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The Honorable Bernie Sanders
Chairman
Committee on Health, Education, Labor and Pensions
U.S. Senate
Washington, DC 20510

The Honorable Bill Cassidy, MD
Ranking Member
Committee on Health, Education, Labor and Pensions
U.S. Senate
Washington, DC 20510

RE: AMA Recommendations to Resolve NSA-Related Problems

Dear Chairman Sanders and Ranking Member Cassidy:

On behalf of the physician and medical student members of the American Medical Association (AMA), thank you for the opportunity to provide input on the implementation of the No Surprises Act (NSA). The AMA supports the NSA's goal of protecting patients from surprise medical billing, but we remain very concerned that the implementation of the statute does not support physicians' ability to meaningfully engage in the dispute resolution process as Congress intended. Congress drafted the NSA in a purposeful way to protect patients from surprise medical bills while ensuring important checks and balances on the physician-insurer contracting process. The AMA believes that some of those checks and balances have been undercut in the implementation process.

To be clear, the AMA supports the concept of an Independent Dispute Resolution (IDR) process and believes this process has the potential to fairly resolve payment disputes between physicians and health plans. Our current concerns are not with the process as outlined in the statute, but with its implementation. We believe the Administration has made several *correctable* missteps in the implementation process and urge Congress to support quick action by the Administration to address these issues and ensure that the NSA functions as intended.

I. Problematic reliance on the QPA in the IDR process

The statute was *not* drafted in a way that suggests the median contracted rate paid to other physicians should systematically be valued over other factors by IDR entities (IDREs) when determining the appropriate out-of-network rates, but rather in a way that recognizes there are many relevant factors that the IDREs should consider when determining a fair payment amount.

Unfortunately, the Administration has twice directed IDREs to consider the qualifying payment amount (QPA) the dominant factor in determining an out-of-network rate. As such, the AMA was pleased to finally see guidance in March 2023 that better reflected the statutory balance Congress sought. Subsequently, we were disheartened to learn that the Administration has appealed the Texas District Court ruling that ultimately led to the improved March guidance.

Market impact of overreliance on the QPA

Overreliance on the QPA during the payment resolution process will continue to have negative implications in the health insurance market. With implementation of the NSA, the demands of patients and employers for in-network care for certain services has been reduced, which in turn has reduced 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 reinforce 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. Congress understood that this process 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, when the IDR decision is essentially predetermined to be at or below the QPA, that important check on negotiating incentives established by Congress is significantly diminished.

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 sought contract amendments that slash long-standing fee schedules directly as result of the Interim Final Rule (IFR) that was released in 2021. We have seen similar efforts by health plans across the country.

Whether such payment reductions will translate to reductions in health care premiums for patients is not yet known, though past experience suggests it is not likely. But they are certain to put an additional, if not fatal, financial strain on many independent physician practices and rural providers already struggling to make ends meet in their small businesses and in many areas where patient access is already under serious strain. While financial strain often forces independent practices to close their doors, 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.

To address these issues, **the AMA recommends that the Administration codify the March 2023 guidance to IDREs in regulation and ensure that IDREs are not required to consider any allowable supporting information over another when making a payment determination**.

QPA calculation concerns

Problems associated with overweighting the QPA are compounded by a QPA calculation methodology that continues to permit plans to offer QPAs below the median in-network rates that the QPA is intended and required to represent. For example, the methodology laid out by the Administration in their July 2021 IFR, allows plans to include rates for services that may never be provided (e.g., ghost contract rates), fails to include bonuses and other risk-sharing adjustments that impact final rates, and allows payers the discretion to choose whether they want to use rates solely from their individual product for QPA determination or incorporate all of the health plan's products' rates in the area. These allowances permit plans and payers to manipulate the QPA in order to misrepresent the true median in-network rate to IDREs.

Moreover, there is little transparency required from plans to demonstrate or explain how the QPA is calculated. The QPA remains an important component of the dispute resolution process, but when only one party understands how it was derived and the data used to generate it, the integrity of the process is compromised. Without seeing the data that were used to calculate the QPA, a physician has little chance of effectively verifying it as the appropriate amount or offering additional information to dispute.

Therefore, **the AMA encourages Congress to urge the Administration to ensure that health plans are restricted in their ability to manipulate the QPA and are required to provide physicians and IDREs with the data and methodology used to calculate the QPA.**

II. Administrative fees as a barrier to IDR access

Recently, the three Departments that oversee the NSA implementation (the Departments of Health and Human Services, Labor, and Treasury) announced that the nonrefundable administrative fee, used to cover the Departments' costs associated with the IDR process, would increase **600 percent**, from $50 to $350, in 2023. Notably, this decision was released in updated guidance on December 23, 2022, one week prior to taking effect, and reversing guidance released just two months prior stating that administrative fees would remain the same. This gave physician practices no time to anticipate or financially plan for this fee increase. Furthermore, the same guidance also simultaneously increased the IDRE fees by up to 40 percent for individual claims and up to 82 percent for batched claims.

The AMA is very concerned that the increases ensure that the IDR process is inaccessible for many physician practices, including independent practices and those serving minoritized and marginalized communities. In the immediate term, the $350 administrative fee creates a threshold cost to participating in the IDR process, a policy which we note was considered but rejected by Congress during drafting of the NSA. Essentially, if a physician is paid at or below $350 for a claim, which is the case for many claims currently being advanced to IDR, the process becomes cost prohibitive for physicians. While this is a barrier for all physicians, it is particularly harmful for smaller, less resourced practices, and for those practices that serve large Medicaid or uninsured populations whose ability to overcome this threshold through the use of batching of claims is extremely limited. Moreover, it is unlikely that financially strained practices would be able to withstand an IDR loss and cover the increasing IDR fees in addition to the administrative fee, making pursuit of the dispute resolution process too financially risky.

Over the long term, the higher fees and resulting inaccessibility of the IDR process means that the careful balance of the NSA's statutory scheme is thrown off once again. Without an IDR backstop, these physician practices have no resolution process available to them when they are consistently underpaid by health plans and the underpayment will, therefore, persist. Moreover, there will be even less incentive by health plans to offer these physician practices a fair contract, or keep contracted physicians in their networks, because their ability to underpay these physicians while out-of-network is now even easier. For these reasons, **the AMA has urged the Departments to immediately rescind the 2023 administrative fee increase and ask Congress to do the same.**

III. Reducing backlog in IDR process

Despite statutory timelines governing payment resolution in the NSA, there continues to be significant delays in the IDR process. According to the Departments' Initial Report on the Federal Independent Dispute Resolution (IDR) Process, April 15 – September 30, 2022, there were over 90,000 claims submitted to IDREs between April 15 and September 30, 2022, but only 23,107 had been resolved by the

end of the report period, and only 3,576, or 15 percent, resulted in an IDRE making a payment determination. A follow-up report looking at the fourth quarter of 2022, found that while a greater percentage of closed disputes resulted in a payment determination (40 percent), still only 31,714 of the 110,034 initiated disputes had been closed. **The AMA is very concerned about the financial impact of the IDR backlog on the physician practices waiting for resolution of their claims**.

According to the reports, a cause of IDR claim delays has been the complexity of determining whether a claim is eligible for the federal process. Specific eligibility determination issues highlighted in the initial report include determining whether the federal IDR process or a state process applies; whether claims were batched correctly according to regulatory guidelines; and whether pre-IDR requirements, such as completion of the open negotiations period, have been satisfied.

Suggestions that the backlog is due to physicians and other health care providers submitting frivolous claims overlook the complexity associated with determining eligibility at the physician practice level; the regulatory requirements, or lack thereof, that fail to promote efficiencies; and the incentives for plans to challenge eligibility at every turn and disengage from the process all together.

Use of Remittance Advice Remark Codes

The AMA continues to hear from physicians who are struggling to determine whether an out-of-network claim is eligible for the federal process, or whether the specified state law applies. While there are many nuances to determining the correct process beyond whether the health plan is state or federally regulated, including whether the federal law fills gaps in the specified state law, **the AMA believes that requiring plans to use Remittance Advice Remark Codes (RARCs), when providing the initial payment or notice of denial, would significantly reduce confusion**. Ensuring the use of the RARC codes for all claims will provide IDREs and physicians with critical information about whether a particular claim is eligible for the federal IDR process and how to process claims if they are eligible.

Flexibility for batching of claims and bundling of services

The strict regulatory rules on batching of claims to take to the IDR process have created inefficiencies and confusion, perpetuating the IDR claims backlog. Under the statute, batching is permitted whenever "items and services are related to the treatment of a similar condition," but the Departments' currently allow batching only in much narrower circumstances—if the "items and services are the same or similar items and services," which are defined as an item or service that is "billed under the same service code, or a comparable code under a different procedural code system." This narrowing of the definition means that far fewer claims can be batched together for IDR. **The AMA suggests that the Departments expand the ability of physicians to batch claims for IDR purposes to reduce the backlog.**

Similarly, the Departments should consider allowing greater flexibility in the bundling of services for a single claim. Although an October 2021 IFR described a bundled claim as one for which the health plans pays a single payment for multiple items or services furnished during an episode of care, August 2022 guidance clarified that a single payment for multiple items or services must be made at the service code level for the entire bundle in order to be considered a bundled arrangement and therefore be treated as a single determination under the IDR process. We think that **greater efficiency, and reduced IDR backlog, could be achieved through a broader definition of bundled claims that includes services furnished during a single episode of care.**

Lack of engagement in open negotiations and other poor health plan behavior

Congress required the open negotiations process as an important component of the dispute resolution process under the NSA and consistent and good faith use of this process should lead to fewer IDR claims. Unfortunately, we understand that health plans are frequently dismissing outreach from physicians to participate in the open negotiations process and refusing to respond with offers for payment. We also understand that payers may be using questions of eligibility regarding completion of the open negotiations period as a tactic to delay or deter the dispute resolution process from proceeding.

To address any disingenuous questions of eligibility, **the AMA has asked the Departments to collect information from IDREs about parties that regularly question claim eligibility with a frequency and manner that suggests bad faith and urged the Departments to immediately address the actions of these parties through corrective action and penalties when necessary.**

Additionally, to address a lack of engagement in the open negotiations process, **the AMA suggests there are potential benefits to formalization of the open negotiations period and requiring the process to be conducted through the federal IDR portal**. Such benefits include increased clarity on initiation and completion of the open negotiations period, which would reduce related eligibility issues. This transition could also reduce confusion about to whom or where initiating parties should send the open negotiation initiation form. Additionally, moving the open negotiations process to the portal provides an opportunity to make a preliminary eligibility determination regarding federal or state authority on a claim prior to IDR initiation. As such, the AMA believes the Departments should further explore the feasibility of this transition. However, **the Departments must refrain from requiring any administrative fee for use of the federal portal for the open negotiations period** (i.e., the administration fee must not apply until the claim advances to the IDR phase). Good faith negotiations during this stage of the dispute resolution process must be encouraged and assessing a fee at this time would do just the opposite.

IV. Failure of plans to make payments upon an IDR decision

The AMA has heard from many physicians that they are not receiving payment from health plans within the statutory 30-day time period following an IDR decision in their favor, and in fact many physicians are reporting receiving no payment at all. A recent survey by the Emergency Department Practice Management Association (EDPMA) reported that 87 percent of payers did not pay in accordance with the IDRE's decision. To be clear, **health plans are blatantly ignoring binding IDRE decisions, continuing to collect interest on money owed to physicians, and threatening the financial stability of thousands of physician practices across the country.** This is unacceptable and immediate action must be taken.

The AMA has asked that the Departments work closely with state regulators to ensure that once an IDRE makes a final determination, payment is made to the prevailing party within the 30-day statutorily required timeframe. Should a party not comply with a required timeframe, a financial penalty should be applied and compounded over the course of the delay. Another option that the Departments might consider, especially for repeat offenders, is a requirement that payment be made up front and held by the IDRE, along with the IDR fee, and refunded with the IDR fee if the party wins or paid to the winning party when appropriate.

The AMA urges Congress to work with the Administration to ensure that health plans are not ignoring IDRE decisions and are paying physicians within the required timeframe.

V. Complaints, audits, and reports

Complaints

The AMA has heard from many physicians that overall enforcement of NSA dispute resolution requirements is lacking, including but not limited to plan failure to pay post-IDR decision, failure to pay administrative fees, provide the QPA with the initial payment, etc., and that when physicians encounter enforcement issues, there is not a reliable way to quickly have concerns resolved.

While we appreciate tools such as the NSA Help Desk and email addresses for provider questions, we also understand that in many cases it takes several weeks for physicians to even receive confirmation that the request has been received or is being addressed. In addition to being frustrating and financially impactful for physician practices, such delayed responses undercut a system that was set up with clear timelines and requirements and perpetuate disregard by certain parties for the rules. Accordingly, **the AMA has urged the Departments, working closely with state regulators, to establish a more functional and responsive process for physicians to report compliance issues and ask questions and receive a timely response**.

Audits and reports

The AMA understands that some statutorily required audits are being performed, however, little if any of this information has been made public to date. The NSA requires the Department of Health and Human Services (HHS) to submit an annual report to Congress on the number of plan audits that were conducted during such year, starting in 2022. To our knowledge, such a report has not yet been submitted. The AMA has urged HHS to submit this report with all due expediency and to make the report available to the public. HHS is also expected to issue a report on downcoding and other such payer behaviors. We similarly ask that this report be made available to the public.

Furthermore, the most common failures identified in the audits, including but not limited to submitting incomplete information, should be used to develop specific, tangible financial penalties or other policy solutions to avert these continued behaviors, which should be developed in collaboration with relevant stakeholders and made transparent in public guidance to encourage future compliance.

VI. Conclusion

The AMA supports the framework laid out by Congress in the NSA to resolve out-of-network payment disputes in surprise billing situations. As such, we ask that Congress urge the Departments to expeditiously address the problems we have identified above. We look forward to working with the Committee to ensure that the NSA is working as Congress intended.

Sincerely,

James L. Madara, MD