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December 6, 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: AMA Comments on 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 our physician and medical student members, the American Medical Association (AMA) appreciates the opportunity to offer comments on the Interim Final Rule (IFR): Requirements Related to Surprise Billing; Part II," 86 Fed. Reg. 55,980 (Oct. 7, 2021).

The AMA continues to support the broad goal of the NSA—to protect patients from the financial burdens of surprise medical bills. However, we have significant concerns with several provisions of the IFR that could jeopardize patient access to care (including rural and underserved communities) by putting unnecessary strain and burden on physician practices, undercutting efforts by physicians to negotiate fair contracts with insurance companies, and reducing the breadth of provider networks across the country.

Above all, we are very disappointed that the Departments have chosen to capitalize on a targeted policy response to surprise medical billing and use it as an opportunity to myopically address health care costs by artificially deflating payment rates for physicians who are providing the direct medical care to patients. By taking the balanced Independent Dispute Resolution (IDR) process specified in the statute and stripping it down to a process where the outcome is nearly always predetermined and prejudicial to physicians and other providers, the Departments have disregarded the result of years of Congressional negotiations and placed yet another thumb on the scale in favor of health insurers in already highly concentrated health insurance markets.

Unfortunately, the Departments have allowed insurer-driven media about a handful of bad provider actors to drive massive policy changes that undercut the ability of all physician practices—large and small, urban and rural—to negotiate fair contracts with insurers. The policies in this rule do not correct an imbalance in the system, they exploit it. Under this IFR, the immensely dominant insurance companies in already concentrated markets will gain more market power and physician practices will be forced to make

difficult choices in response—consolidate, join health care systems, sell to insurance companies, turn to private equity, or close their doors. The result is not increased value for patient premiums but decreased patient choice and access. **We strongly urge the Departments to issue a final rule prior to the January 1, 2022 implementation date that allows for a truly independent and balanced IDR process as intended by Congress and specified in the statute.**

AMA comments on specific provisions in the IFR

Initial payment

The IFR states that 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. **We urge the Departments to require that this is also the health plan's offer to the IDR entity, should the resolution process proceed to that point.** Additionally, we suggest that at the point the initial payment is provided, the plan offer a determination to the provider as to whether the federal dispute resolution process would apply to the claim. While this determination would not necessarily be binding, it would offer a level of certainty throughout the process if the dispute resolution process is pursued. Otherwise, the timing of the next determination in the process, done by the IDR entity, comes after a significant portion of the process (the open negotiations) has already taken place.

Open negotiations

In terms of the open negotiation period, we appreciate the clarification that the statutory 30-day open negotiations period will be measured in business days, as this will provide an appropriate time for the parties to engage in payment negotiations.

Initiating the IDR process

As stated in the IFR, either party may initiate the IDR process in the four-business-day period after the end of open negotiations period and the initiating party is to submit a notice of IDR initiation to the other party and to the Departments through the IDR portal on the same day. We strongly believe, especially given the dominance of health insurers and the restrictions on the IDR entity's decision-making as discussed below, that it will nearly always be the provider initiating the IDR process, as opposed to the payer. As such, we are concerned that information required to be submitted in the notice of IDR initiation is not easily accessible for a provider.

For example, the qualifying payment amount (QPA) value, information related to the calculation of the QPA, and information related to the amount of cost-sharing allowed is best sought from the payer and not likely to be easily accessible by the provider. **The AMA urges the Departments to require that this information be submitted by the plan to ensure efficiency and accuracy in the process.**

The AMA also urges the Departments to require additional information to be submitted by the plans to the IDR entity upon receiving the notice, including the original claim and the QPA associated with the original claim if the original claim has been modified, downcoded, or otherwise changed.

We also urge the Departments to allow for potential delays to the initiation of the IDR process due to extenuating circumstances. The AMA suggests the Departments establish a maximum allowance of extra days (e.g., five business days) if parties mutually agree to the delay.

Selecting an IDR entity

The IFR requires that the IDR entity make a determination of the applicability of the NSA to the claims or claims being brought to IFR. From our perspective, this appears to be the first time a formal determination as to the applicability of the federal law is made. Unfortunately for physicians, this is extremely late in the process (it could be 60 or more days after the initial payment) to potentially find out that they are not pursuing the correct resolution process. As such, as requested earlier in these comments, **we urge the Departments to require that the health plan make their determination as to the applicability of the federal law at the time of the initial payment.** This would prevent the health plans from "challenging" the use of the federal law at the time of IDR initiation.

The AMA also seeks clarity as to whether and how the IDR entity will be equipped and qualified to make a determination as to applicability of the federal law and how a provider can dispute a determination regarding applicability of federal law if they disagree.

IDR entity fees

The IFR states that parties must pay an administrative fee due to the Departments when an IDR entity is selected as well as a fee to the IDR entity at the time the offers are submitted. The AMA appreciates that the IDR entity fees and administrative fees will be accessible through the IDR portal when engaging in the selection process.

The IDR entity will hold the funds in a trust or an escrow account until an offer is selected or when parties agree on an out-of-network rate prior to the IDR entity's decision. If the parties negotiate a payment prior to the IDR entity making a determination, the IDR entity must return half of each party's payment for the IDR entity fee. For batched claims, the IFR requires that the party with the fewest determinations in its favor is considered the non-prevailing party and responsible for the IDR entity fee. If each party prevails in an equal number of determinations, the fee is split evenly between the parties.

We believe that the fee structure established in the IFR puts greater emphasis on the need for a fair and balanced IDR process. To engage in the IDR process, parties will need to pay prior to the process, which is a much tougher ask for a small practice as opposed to a large insurance company. If the IDR process is set up to favor the plan as a prevailing party, the fee structure only serves to further disincentivize the physician participation.

Furthermore, in terms of the batched claims fee structure, the AMA requests that the Departments consider a structure based on each party's percentage of "wins" rather than having the party who "wins" less pay the entire fee. For example, if the IDR entity picks the physician's offer in 60 percent of the batched plans, the physician would be responsible for 40 percent of the IDR entity fee. Such a fee structure might be fairer and therefore incent batching, creating more efficiencies in the IDR process.

Batching claims

Generally, the AMA appreciates the Departments' allowance on the batching of claims, and we believe efficiencies in the IDR process will result. For example, we agree that it is most efficient to allow parties to batch qualified claims across the 90-day suspension period together. However, we ask the Departments to consider additional scenarios where claims may be batched together to increase efficiencies, including, for example, when an individual payer is using a common (arguably flawed) payment methodology across claims, but those claims do not meet the other batching requirements.

90-day suspension period

The AMA appreciates that the Departments created consistency throughout the NSA regulations by defining "such item or service" in the suspension period context as "same or similar item or service" as defined in the IFR Part I. Additionally, as stated above, the AMA was pleased to see that services provided during the 90-day suspension period are eligible for IDR and may be included in the same batch following the end of that period.

The AMA seeks clarity on whether an open negotiations period is available and/or required for claims for care provided during the 90-day suspension period.

IDR entity certification

The AMA appreciates the Departments' commitment to ensuring that the IDR entities have no conflicts of interests or evidenced biases, and we support the measures presented in the IFR to help achieve this. The AMA encourages the Departments to recognize the need for monitoring of individual IDR entities and biases that may be apparent through decisions over time.

IDR entity reporting

The IFR requires that within 30 business days of the close of each month, the IDR entity must report certain data to the Departments on the IDR process. The AMA is concerned that the reporting requirements are heavily centered on the QPA and deviations from the QPA rather than reporting data that are free from the biases associated with a QPA comparison.

The IFR also requires that provider practice size be reported to both help the Departments determine whether certain smaller providers are able to access the IDR process in the same way larger providers do, as well as the impact of the IDR process on horizontal and vertical integration of providers. The AMA appreciates efforts to look at the impact of the IDR process on the physician practices, especially independent practices. As the assessment process is developed, the AMA would be interested in understanding how the analyses will be completed and engaging with the Departments to provide additional data, information, and perspective.

The AMA seeks clarity on whether these data will be publicly available and, if so, how the Departments intend to protect the privacy of named physicians and other providers whose information is collected.

Payment determination in IDR process

Submitting offers to the IDR entity

The IFR states that information to be submitted to the IDR entity with each party's offer must include:

- The party's offer expressed as both a dollar amount and percentage of the QPA;
- Information requested by IDR entity;
- For providers, the size of their practices;
- For plans, information on the coverage areas, geographic regions, and other limited information for purposes of QPA calculation; and
- Any additional information (excluding prohibited information) to support an offer.

The AMA has concerns about the requirement that each party's offer be expressed as a percentage of the QPA. This requirement immediately establishes a bias toward the QPA as the reasonable amount for payment. Moreover, while payers have all the information needed to craft their offer around the QPA, physicians are going into the IDR process having very little information on how the QPA is calculated. This is even more pronounced when a plan has modified or downcoded the original claim and the two parties are potentially using different rates as their basis for comparison.

Additionally, physicians do not establish their fee schedules based on a plan's median contracted rate, but rather on their costs of providing care. Requiring providers to compare their offer to each plan's individual QPA for the service undercuts a drive toward consistency and predictability. For example, if a physician charges $100 for their service and one plan has a QPA of $90 for that service while another has a QPA of $60, the offer of $100 will appear very different as a percentage of the two QPAs and will potentially lead to different IDR decisions for the same offer for the same service. **Therefore, we urge the Department to reconsider the requirement that the parties' offers be submitted as a percentage of the QPA.**

The AMA also urges the Departments to require more information regarding the calculation of the QPA be presented to the IDR entity with the plan's offer. For example, it is relevant as to what types of providers are included in the QPA calculation, how many individual providers were represented by each contract included in the calculation, and the specific types of services that were a part of the calculation.

Written decision by the IDR

The IFR requires that the IDR entity provide a written decision to the Departments at the end of each IDR process. If the IDR entity does not choose the offer closest to the QPA, the report must include a detailed explanation of additional considerations relied upon, whether the information submitted by the parties was credible, and the basis upon which the IDR entity determined that the credible information demonstrated that the QPA is materially different from the appropriate out-of-network rate.

The AMA is concerned about the emphasis on the QPA in the written report and the requirement that the IDR entity justify in a detailed manner the reasons for deviation from the QPA in their decision making, if applicable. We also think this requirement provides an inappropriate incentive to IDR entities to pick the

party's offer that is closest to the QPA to avoid the administrative hassle of creating such a detailed report justifying a decision in favor of the other party.

Departments' standard for decision-making by the IDR entity

When deciding which offer to select, the Departments require that the IDR entity begin with the presumption that the QPA is the appropriate out-of-network rate and must select the offer closest to the QPA unless the credible information submitted by the parties clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate.

As specified in the NSA statute, a party may provide additional information to an IDR entity to support their offer. In particular, the statute delineates several factors that are relevant and "shall" be considered by the IDR entity when determining an out-of-network payment. Unfortunately, contrary to the statutory language, the Departments significantly limit in the IFR how these factors may be used by the IDR entity. By disregarding the process established by Congress to ensure fair payment, the Departments are in effect anchoring the IDR's decision to the QPA and predetermining the outcome of the IDR process.

The AMA believes that the Departments have exceeded the statutory authority by establishing such weighting of the QPA in the IDR's decision and promulgating a policy contrary to the intent of Congress that will have long-term negative consequences on patients, providers, and the health insurance market. As such, **we urge the Departments to issue a final rule that removes provisions in the IFR that create a rebuttable presumption that the QPA is the appropriate out-of-network rate.**

The Departments' statutory interpretation

The IFR states that the Departments believe the best interpretation of the statute is that the IDR entity must look first to the QPA as the presumptive out-of-network payment amount and then to other considerations when determining a fair payment amount. The Departments highlight a number of reasons why they believe this to be the case, including:

- The statute lists the QPA as the first factor that the IDR entity must consider in determining which offer to select;
- The statute provides relatively limited guidance on how to consider the additional circumstances, but sets out detailed rules for calculating the QPA;
- Plans must provide information on how the QPA is calculated to out-of-network providers, ensuring they are aware of how this amount is calculated;
- Plans are subject to audit requirements on calculating the QPA;
- Cost-sharing for patients is based on the recognized amount, which will generally be the QPA; and
- The Departments must report how payment determinations compare to the corresponding QPA.

It is clear to the AMA that this list highlights nothing more than the fact that the QPA concept was a novel creation under the NSA and therefore needed attention in terms of a clear definition, a methodology for calculation, and a process for ensuring that it is consistently calculated correctly (given the implications of miscalculations on patient cost-sharing). Conversely. the "additional circumstances"

identified in the statute to be considered by the IDR entity (e.g., the level of training of the provider and the teaching status and case mix of the facility) are largely self-explanatory concepts that do not need lengthy statutory definitions or additional clarity in regulations.

Moreover, Congress does not ask the Departments to weigh in on how the QPA and other factors should be used by the IDR entity in making a determination. The statute simply says that the IDR entity *shall* consider the QPA, information requested by the IDR entity, and other information relating to the offer including information related to the delineated circumstances. The question of whether any factor or circumstance should be weighted more than another is not even raised by the statute, and no discretion is provided to the Departments to create this rebuttable presumption.

Furthermore, the statute identifies factors that the IDR entity "shall not consider" when making their decisions, specifically usual and customary charges, the amount the provider would have billed for the item or service, and the amount a public payer (e.g., Medicaid, Medicare, Tricare) would have paid for the service. The fact that Congressional debate resulted in some factors being included in the text and others being excluded suggests that those included factors were not perfunctory or meant to be dismissed or narrowed by the Departments, but rather factors that Congress concluded were ultimately important to the IDR entity's decision-making process.

To make matters clearer, House Ways and Means Committee Chairman Neal and Ranking Member Brady, both involved in the original drafting of the law, explained in an October 4, 2021 letter to the Departments that "the law provides for an IDR process overseen by an independent and neutral arbiter who must consider a number of factors equally" when deciding which party's offer to select. The letter goes on to state that "Congress deliberately crafted the law to avoid any one factor tipping the scales during the IDR process" and that the IFR "strays from the No Surprises Act in favor of an approach that Congress did not enact in the final law." The letter points out that Congress considered and *rejected* proposals that would make the median in-network rate the default payment and that the law Congress enacted "reflects Congress's intent to design an IDR process that does not become a de facto benchmark."

Similarly, a November 5, 2021 letter signed by more than 150 Members of Congress states that the law "expressly directs the certified IDR entity to consider each of these listed factors…capturing the unique circumstance of each billing dispute without causing any single piece of information to be the default one considered." The bipartisan group of signatories asserts that the parameters of the IDR process in the IFR "do not reflect the way the law was written" and do not "reflect a policy that could have passed Congress." The letter urges the Departments to amend the IFR "to align with the law as written by specifying that the certified IDR entity should not default to the median in-network rate and should instead consider all of the factors outlined in the statute without disproportionately weighting one factor."

It is clear that the creation of this rebuttable presumption toward the QPA as the reasonable out-of-network rate conflicts directly with the statutory language and Congressional intent.

Negative policy implications

Anchoring the QPA to the IDR's decision on the out-of-network rate and creating a rebuttable presumption is not only contrary to the statutory language, it will also have negative policy implications that will ultimately harm patients. Members of Congress who wrote to the Departments last month

realized the implications of an imbalanced IDR process such as that laid out in the IFR, recognizing it "could incentivize insurance companies to set artificially low payment rates, which would narrow provider networks and jeopardize patient access to care…[i]t could also have a broad impact on reimbursement for in-network services, which could exacerbate existing health disparities and patient access issues in rural and urban underserved communities."

As the NSA is implemented, the demands of patients and employers for in-network care will be reduced, which in turn will reduce the incentive for health plans to engage in meaningful contract negotiations with physicians. While we strongly support removing patients from the middle, we also appreciate that Congress recognized an additional check on health plans was necessary to replace this market force—a meaningful and balanced IDR process to allow providers the opportunity to make their case for a fair out-of-network payment. While we do not anticipate frequent use of the IDR process, Congress understood that it could help influence a health plan 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 at or below the QPA, the IFR largely strips away that important check on negotiating incentives established by Congress.

We agree with the analysis that insurers will likely pay many contracted physicians much less in the coming years as they negotiate contracts (and renegotiate current contracts) under the QPA's ceiling**. We have already seen these scenarios playing out in states like North Carolina, where the largest commercial market insurer in the state—with a state-level market share of 55 percent and an average MSA-level market share of 61 percent—is requiring contract amendments that slash long-standing fee schedules directly as result of the IFR.** Whether such payment reductions will translate to reductions in health care premiums for patients is not known, but it is certain to put an additional, if not fatal, financial strain on many independent practices and rural providers already struggling to make ends meet in their small businesses. While financial strain often forces independent practices to close, others are faced with tough decisions whether to accept outside funding (e.g., private equity), join hospital systems, or consolidate with other provider groups. None of these options necessarily increase access to higher quality, lower-cost care for patients, but do serve to decrease patient access, choice, and convenience.

We also anticipate that the IFR in its current form will lead to a significant reduction in contracts being offered to many physicians. With 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, a long-term reduction in network breadth harms patients by reducing access to in-network primary care and specialty physicians, as well as to health care services that patients pay for through their premiums. Additionally, meaningful negotiations that lead to contracting create efficiencies in the health care system including, but not limited to, reduced administrative waste, value-based arrangements, and billing efficiencies.

The impact of all of these negative policy implications will only be exacerbated by the fact that the methodology for calculating the QPA will frequently lead to rates below a true median in-network rate. As discussed in our September 7 comment letter on the July 1, 2021 IFR: Requirements Related to

Surprise Billing; Part I, the AMA believes that the QPA is likely to be skewed low as a result of the way in which contracts are treated in the calculation, the ability of plans to exclude or include certain contracted rates in the QPA, and the disregard for bonuses and other alternate payment methods in the QPA determination, among other reasons. The now outsized role that the QPA will play in the IDR process means that flaws in the calculation methodology are even more problematic.

Changes needed if Departments maintain current process

Although the AMA strongly urges the Departments to remove the required weighting of the QPA in the IDR entity's decision-making process, should the weighting requirement remain, additional information and clarity is needed to make it possible for physicians to participate in IDR.

First and foremost, **additional information regarding the QPA calculation must be provided to physicians upfront.** The Departments are creating an IDR process that requires providers to dispute the appropriateness of the QPA as it applies to the claim(s), rather than make the case for their offer with supporting evidence. Providers will enter the process with minimal information about the QPA and how it is calculated, as the plan possesses all data on the calculation of the QPA. Providers must be able to access all relevant data on the QPA calculation prior to the deadlines for submitting their offer and supporting information. Such data must include information on the contracts used to calculate the QPA, the number of physicians represented by those contracts, information on types of providers and services included in QPA calculation, the use of modifiers and alternative payment arrangements in the calculation, etc.

Additionally, the IFR is very specific in terms of what it will permit the IDR entity to consider as it relates to the use of the statutory factor "patient acuity or complexity of furnishing the item or service." If a plan applies a QPA that uses a different service code or modifier than submitted by the provider, the IFR does permit the provider to submit credible information to the IDR entity showing that the QPA applied by the plan is based on a service code or modifier that did not encompass patient acuity or the complexity of furnishing the service. Unfortunately, without knowing what the QPA for the original claim was, it is impossible for a provider to submit credible information for claims that do not reflect correct service codes or modifiers. **The AMA urges the Departments to require that this information be sent to the provider from the plan immediately upon receiving notice of IDR initiation, and prior to the deadline to submit offers to the IDR entity.**

In addition, the statute requires that the IDR entity consider demonstrations of good faith efforts (or lack thereof) to enter into network agreements and the contracted rates between the provider and the plan during the previous four plan years. **The AMA asks the Departments to clarify that a plan offering a physician a contact at or below QPA rates does not, alone, meet the standard for good faith effort to enter into contract negotiations.**

Finally, the AMA seeks clarity from the Departments that other factors that may support a party's offer can be submitted (per the statute), including ensuring that providers can confidentially submit contracted rates with other plans to support their offer.

External review

The IFR broadens the scope of external review requirements to explicitly state that any adverse benefit determination that involves consideration of whether a plan is complying with the NSA is eligible for external review. Additionally, as the NSA applies to grandfathered health plans, the scope of external review for NSA claims is expanded to grandfathered plans. Patients in such plans can access external review after exhausting all internal and state appeal processes, or if none exists, immediately following the denial.

While we appreciate the list of examples provided by the Departments as to when the external review process is available, in our discussions with physicians and other physician organizations, we find there is a still some confusion and uncertainty about when the external review process is available in the NSA context and how it interacts with NSA dispute resolution processes. We ask that the Departments provide additional resources and educational materials to patients and providers to ensure greater clarity and that the appropriate processes are used.

Good faith estimate

The AMA appreciates the Departments' earlier delay in implementation of the good faith estimate (GFE) requirements as they relate to the Advanced Explanation of Benefits (AEOB) for insured patients. We plan to use this delay to work with stakeholders and the Departments on implementation solutions that ensure meaningful price information is provided to patients prior to care without creating additional costs and waste in the health care system.

The AMA also appreciates the Departments' enforcement discretion under this IFR in the first year of certain provisions of the GFE requirements as they relate to uninsured and self-pay patients, including the gathering of cost estimates from "co-providers" by the "convening provider." However, we have serious concerns about the burden placed on providers, especially the convening provider, and the impact these burdens will have on physician practices as the Departments eventually move to enforce these requirements.

There is simply not an automated process to allow a provider to easily determine who the co-providers are when scheduling care and contact those co-providers to request a cost estimate. Without such an automated process, the disruption in the workflow and the staff time and resources that will be put into tracking down potential co-providers to make cost estimate requests will drain practices of time and money. For example, should this requirement stand as is, similar to prior authorization requirements, we anticipate practices having to hire staff to exclusively create GFEs for patients.

We believe these burdens are important to consider in the context of this IFR's provisions as they relate to self-pay and the uninsured, but also, and perhaps even more so, as it relates to the GFE needed to initiate an AEOB. As the Departments eventually move to implement provisions related to the AEOB, we urge you to deviate from the "convening provider" concept. It is unnecessary to put any single provider in charge of collecting cost estimates when the insurer has all the relevant information needed to generate the AEOB. Importantly, by requiring an unnecessary step (sending cost-estimates to the convening provider rather than information directly to the plan), such a design has the potential to significantly delay care.

Additionally, the AMA feels that the IFR makes this provision unnecessarily and ineffectively broad. For example, the provider must inform a patient when scheduling that they have the right to request a GFE; however, the rule also suggests that any conversation about costs is meant to trigger a GFE, potentially resulting in some patients receiving GFEs when they did not want them or prefer to use other price transparency tools offered by the provider. Additionally, the timeframes laid out in this section may have the impact of delaying care as providers could feel they need to push back scheduled care in order to meet these federal timelines on sending a GFE to a patient.

Similarly, while the AMA certainly supports patients receiving meaningful and actionable cost information prior to care, we urge the Departments to consider the impact of patients using the GFE to "shop" for care from multiple providers. Given the earlier-mentioned lack of automation available to make requests and communicate costs estimates between the convening provider and the co-providers, the impact of patients requesting several different GFEs from several different providers at a time, means that some providers are investing time and resources into developing GFEs for a patient that they may never see. Again, recognizing the value of cost information to patients, it is critical that we also recognize which processes will add costs and waste to the health care system and pursue alternatives.

Finally, the AMA seeks clarity on a number of provisions related to the GFE including:

- The scope of the GFE requirements, including to which types of services and items they apply (e.g., Office-based care? Primary care services? Emergency services?).
- What happens when a co-provider is delayed in providing cost information to the convening provider or when the convening provider is unable to determine within the deadlines who the co-providers will be?
- Do the Departments intend to allow existing state price transparency efforts to continue, or are these requirements meant to preempt related states laws?

We urge to the Departments to publish additional educational materials for physicians and other providers to ensure greater clarity on these requirements.

Patient-provider dispute resolution process

The IFR implements a patient-provider dispute resolution process that can be accessed when charges from an out-of-network provider provided to an uninsured or self-pay patient are substantially in excess of the GFE. The IFR generally defines "substantially in excess" as at least $400 more than the cost listed on GFE.

The AMA appreciates much of the process outlined in the IFR to establish this dispute resolution process including the patient protections (e.g., forbidding moving the patient's bill to collection while the dispute is pending) and the recognition that unforeseen medically necessary care may cause costs to exceed the original GFE. Generally, we seek clarity on some aspects of the process including:

- Is the cost considered substantially in excess of the GFE if cumulatively the cost of care is more than $400 over the GFE, but no single provider's cost exceeds that threshold? If so, how does the dispute process work?

- What are the minimum requirements for states to establish or maintain existing similar dispute resolution process for the uninsured or self-pay patients?

Additionally, the AMA asks that the Departments consider revising the definition of "substantially in excess" for these purposes to reflect a percentage of the cost of care presented in the GFE, rather than flat number. The AMA thinks such a system could be more meaningful and require less adjustments over time.

Finally, we ask that the Departments consider requiring that the disputed GFE must be the GFE provided once care is scheduled, and not one requested by patient prior to scheduling when, for example, shopping for care. This request stems from concerns that information on co-providers, patient's individual needs and requirements, and other details may not be available prior to scheduling care, and that the accuracy of the GFE will be greater after the patient and provider have scheduled the care.

Conclusion

Congress drafted the NSA in a purposeful way to meaningfully protect patients from surprise medical bills while ensuring important checks and balances on the provider-insurer contracting process. In the IFR, however, the Departments exceeded their statutory authority by directing IDR entities to consider the QPA a rebuttable presumptive reasonable payment for out-of-network physicians engaging in the IDR process. **The AMA urges the Departments to issue a final rule that retains the important patient protections included in the NSA and implementing regulations, removes the provisions that creates a rebuttable presumption that directs the IDR entity to consider the offer closest to the QPA as the appropriate payment amount, and conforms with the NSA's statutory language to allow IDR entities the discretion to consider all the relevant information submitted by the parties to determine a fair out-of-network payment to physicians and other providers.**

The AMA appreciates the opportunity to submit comments on the IFR and the opportunities that have been provided by the Departments thus far for engagement on implementation of the NSA. We hope to continue such engagement moving forward to ensure that the physician perspective is considered as the Departments make implementation decisions, as well as to offer any assistance and resources that may be useful to the Departments during this process.

If you have any questions or would like to discuss these comments further, please contact Margaret Garikes, Vice President, Federal Affairs at margaret.garikes@ama-assn.org.

Sincerely,

James L. Madara, MD