⁴

Second, the Departments cite as authority "*How States are Using Independent Dispute Resolution to Resolve Out-of-Network Payment in Surprise Billing*" (To the Point 9blog, Commonwealth Funds, Feb. 27, 2020), yet this study is for all medical providers. Rather than setting a fee range based upon state-run IDR program experience for non-air ambulance services, the Departments should instead allow IDR Entities to set their own prices and provide efficient and valuable services so that air ambulance and insurers will return to them for fair treatment in independent dispute resolution.

Page 91, Part III.D.6.

The Departments seek comment on whether final rules should include additional bases for revocation. The Departments also seek comment on whether certain facts and circumstances should result in immediate revocation of certification of the certified IDR entity and reassignment of any pending payment determinations prior to completion by that certified IDR entity.

³ See: <https://www.unitedhealthgroup.com/newsroom/2021/2021-10-14-third-quarter-results.html> (October 14, 2021) for United Healthcare's earnings notice.

⁴ For a recent example of United Healthcare's mistreatment of its providers, see: <https://www.globenewswire.com/news-release/2021/11/29/2342578/0/en/Nevada-Jury-Finds-UnitedHealthcare-and-Affiliates-Guilty-of-Oppression-Fraud-and-Malice-in-its-Conduct-against-Frontline-Healthcare-Heroes.html>

and

Page 93, Part III.D.6.

The Departments will monitor the implementation of the Federal IDR process, as well as the petition process, to determine whether certified IDR entities are abiding by the applicable requirements. The Departments seek comment on any additional requirements regarding denial and revocation, and whether other steps may be required to prevent patterns and practices of noncompliance.

In order to ensure the **independence** of the independent dispute resolution process, it is essential that IDR entities' status as "certified" to resolve disputes is not subject to review by HHS based on the outcome of a particular IDR Entity's decisions. A perception of bias towards insurers or air ambulance providers is not listed among the seven factors for revocation of certification, nor should it be included. See section III.D.6., 86 Fed. Reg. 56007. The IDR IFR's rules for mutual agreement between insurers and providers in the selection of an IDR Entity already provide a basic protection against the selection of an IDR Entity that is perceived as biased. Moreover, as independent businesses seeking to provide a service to commercial insurers and air ambulance providers, IDR Entities should also not have to pass a litmus test by the government for qualification to enter into business or to maintain that business -- especially since the Departments have effectively stated in the IDR IFR that their goal is to drive prices down without regard to other factors such quality or costs via reliance on the QPA. Thus, the revocation of an IDR Entity should not be a decision for HHS alone. The decisions made by IDR entities will affect access to emergency air ambulance care for patients and consumers across the country. As such, any decision made to revoke certification should be made by an independent body of experienced arbitrators operating at arm's length from government regulators and the parties involved, considering and reaching a decision based upon the seven factors listed for revocation.

Page 99, Part III.E.

The Departments solicit comment on whether any differences or departures from the approach taken in the July 2021 interim final rules are warranted.

As stated above, PHI's comment on Part One explains how the QPA fails to be an appropriate measure for reimbursement for air ambulance services. It states that Part One of the NSA IFR:

- fails to recognize that the median contracted rate can be manipulated by health insurers to drive the qualified payment amount down, thus lowering health insurers' reimbursements;
- fails to include single contract agreements in determining a median contracted rate, despite such contracts representing what air ambulances and insurers have historically agreed upon for payment of air ambulance services, and expanding the available data for accurate pricing of reimbursements;
- fails to account for the fact that air ambulance services are provided by for-profit and non-profit organizations, and the degree to which a provider may be subsidized by health system cost allocations, charitable contributions, or tax support. The presence of these subsidies allows such subsidized providers to charge lower prices and accept lower contracted reimbursement amounts, thus skewing the data for the median contracted rate down.

These misguided parameters for the QPA in IFR Part One are compounded by the IDR IFR's over-reliance on the QPA to the exclusion of other statutory requirements, as discussed in this comment. The July 2021 IFR Part One should be revised to expand the available pool of information for determining a median contracted rate to include single contracts; to take into account the distortion in the QPA via direct and indirect subsidies received by some air ambulance providers; and to reduce the reliance on the QPA to prevent undue influence by insurers from distorting its validity.

Furthermore, in basing the IDR process almost entirely on the QPA, the IDR IFR makes the accuracy and reliability of the QPA of paramount importance. In its comment on the NPRM for section 106 of the NSA, PHI provided a comparison of the relative data disclosure burdens on insurers and air ambulance providers and recommended to the Departments that insurers provide additional basic information. However, it is now apparent from the IDR IFR that insurers should provide not just the basic data, but also the calculations they have used to determine a QPA from that data in preparation for the audit discussed below. In other words, they must show their work so that HHS and air ambulance providers can be certain of its accuracy, reliability, and fairness.

Moreover, in IFR Part 1, in addressing the requirement of the Act for rulemaking to establish an audit process for compliance with the calculation of the QPA by insurers or plans, the Departments approach does not follow the actual text of the Act. Section 102(a) amends the Public Health Service Act to add:

“PART D—ADDITIONAL COVERAGE PROVISIONS

“SEC. 2799A–1. PREVENTING SURPRISE MEDICAL BILLS.

“(a) COVERAGE OF EMERGENCY SERVICES.—

“(2) AUDIT PROCESS AND REGULATIONS FOR QUALIFYING PAYMENT AMOUNTS.—

“(A) AUDIT PROCESS.—

“(i) IN GENERAL.—Not later than October 1, 2021, the Secretary, in consultation with the Secretary of Labor and the Secretary of the Treasury, shall establish through rulemaking a process, in accordance with clause (ii), under which group health plans and health insurance issuers offering group or individual health insurance coverage are audited by the Secretary or applicable State authority to ensure that—

“(I) such plans and coverage are in compliance with the requirement of applying a qualifying payment amount under this section; and

“(II) such qualifying payment amount so applied satisfies the definition under paragraph (3)(E) with respect to the year involved, including with respect to a group health plan or health insurance issuer described in clause (ii) of such paragraph (3)(E).

In IFR Part 1, the Departments acknowledge the requirement of the Act for rulemaking to establish an audit process for compliance of insurers with the requirement to properly calculate the QPA. However, the Departments then disregard the Act by stating their intent to rely on the established process for receipt and investigation of complaints (and potential enforcement), stating “[t]he interim final rules include an audit provision establishing that HHS’s existing enforcement procedures will apply with respect to ensuring that a plan or coverage is in compliance with the requirement of determining and applying a QPA consistent with these interim final rules.” The Departments then go on in the next sentence to state, “HHS intends to amend its enforcement regulations through future notice and comment rulemaking to reflect the amendments made to the PHS Act by the No Surprises Act.”

Given the enormity of the impact of the QPA on healthcare providers, this decision is insufficient in addressing the text of the Act, which requires a rulemaking to create

an audit process specific to the QPA and compliance by payers. While the Departments have stated intent to perform “future” rulemaking, the Act is clear and unambiguous that the rulemaking should have been completed two months ago, well ahead of the implementation of the No Surprises Act.

PHI asks that the Departments move forward with all possible speed in rulemaking to establish the specific process created by Congress to audit the payer’s compliance with the QPA calculation methodology.

Page 102, Part IV.

The Departments solicit comment on whether and to what extent additional guidance or changes to the existing regulations are needed to protect participants, beneficiaries, and enrollees from surprise medical bills, consistent with section 110 of the No Surprises Act.

The Departments state in Part One of the NSA IFRs that medical necessity denials will be considered as Adverse Benefit Determinations (“ABD”), which may be appealed through an insurer’s claims and appeals process rather than Notices of Denial of Payment, which can be contested through the IDR process. See section III.B.1.i., 86 Fed. Reg. 36878. Unfortunately, health insurers make it a practice to routinely and perfunctorily deny air ambulance claims for lack of medical necessity to avoid or delay paying claims.

Because of repeated, baseless claims denials for lack of medical necessity, PHI must devote additional staff time and effort to assist our patients in navigating the claims appeals processes created by insurers. Resolution of these appeals may take months, while patients worry about the financial responsibility they may face if their insurer denies coverage for emergency air ambulance services. The Departments’ proposed regulations to treat such denials as ABDs will subvert the intent of Congress to remove patients from disputes between air ambulance providers and insurance payers. This error must be corrected.

Page 198, Part VI.B.7.iv.

HHS seeks comment on the approach regarding SDR entity determinations being binding, including the feasibility of such approach, as well comment on alternative approaches. HHS also seeks comment on the subject of judicial review. PHS Act section 2799A-1(c)(5)(E) requires that determinations not be subject to judicial review, except in a case described in any paragraphs (1) through (4) of section 10(a) of title 9, United States Code. HHS seeks

comment on the feasibility or desirability of adopting a similar application for the patient-provider dispute resolution process, as well as comment on alternative approaches.

Section 105(b)(5)(E)(i)(II) of the No Surprises Act states that a determination of a certified IDR Entity . . . "shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a)(2) of Title 9, United States Code." Section 10(a)(2) of Title 9, United States Code, states that a District Court may vacate an arbitration award when the arbitrator refuses to hear evidence pertinent and material to the controversy. Nevertheless, the Departments have *deliberately excluded evidence* shown by the additional circumstances in section 105(b)(5)(C)(ii) of the No Surprises Act that is *pertinent and material* to air ambulance reimbursements from consideration by the IDR Entity. Thus, the Departments have done by rule -- i.e., exclude evidence -- what an IDR Entity would be prohibited from doing, at risk of having its award vacated. The presumption in the IDR IFR should be stricken to remove this unjustifiable result.

Page 218, Part VIII.B. (1.1).

The Departments and OPM seek comment on how private equity ownership structures may be affected by the Federal IDR process.

The Departments should not be swayed by media accounts of private equity ownership as detrimental to the provision of air ambulance services. Any inquiry into the commercial factors at work in providing such services should first reflect upon the fact that private capital is at risk to provide medical and transportation services to the public, and this investment must earn a profit or such resources must be invested elsewhere. If that occurs, the public sector would be expected to provide such services at great expense to the taxpayer. Second, such an inquiry should be broadened to consider whether health insurers are exploiting the public because of the tens of billions of dollars they earn in profits while denying claims for coverage of health insurance costs from the public.

Part Two of the No Surprises Act regulations is primarily focused on resolving payment disputes between insurers and health care providers. It is troubling to see the discussion of private equity's role in healthcare on pages 216-218 without a discussion and comparison of health insurers' role in healthcare, and the enormous profits they accumulate. As noted above, United Healthcare reported \$15.4 billion in the last twelve months alone. See <https://www.unitedhealthgroup.com/newsroom/2021/2021-10-14-third-quarter-results.html> (October 14, 2021) for United Healthcare's earnings notice.

When combined with the obvious favoritism to insurers in the IDR process and the QPA definition, the absence of an examination of insurer behavior and profits in the IDR IFR makes it hard not to find that the rulemaking process has been biased.⁵

Page 244, Part VIII.B. (1.5.1).

Accordingly, the Departments estimate that there will be approximately 17,000 claims that are submitted to the Federal IDR process each year. The Departments seek comment on this estimate.

With approximately 49,000 air ambulance transports of out-of-network commercially insured patients in a given year, it is reasonable to assume that approximately one third of those claims could end up in IDR because of insurers' efforts to deny payments. Thus, an estimate of 17,000 claims per year for all providers' services is optimistic. However, the number of cases may dwindle over time as providers and insurers experience IDR case resolutions, as was the case in New York, and adjust payments accordingly.

Page 245, Part VIII.B. (1.5.1).

The Departments estimate that 25 percent of disputes will be resolved in open negotiation before entering the Federal IDR process. The Departments request data or comments on this assumption.

Based on PHI Health's experience, and the fact that insurers will benefit by the outsized weight the QPA under the mechanical IDR process, it is our belief that health insurers will continue to deny claims and refuse to negotiate coverage of their subscribers for air ambulance services unless forced to pay a reasonable and sufficient reimbursement through the IDR process.

Page 247, Part VIII.B.(1.5.2.).

The Departments assume that 10 percent of out-of-network claims for air ambulance services will be submitted to the Federal IDR process, which would result in nearly 4,900 air transport payment determinations in the Federal IDR process each year. The Departments seek comment on this estimate.

⁵ See <https://www.americanactionforum.org/weekly-checkup/insurers-notch-a-win-in-the-ongoing-battle-over-surprise-medical-bills/> (October 8, 2021).

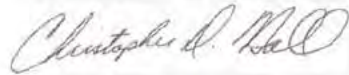
Based upon the Departments' exclusion of medical necessity determinations from the IDR process, the Departments have reduced the number of air ambulance claims that will be submitted to the Federal IDR process. Should this error be fixed, it is reasonable to assume that a greater number of air ambulance claims will be submitted to IDR based upon air ambulance companies' experience with insurers unjustly denying payments for claims by their subscribers.

Conclusion

In conclusion, the Departments' narrow definition of the QPA in IFR Part One combined with the exclusion of additional information in a mechanical IDR process favoring insurers will likely threaten the viability of air ambulance providers unless it is revised, and a fair IDR process that diminishes reliance on the QPA and takes additional circumstances into account can be established.

PHI Health urges the Departments to reconsider and correct these troubling and erroneous provisions in the IFR, so that emergency air ambulance services are supported in their efforts to sustain access to emergency healthcare in underserved and rural populations throughout the United States.

Sincerely,



Christopher Hall

Program Director, Government Affairs & Industry Relations



December 6, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-8016
Submitted via <https://www.regulations.gov>

Re: Requirements Related to Surprise Billing; Part II; CMS-9908-IFC; RIN 0938-AU62

Dear Administrator Brooks-LaSure:

The Society of Nuclear Medicine and Molecular Imaging (SNMMI) appreciates the opportunity to comment on the Requirements Related to Surprise Billing; Part II interim final rules with comment period (“IFCs Part II”) implementing provisions of the No Surprises Act (“Act”) issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor, and the U.S. Department of the Treasury (collectively, the “Departments”).¹ SNMMI’s more than 15,000 members set the standard for molecular imaging and nuclear medicine practice by creating guidelines, sharing information through journals and meetings, and leading advocacy on key issues that affect molecular imaging and therapy, research, and practice.

SNMMI strongly supports the goals of the No Surprises Act, including protecting patients from surprise medical bills, improving the availability of affordable, high-quality, in-network care, and developing a fair and impartial process for resolving provider-insurer payment disputes.

Consistent with accomplishing these goals, we recommend that the Departments provide certain important clarifications and/or modifications to the interim final rules (IFCs), as appropriate, for the following issues:

- 1) The Departments should issue subregulatory guidance clarifying the scope of items and services deemed to be furnished “with respect to a visit,” particularly as these rules apply to out-of-network ancillary services that are ordered during a visit but furnished after an applicable in-network facility visit. Specifically, the Departments should clarify that ancillary services merely ordered or referred during an in-network “visit” but not furnished

¹ 86 Fed. Reg. 55,980 (Oct. 7, 2021).

until a separately scheduled period of care occurring at a later point in time are not within the scope of the original “visit.”

- 2) The Departments should establish rules to enhance the transparency and oversight around an insurer’s calculation of the “qualifying payment amount” (QPA) to ensure that it appropriately reflects the in-network market rate for the same or similar item or service.
- 3) The Departments should amend the rules regarding the independent dispute resolution (“IDR”) process to appropriately reflect Congress’s intent that IDR entities consider all relevant considerations equally when selecting between the two parties’ offers, rather than presuming that the QPA reflects the appropriate out-of-network rate.

Our detailed recommendations follow below.

I. Clarifications are Needed Regarding the Scope of a Visit with Respect to Ancillary Services

To understand and implement the No Surprises Act and the Departments’ IFCs, patients, providers, and insurers need additional guidance clarifying the scope of a “visit” in the case of ancillary services furnished pursuant to an order or referral received by a patient during a visit to an in-network facility. Under the Act and the IFCs, items and services can result in “surprise bills” when they are “furnished to [an insured patient] . . . by a nonparticipating provider . . . **with respect to a visit** at a participating health care facility” (unless the provider has satisfied notice and consent criteria).² As it relates to ancillary services ordered or referred during care provided at an in-network facility, the “**with respect to a visit**” language is vague and requires additional clarification to specify clearly when subsequently furnished items and services are no longer “with respect to” a prior visit.

In particular, SNMMI’s members provide patients with diagnostic imaging services, referred to in the Act the implementing IFCs as a type of “ancillary service,” pursuant to a practitioner order or referral. As a general matter, imaging services include both a technical component (e.g., performing the imaging scan including the instrumentation, technical personnel, facility and radiopharmaceuticals) and a professional component (e.g., planning and interpreting the imaging scan). Typically, a patient will receive an order for nuclear or molecular imaging services, which their practitioner believes will enable him or her to diagnose or inform treatment of the patient’s disease. The patient may, for example, receive this order during an appointment with that practitioner. In some cases, the patient may be able to receive the technical component of imaging services on the same date as the “visit” as a part of the original appointment. In other words, after the practitioner orders an imaging examination, the patient may be able to receive the ordered scan at the same facility of their appointment, perhaps by walking down the hall of the facility to the site where imaging services are performed.³ However, in many cases, the patient may not receive any component of the imaging services during their original appointment, or even at the same

² 45 C.F.R § 149.120(b) (emphasis added); see also 42 U.S.C. § 300gg-132(a).

³ Usually, the professional component of the service, wherein a practitioner interprets the imaging scan, would then occur at a later point in time. As discussed below, SNMMI presumes the relevant facility for the purposes of assessing whether the professional component of imaging services triggers a surprise bill is the facility in which the imaging scan/technical component was performed. SNMMI also seeks clarification in this regard.

facility. In these cases, the patient may be required to reach out to the imaging provider and schedule a separate appointment for the ordered services. Then the patient would travel to the location of the imaging services provider for the ordered examination.⁴ In the latter scenario, the imaging services could be performed days or weeks after the initial “visit” in which those services were ordered. While SNMMI believes the first example describes ancillary services that are provided “with respect to” the patient’s original “visit,” the IFCs do not clearly describe how to consider ancillary services that are ordered during an original “visit” but are furnished during a separately-scheduled period of care occurring at a later point in time.

After a careful review of the Act, the IFCs, the Departments’ preamble discussions, and the animating purposes behind surprise billing protections, SNMMI believes subsequently furnished items and services, such as imaging services ordered during an in-network visit, are not “furnished . . . with respect to” the initial visit when they are performed during a separately scheduled period of care occurring at a later point in time. SNMMI urges the departments promptly to issue subregulatory guidance to clarify this important issue: ancillary services merely ordered or referred during an in-network “visit” but eventually furnished during a separately scheduled appointment at a later point in time are not within the scope of the original “visit” and therefore cannot trigger a related “surprise bill” under the No Surprises IFCs.

Although clarity is needed, SNMMI believes the Act and IFCs support this understanding that a “visit” does not extend to care provided at a later point in time, for example, after the patient has left the in-network facility. In particular, both the Act and the IFCs provide that:

Visit, *with respect to items and services furnished to an individual at a health care facility*, includes, in addition to items and services furnished by a provider at the facility, equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, *regardless of whether the provider furnishing such items or services is at the facility*.⁵

This definition indicates that a “visit” includes the items and services furnished while the patient is physically located “at” the in-network facility. Even though the provider does not need to be “at” the in-network facility, the visit definition requires that the patient must be. Therefore, items or services separately furnished to a patient after the patient has left the facility do not fall within the statutory limitations defining the scope of a “visit.”⁶

⁴ By contrast to the former example, this scenario involves a patient who is furnished the technical and professional component of an imaging service at a later point in time following the appointment in which the service was ordered and at a different facility. SNMMI also seeks clarification regarding the scope of a “visit” when a patient receives the imaging services at a later point in time following the appointment in which the service was ordered at the same location of the original visit.

⁵ 45 C.F.R. § 149.30 (emphasis added).

⁶ In addition to the scenarios discussed above, a patient’s care might also involve imaging services that were ordered by a practitioner but are unaffiliated with any given appointment or scheduled “visit” at a facility in which care was provided to a patient. For instance, a practitioner might order imaging services after reviewing certain other diagnostic test results without otherwise treating the patient in person at a facility. SNMMI assumes that such imaging services would not trigger a surprise bill as it relates to the facility of the ordering practitioner because they will not have been performed “with respect to” any patient “visit.” SNMMI also seeks clarification in this regard.

The IFCs Part I preamble provides examples highlighting the temporal element of this statutory limitation. In particular, these examples emphasize that items and services must be furnished during the “visit” to be considered a surprise bill.

- **Example 1:** “[I]f a *sample is collected during an individual’s hospital visit* and sent to an off-site laboratory, the laboratory services would be considered to be part of the individual’s visit to a participating health care facility, if laboratory services are covered by the plan or coverage.”⁷
- **Example 2:** “[I]f an individual *receives a consultation with a specialist via telemedicine during a visit to a participating hospital*, those telemedicine services would be considered part of the individual’s visit to a participating health care facility.”⁸

These examples underline that items and services are only “considered to be part of the patient’s visit to an in-network facility” when those items or services are furnished during the period of care that occurs at the in-network facility.

To delineate the items and services considered to be furnished “during” a patient’s in-network visit, the Departments should rely on the same distinction they highlighted in the context of good-faith estimates. There, the Departments designate the items and services to be included in a good-faith estimate based on those items or services “reasonably expected to be provided” at the facility in connection with a patient’s scheduled appointment for a “period of care.”⁹ Specifically, the IFCs Part II provide that a “period of care” means:

“[T]he day or multiple days during which the good faith estimate for a scheduled or requested item or service (or set of scheduled or requested items or services) are furnished or are anticipated to be furnished, regardless of whether the convening provider, convening facility, co-providers, or co-facilities are furnishing such items or services, including the period of time during which any facility equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services that would not be scheduled separately by the individual, are furnished.”¹⁰

In other words, a period of care includes all of the items and services that a patient receives at a facility when they schedule an appointment for care with a provider. According to the IFCs Part II, a period of care can include related imaging services (even if furnished by a provider other than the primary provider with whom the patient schedules the appointment), but only those ***“that would not be scheduled separately by the individual.”***¹¹ In short, a period of care is distinguished

⁷ 86 Fed. Reg. at 36,883 (emphasis added).

⁸ 86 Fed. Reg. at 36,883 (emphasis added).

⁹ 45 C.F.R. § 149.610(a)(2)(vi), (c)(1)(iii).

¹⁰ 45 C.F.R. § 149.610(a)(2)(x).

¹¹ See 45 C.F.R. § 149.610(a)(2)(x).

based on the items and services that are part of the patient's scheduled appointment. Items and services that require a distinct appointment are not within the same "episode of care."¹²

The Departments should adopt this same framework to define clearly the scope of a "visit." Namely, in alignment with the "period of care" definition, the items and services that are part of a visit should include only the items or services provided to the patient during the period of time at which the patient is at the facility (i.e., on that date or, if the patient is continuously at the facility, until the patient leaves the facility), either as a result of a scheduled appointment or an emergency stay. If items or services are provided during a separately-scheduled appointment (e.g., occurring at a later period in time), that separate scheduling triggers a separate "visit." In that case, the location of the separate visit where the patient receives care is assessed to determine whether items or services provided during that visit result in a surprise bill, and the network status of the facility of the prior visit is no longer relevant. This clarification creates a clear standard to identify the scope of a "visit" that aligns with both the language of the Act and IFCs defining the term, as well as the information that patients will receive as a part of a good-faith estimate.

This clarification also would be consistent with the animating purposes behind the Act, which according to both the Departments and lawmakers is to protect patients from unexpected medical bills.¹³ Patients might reasonably expect all items and services that they receive during a single "visit" at a facility to be in-network with their insurance if that facility also is in-network. However, it may not be reasonable for that patient to assume that all services ordered as a result of that original visit also are in network, particularly where the patient must make a separate appointment at a later point in time, at a separate facility and with a separate provider. In that scenario, the patient would have an appropriate opportunity to determine the network status of the ancillary services provider or select another provider based on their insurance network. Without clear parameters defining the scope of a visit, surprise billing protections could become detached from the Act's initial purpose and extend without limitation to situations not intended by Congress.

Therefore, for the above reasons, SNMMI urges the Departments to issue subregulatory guidance clarifying that ancillary services merely ordered or referred during an in-network "visit" but eventually furnished during a separately-scheduled appointment (i.e., period of care) at a later point in time are not within the scope of the original "visit" and therefore cannot trigger a related "surprise bill" under the No Surprises IFCs.

In addition to this key clarification, SNMMI also urges the Departments to issue subregulatory guidance addressing the following two points:

- First, as discussed above, imaging services typically include both a technical component (e.g., performing the imaging scan) and a professional component (e.g., interpreting the

¹² See 45 C.F.R. § 149.610(c)(1)(vi) (referring to separately-scheduled items or services as occurring prior to or following a particular "period of care"); see also 86 Fed. Reg. at 56,019. Infeed, for items and services that require separate scheduling by the patient, the IFCs Part II instruct providers to list the items or services separately on the good faith estimate and clearly disclaim that expected charge information is not required to be included in the good faith estimate "as that information will be provided in separate good faith estimates upon scheduling or upon request of such items or services." 45 C.F.R. § 149.610(c)(1)(vi).

¹³ See, e.g., 86 Fed. Reg. at 36,919; Letter from Congressmen Thomas R. Suozzi, Brad R. Wenstrup, Raul Ruiz, & Larry Bucshon, to Xavier Becerra, Secretary of HHS, Martin Walsh, Secretary of the Dep't of Labor, & Janet Yellen (Nov. 5, 2021), https://wenstrup.house.gov/uploadedfiles/2021.11.05_no_surprises_act_letter.pdf

imaging scan). Where the technical component of imaging services (i.e., performing the imaging scan) is performed during a separately scheduled appointment, and thus involves a distinct “visit” from the period of care during which the imaging service was ordered, SNMMI presumes that the relevant facility for the purposes of assessing whether the professional component of imaging services triggers a surprise bill is the facility in which the imaging scan/technical component was performed. In this case, SNMMI understands that the professional component of the imaging services would be furnished “with respect to” the patient’s visit at the facility in which the scan was physically performed on the patient (regardless of whether the professional reading the scan is “at” the facility). In other words, the network status of the facility where the test was ordered is not relevant in establishing whether a surprise bill occurred.

- Second, also referenced above, SNMMI envisions a scenario in which a patient receives imaging services ordered by a practitioner that are unaffiliated with any given appointment in which care was provided to a patient. For instance, a practitioner might order imaging services after reviewing certain other diagnostic test results without otherwise treating the patient in person. SNMMI assumes that such imaging services would not trigger a surprise bill as it relates to the facility of the ordering practitioner because they will not have been performed “with respect to” any patient “visit.”

II. The No Surprises Act Regime and the Adequacy of Provider Payments More Generally Require Enhanced Transparency and Oversight of QPA Calculations

The QPA under the Act is intended to reflect the “median of the contracted rates recognized [by insurance] for the same or similar item or service.”¹⁴ Confidence in the No Surprises Act requires the QPA correctly and justifiably reflect the amount insurers reimburse for the same or similar contracted item or service. The QPA has significant implications under the Act and the IFCs because, in the case of a surprise bill, it directly impacts a patient’s cost-sharing amount, out-of-network payment determinations during the IDR process, and equally important, is very likely to affect payment rates more generally.¹⁵ Recognizing its importance, the Departments described their view that “the statute sets out detailed rules for calculating the QPA, suggesting that an accurate and clear calculation of the QPA is integral” to the No Surprises Act framework.¹⁶ For these reasons, the IFCs require insurers to account for provider type, procedure complexity, and patient acuity, and billing code modifiers when calculating the QPA to help ensure that the QPA accurately reflects the in-network payment rate for the actual item or service provided.¹⁷ The Departments again highlighted the importance of an accurate QPA in the IFCs Part II preamble, indicating their belief that the calculated metric will represent a “reasonable” out-of-network rate

¹⁴ See 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I).

¹⁵ Exemplifying that reliance on the QPA as a benchmark influences provider reimbursement downward *see e.g.*, Cal. Med. Ass’n, *Surprise Billing Survey Results* 4 (rev. Nov. 1, 2019), <https://www.cmadoes.org/Portals/CMA/files/public/CMA%20Suprise%20Billing%20Survey%20Results%202019.pdf>; *see also* Ambar La Forgia et al., *Association of Surprise-Billing Legislation with Prices Paid to In- Network and Out-of-Network Anesthesiologists in California, Florida, and New York: An Economic Analysis*, 181 JAMA Internal Med. 1324, 1328 tbl.2 (2021).

¹⁶ 86 Fed. Reg. at 55,996 (emphasis added).

¹⁷ 86 Fed. Reg. at 55,997

under most circumstances.¹⁸ The importance of the QPA cannot be understated; and likewise, its correct calculation is essential to a fair and efficient No Surprises regime that is rooted in precision and accountability.

Considering the importance of the QPA, SNMMI encourages the Departments to take all necessary steps to ensure that the QPA is calculated accurately. Despite the Department's acknowledgement that a correctly calculated QPA is fundamental to the IDR process, the assumption that the QPA will be correct without transparency and further oversight into the calculation methods is worrisome.

The QPA is arguably the most integral piece of the No Surprises Act, and its influence over IDR entities' determination of the appropriate out-of-network payment amounts incentivizes insurers to calculate the QPA as low as possible. Not only would this undermine the No Surprises regime, it could have a ripple effect through the healthcare marketplace. Specifically, if insurers are able to advance QPAs that are lower than actual market rates, they may be disincentivized from entering into network contracts, resulting in reduced patient access to in-network providers and greater exposure to out-of-network cost-sharing rates in circumstances where the No Surprises regime does not apply.

At the same time, as currently drafted, the IFCs do not permit either providers or IDR entities to obtain sufficient information to evaluate the accuracy of the calculation or provide sufficient mechanisms to challenge or report miscalculations. Therefore, it is critical the Departments establish safeguards to promote greater oversight and increased transparency around the QPA calculation. SNMMI urges the Departments to issue sub-regulatory guidance and/or modify its existing policies to incorporate the following safeguards:

- Certified IDR entities should be required to determine whether the QPA was calculated appropriately. As currently codified in the IFCs, "[t]he certified IDR entity must select the offer closest to the qualifying payment amount unless the certified IDR entity determines that *credible information* submitted by either party under paragraph (c)(4)(i) clearly demonstrates that the qualifying payment amount is materially different from the appropriate out-of-network rate."¹⁹ The Departments make clear, however, that a certified IDR entity does not have a role in verifying that the insurer has properly calculated the QPA in the first instance.²⁰ The Departments only *encourage* the certified IDR entity to submit a complaint against the insurer or notify the appropriate state or federal authority of their suspicion that "the QPA has not been calculated in accordance with the [regulatory] requirements."²¹ Because a correctly calculated QPA is so vitally important to the IDR process, SNMMI implores the Departments to require the certified IDR entity to confirm the accuracy of the QPA calculation as part of the IDR process when this issue is raised by the provider. This additional safeguard will not only support appropriate calculations of the QPA, consistent with regulatory requirements, but will help inform IDR entities' examination of whether "credible information [. . .]clearly demonstrates that the QPA is

¹⁸ 6 Fed. Reg. at 55,996 ("Generally, the QPA should reflect standard market rates arrived at through typical contract negotiations and should therefore be a reasonable out-of-network rate under most circumstances.")

¹⁹ 45 CFR 149.510(c)(4)(ii)(A) (emphasis added).

²⁰ 86 Fed. Reg. at 55,996.

²¹ 86 Fed. Reg. at 55,996 n.31.

materially different from the appropriate out-of-network rate.”²² Moreover, without additional information about how an insurer calculated the QPA, it is unclear how any provider could appropriately challenge or IDR entity determine whether the QPA does not accurately reflect the value of the item or service provided.²³

- The Departments should require plans to disclose enough information about the QPA calculation to facilitate validation by the provider or IDR entity that the calculation conforms with the requirements of the IFCs. SNMMI commends the Department’s goal of “transparency regarding how the QPA was determined.”²⁴ However, the requirements outlined by the IFCs Part I only require limited information sharing including the calculated QPA, certification statements indicating it was calculated in compliance with the law, and other limited information upon the provider’s request. SNMMI urges the Departments to require insurers to provide affirmative information regarding the service code-modifier combination used to calculate the QPA, the number of contracted rates relied upon by the insurer, the geographic region used to calculate the QPA, as well as the additional information described in 45 C.F.R. § 149.140(d), regardless of whether it is requested by the provider. These crucial disclosure requirements will allow providers the necessary insight to determine whether the QPA was calculated in an allowable manner and challenge an inappropriately low QPA.
- HHS should enhance its complaint process, including requiring IDR entities to report insurers who miscalculate QPAs. Because of the QPA’s importance and the general effect it can have on the healthcare system outside of the No Surprises regime, it is crucial that regulators have the ability to promptly address insurers who incorrectly calculate QPAs. SNMMI encourages the Departments to create a more specific and streamlined complaint process. Currently, the complaint process outlined in 45 C.F.R. § 149.150 applies generally to complaints against insurers who “may be failing to meet the requirements” of the regulations. Moreover, it does not clearly indicate it should (or must) be used against insurers who are inappropriately calculating the QPA. It merely indicates the Departments “may . . . [r]efer the complainant to another appropriate Federal or State resolution process [or] [r]efer the plan or issuer for an investigation for enforcement.”²⁵

SNMMI hopes the Departments will provide a more responsive and decisive complaint process to ensure repeat offenders and egregious errors do not influence the healthcare market. For example,

²² 45 C.F.R. § 149.510(c)(4)(ii)(A).

²³ For example, the regulatory text codifies an example of this standard describing a provider who appropriately submits credible information “relating to the acuity of the patient that received the service, and the complexity of furnishing the service to the patient, by providing details of the service at issue and the training required to furnish the complex service.” In this example, according to the Departments, the provider’s submitted evidence “does not clearly demonstrate that the qualifying payment amount fails to encompass the acuity and complexity of the service,” and therefore, the certified IDR entity must select the offer closest to the QPA. Without information regarding how the insurer calculated the QPA, e.g., how it accounted for acuity and complexity in the first instance, it is unclear how any provider would have sufficient information to demonstrate that a QPA calculation failed to appropriately take those factors into account.

²⁴ 86 Fed. Reg. at 36,898.

²⁵ See 45 C.F.R. § 149.150(b)(3).

the Departments could develop a federally operated, particularized complaint process for inappropriate QPA calculations.²⁶

Lastly, IDR entities should be required to use the complaint submission process outlined in 45 C.F.R. § 149.150 and as modified above, not just encouraged to do so, when IDR entities conclude the QPA has been incorrectly calculated.

III. The Departments should Direct IDR Entities to Consider All Relevant Statutory Factors When Determining the Out-of-Network Rate

The Act plainly requires that IDR entities consider a number of relevant factors when determining the out-of-network rate. To ensure compliance with these statutory requirements, SNMMI urges the Departments to amend its regulations that give outsized consideration to the QPA by requiring IDR entities to “presume that the QPA is an appropriate payment amount.”²⁷ This presumption is in direct opposition to the plain language of the Act and Congress’s intent in crafting the statutory language as it did, and as a result, we believe the Departments have exceeded their authority by establishing a presumption in favor of a single factor.

The Act stipulates that a certified IDR entity “shall” consider “the qualifying payment amount . . . and . . . information on any circumstance described in clause (ii) [the “additional considerations” factors], such as information requested [by the certified IDR entity], and any information [submitted by either party].”²⁸ There is no indication that one factor should, or must, be weighed more heavily than any other, including singular prioritization of the QPA alone.²⁹ Likewise, is the Act does not include any indication that non-QPA factors may only be considered to the extent they “clearly demonstrate” that the QPA is “materially different” from the applicable reimbursement amount. Moreover, the IDR entities’ considerations under the Act are self-executing -- the statute does not imbue the Departments with the authority to dictate how certified IDR entities should reach payment determinations, nor does the statutory language require clarification. This is in contrast to other aspects of the surprise billing regime, such as the methodology for calculating the QPA, in which the Act specifically requires the Departments to issue regulations implementing the Act.³⁰ Thus, in our view, the Departments’ approach is both counter to the clear statutory language and outside the Departments’ authority.

Our view is reinforced by an examination of the legislative history of the Act. The Departments’ approach reverts to a methodology explicitly rejected by Congress. Specifically, Congress considered and did not adopt a version of the Act which would have established the QPA as the

²⁶ HHS has established primary enforcement of other provisions of the No Surprises Act. See 86 Fed. Reg. at 51,744 (“HHS is of the view that states would not look to enforce these PHS Act provisions because . . . states would not have access to the submissions to assess compliance. . . . HHS therefore proposes to have direct enforcement authority for these issuer requirements in all states, unless the state notifies HHS of its intent to enforce.”) The QPA is parallel to insurer reporting requirements as “states” (or stakeholders) would not have access to insurer submissions to monitor compliance.

²⁷ 86 Fed. Reg. 55995

²⁸ 42 U.S.C. § 300gg-111(a)(3)(H).

²⁹ See § 300gg-111 (c)5(C)(i)(I): “Considerations in determination [. . .] the qualifying payment amounts [. . .] Additional circumstances [. . .] The level of training, experience, and quality and outcomes measurements. . .”

³⁰ See, e.g., 42 U.S.C. § 300gg-111(a)(2)(B)(i), (3)(E)(i)(I).

de facto out-of-network amount. The final language represents a carefully crafted compromise among legislators in which the QPA is considered along with other pertinent, enumerated factors, without any single factor outweighing any other.

As a policy matter, overreliance on the QPA creates additional incentive for payers to exert inappropriate, downward pressure on the QPA, which is particularly problematic given the lack of transparency and oversight regarding this calculation, as discussed above. We are concerned that the current regulatory scheme leaves open the opportunity for gaming within the No Surprises regime and outsized contract negotiating power for insurers. Thus, not only is the presumption that the QPA is the appropriate out-of-network rate contrary to the intent of the IDR process as a neutral dispute resolution mechanism, it also may result in fewer in-network providers and reduced patient access to in-network care. For these reasons, SNMMI appeals to the Departments to follow the statutory model for dispute resolution outlined by Congress and amend its regulations to better reflect the plain language of the Act and Congress' intent.

* * *

SNMMI thanks the Departments for their consideration of these comments and the opportunity to engage with the Departments on these important issues. Wherever possible and appropriate, we encourage the Departments to issue subregulatory guidance as soon as possible to enable our members and other providers and insurers to develop the processes required to operate in compliance with this new regulatory regime. We would be pleased to discuss our recommendations with you at your convenience. In this regard, please contact Julia Bellinger, Director of Health Policy at jbelling@snmmi.org or (703) 326-1182.

Sincerely,

A handwritten signature in dark ink, appearing to read "Richard Wahl". The signature is fluid and cursive, with the first name "Richard" and last name "Wahl" clearly distinguishable.

Richard Wahl, MD
President, SNMMI