



AMERICAN ACADEMY *of* ACTUARIES

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June 25, 2021

Honorable Xavier Becerra
Secretary of Health & Human Services
200 Independence Ave. SW
Washington, DC 20201

Honorable Martin J. Walsh
Secretary of Labor
200 Constitution Ave. NW
Washington, DC 20210

Honorable Janet Yellen
Secretary of the Treasury
1500 Pennsylvania Ave. NW
Washington, DC 20500

Re: Possible Agency Actions Related to the *No Surprises Act*

Dear Secretaries Becerra, Walsh, and Yellen,

On behalf of the Individual and Small Group Markets Committee and the Active Benefits Subcommittee of the Health Practice Council of the American Academy of Actuaries (Academy),¹ we would like to offer input as the departments of Health & Human Services, Labor, and the Treasury work to develop proposed rules related to the *No Surprises Act*² (“the Act”).

Summary of the Problem

Surprise medical billing can happen when someone seeks care at an in-network facility, such as a hospital, but unintentionally receives some services from out-of-network providers. In these circumstances, patients risk higher bills largely because out-of-network providers are allowed to balance bill patients for any differences between the provider’s charges and what the health plan pays.

¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

² As enacted as part of the [Consolidated Appropriations Act of 2021](#), H.R. 133; *Division BB—Private Health Insurance and Public Health Provisions*.

In addition, plan members typically face higher deductibles, coinsurance, and out-of-pocket limits for out-of-network services. These higher cost-sharing requirements are intended to provide patients incentives to use in-network providers but can penalize patients who unknowingly receive out-of-network care.

As detailed in the Academy's 2019 public policy issue brief, [*Surprise Medical Bills: An Overview of the Problem and Approaches to Address It*](#), numerous studies have examined the incidence of surprise bills and their causes as well as state-level efforts to address them.

Findings include:

- One in five inpatient admissions from the emergency department may lead to surprise bills. Ambulances and air or water ambulances have an even greater risk of resulting in a surprise bill, with more than half being furnished by out-of-network providers.
- The percentage of visits with potential surprise bills appears to be increasing over time.
- Out-of-network billing has been concentrated among certain hospitals.
- Particular specialties represent larger shares of out-of-network claims, including anesthesiologists, primary care, emergency medicine, non-physician services (physician assistants, registered nurses, etc.), and radiology.

Summary of the *No Surprises Act*

The provisions of the *No Surprises Act* are applicable to the individual market, the large and small groups fully insured markets, and self-insured group health plans. The provisions of the Act are effective January 1, 2022.

The Act contains a number of provisions including the following: Coverage for Emergency Services, Coverage of Non-Emergency Services Performed by a Non-Participating (Non-Par) Provider at a Participating (Par) Facility, Determination of OON Rates / Independent Dispute Process, Transparency, Advance Cost Estimates, Ending Surprise Air Ambulance Bills, Continuity of Care, Price Comparison Tools, Provider Directory Accuracy, Disclosure Provisions, Other Patient Protections and Reporting / Database Requirements.

Specifically, the Act provides that if a group health plan or a health insurance issuer covers emergency services, these services must be provided:

- Without the need for any prior authorization;
- Whether the health care provider furnishing such services is a participating provider or a participating emergency facility;
- Where the cost-sharing requirement for Non-Par providers and facilities is not greater than the cost sharing requirements for Par providers and facilities; and
- Where any cost-sharing payments for all emergency services (Par and Non-Par) are counted toward any in-network deductible or in-network out-of-pocket maximums.

There are also provisions addressing services provided by Non-Par providers located at Par facilities and for air ambulance services. These services must be provided:

- Where the cost-sharing requirement for Non-Par providers is not greater than the cost-sharing requirements for Par providers; and
- Where any cost-sharing payments for these Non-Par provider services are counted toward any in-network deductible or in-network out-of-pocket maximums.

An important consideration is how the out-of-network rate is determined and how the payer pays the Non-Par provider and Non-Par facilities. In determining the out-of-network or Non-Par rate for each service, the payer must determine whether there are state-specific laws or provisions applicable to Non-Par payments. If a state does not have in effect such a law with respect to the service provided, there are options to determine the payment:

- The provider/facility may openly negotiate with the payer and agree on a payment amount for the services provided, or
- If these negotiations do not result in agreement between the provider and the payer, the two parties may enter the independent dispute resolution process, or
- In the case such state has 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 furnished.

As required by the Act, when a claim is incurred by a patient with an affected provider, the payer and provider must agree upon a payment level within 30 days. If this negotiation is not agreed upon within 30 days, then an independent dispute resolution (IDR) process is followed using a third-party mediator. A key consideration of the IDR entity is the median contracted rate in the same geographic area for the same or similar services. Under this process, each party submits a final offer and then within 30 days the IDR entity rules in favor of the party with the most reasonable claim. The IDR decision is binding; the losing party pays the cost of the arbitration process and there is a “cooling off period” wherein the party that initiates IDR cannot seek IDR again with the same party for the same service for 90 days.

The remainder of this letter will discuss considerations for determining the amount paid by the payer to Non-Par providers, the impact on premium rates in 2022 and later, and specific state experience for states with existing surprise billing laws.

Considerations for the Provider Payment Amount

In compliance with the Act, providers and payers will determine agreeable payment amounts, and over time various common practices will likely develop. To cultivate consistency and equity across markets (and service types where possible), federal regulations could provide guidance regarding criteria for sources of payment data to consider, along with weighting for each referenced source and supporting rationale (e.g., not less than 50% weight to median in-network payments, when such payments represent geographic area out-of-network services provided). It also may be beneficial to note when deviations from such sources and weight ranges would be allowable.

The development of guidelines could ease administrative burdens and facilitate arbitration of multiple payments for similar out-of-network services. It should be noted that the Act does not provide parameters regarding how payers and providers determine proposed payments; it

provides only factors that are allowed (and prohibited) from being considered related to dispute resolution.

Citable payment sources

As noted in the Act, median in-network allowed charges for fee-for-service (FFS) based payments³ could be a primary consideration in determining agreeable out-of-network payments. Because not all in-network services payments to a provider are on a FFS basis, FFS payments referenced would not include additional performance-based payment arrangements such as withholds or bonuses to providers, because performance criteria are not applicable to uncontracted or non-network providers. Other payment arrangements such as capitation, bundled payments, and risk-sharing arrangements may be difficult to use as citable sources, as the amounts may not be representative of FFS contracted charges or be easily associated with a procedure.

Medicare-allowed amounts also may be a useful reference for payment sources. For example, Medicare Advantage Preferred Provider Organization (PPO) plans reimburse out-of-network services at up to 115% of Medicare allowed, if the provider accepts Medicare. This may be a citable starting amount in determining payments to out-of-network providers, although it also may be appropriate to vary from 115%. The Medicare benchmark may vary by not only procedure code but also applicable modifiers.

Data repositories may be valid sources of provider payments. For example, state insurance departments may collect insurance company data or other statewide health claims data, and several private companies collect and summarize claim data from insurance companies. In addition, with the publication of the Transparency in Coverage final rules in November 2020, payers, providers, and regulators are able to reference in-network allowed charges across entities.

Other sources when citable median in-network payment rates are not available

Other possible starting points for determining reasonable out-of-network payments include:

- Reimbursement amounts for other geographic areas utilizing in-network providers. The Transparency in Coverage final rules allow payers and providers from other geographic areas to obtain information related to in-network reimbursement rates.
- Applicable Medicare Relative Value Unit (RVU) amounts, adjusted, at a minimum, for geography using Geographic Practice Cost Indices (GPCI).
- A “cost-plus” pricing approach, which would produce a total charge based on cost of furnishing services (inclusive of fixed and variable costs), plus a reasonable amount of profit, determined by both parties. This approach may be suitable as a primary reference for services that are almost exclusively out-of-network, such as air transportation. Cost-plus pricing may be challenging due to difficulty in determining depreciation and utilization to allocate the fixed cost of equipment and infrastructure.

³ Would exclude Medicare and Medicaid payment schedules.

- Reimbursement amounts for other geographic areas utilizing out-of-network providers, adjusted for GPCI differences if utilization in the other areas is sufficiently material to suggest an underlying true fair market value for the service.

These referenced amounts may require adjustment for factors such as market share, training/education of providers, and complexity of the patient’s medical condition.

Projecting historical charge data

The Act recognizes that historical sources of provider payments should be projected to the time services were provided (i.e., trend). Determining appropriate cost trend requires consideration of the type of service and available data supporting the change in cost. There are several sources of such information, though likely no single source should be the sole basis of cost trend. Most sources suggest ranges of cost trends, separated by service category.⁴ The final rules could use such sources to establish guidelines for acceptable trend ranges. Trend ranges allow for a balance of providing parameters to payers and providers, with a recognition that trends by service category reflect not only unit cost changes over time, but also changes in the mix of services.

Another consideration is making appropriate updates to reference payment bases to reflect market and treatment changes. Trending prior historical data (e.g., calendar year 2016) to a more recent historical period (e.g., calendar year 2019) without appropriate adjustments for known changes could result in payment estimates that are inconsistent with the more recent (e.g., calendar year 2019) payments. We suggest using reference bases that are updated annually, if possible. This frequency would limit the impact of trend.

Finally, non-discounted payments (i.e., billed charges) may vary materially by provider. This is because billed charges may not reflect the actual cost of delivering the services, often do not reflect market norms, may receive little attention, and may be developed to present favorable discounts to patients or payers. Therefore, changes in billed charges over time may not represent suitable trends in historical rates agreed to between payers and providers. Changes in payment rates for in-network services may be more appropriate for trend development.

Weighting of referenced payment amounts

To determine weighting, we suggest considering both the “Applicability” and the “Credibility” of sources. Applicability means similarity of the referenced payment source to the out-of-network service, such as when a provider operates in a small portion of a geographic area. Credibility means the extent to which the payment source reflects payments provided by the underlying reference, such as when a provider’s services represent a high proportion of utilization across a geographic area. Credibility likely is determined primarily by number of services paid using the basis as well as the variance of payments to providers.

⁴ Typical medical service categories may include: Inpatient Facility, Outpatient Facility, Emergency Room, Primary Care Physician, Specialty Physician, Diagnostic Services, and All Other.

Impact on Costs and Premiums

The Act will be important for patients receiving care from non-contracted providers, as well as the providers and payers, and likely will reduce enrollee premiums and out-of-pocket costs over time. While patients will experience both financial and peace-of-mind value from the Act, provider and payer costs will be affected both directly and indirectly. The longer-term impact of the Act is yet to be determined for contracting behavior, network, benefit design and long-term cost trends.

Direct cost implications

The Act will affect both the cost of claims and the administrative costs reflected in premiums and plan costs.

Lower covered claim amounts

In general, the Act is expected to reduce costs and thus premiums. Out-of-network claims that would have been paid as submitted, or with some adjustment to reflect usual, customary and reasonable (UCR) levels, likely will reduce to something similar to the median in-network payment amount. The cost reduction will vary based on:

- Approach to the 30-day agreeable determination period: With the median in-network rate as the likely backstop, it is unclear whether the parties will agree to somewhat lower or higher amounts based on intent to use IDR, and how contracting strategies will be affected;
- Variance by geography, due to the prevalence of in-network providers as well as the variance in cost between contracted and non-contracted rates;
- Any precedence and pattern in previous state-led approach and adoption of surprise billing laws and regulations;
- Design and administrative practice of IDR;
- Variance in benefit design, such as the difference between in-network cost-sharing and out-of-network cost-sharing for a given patient, or whether out-of-network coverage is included. In some cases, plan costs might increase if patient cost sharing is reduced, or services previously excluded from coverage are now covered; and
- Historical claim practice of the claims fiduciary; that is, the claims adjudication norms around whether to either deny out-of-network claims in non-emergency situations, or pay the claim to avoid undue patient payment responsibilities and appeals, when benefit designs include in-network services only.

Higher administrative costs

It is likely that providers and payers will experience higher administrative costs due to the implementation and administration of the Act. These additional costs likely will be passed to customers in higher premiums or plan costs, including:

- Modifying claims adjudication processes to reflect the requirements of the Act, including determining median in-network and any additional staffing associated with negotiated agreement in 30-day period; and
- Costs of IDR. Under the Act, the loser of the arbitration pays the IDRE—providers may increase unaffected billings to cover extra expenses, administrators may increase administrative fees for self-insured plan sponsors, and insured premiums may increase.

Indirect cost implications

The contracting strategies of providers and payers have changed over time and will continue to evolve. In addition to the direct cost changes of lower claim costs and higher administrative costs, the Act likely will drive longer-term changes in contracting approaches for providers and payers, which could either increase or decrease costs over time. This will be supported by transparency requirements in the Act for disclosing payment requests and decisions. Both non-contracted and contracted payments likely will have reduced variance over time and will move to the “recognized amount” or the median. Further, the median payment level typically is lower than the average payment level for non-contracted services due to exceptionally high payments. Thus, with median payments being less than average payments, there could be cost reductions.

Possible actions by Non-Par providers

If providers believe the median is the best they can receive for non-contracted services, they may be willing to sign in-network contracts at something near median rates for these services to receive patient volume, although they would consider other aspects of being in-network, such as reporting and coordination requirements and participation in value-based contracts.

It’s also possible that Non-Par providers might join forces with others to negotiate more global contracts. This already is happening with stand-alone emergency physician groups and facilities. This provider consolidation may increase acquisitions by for-profit companies, likely creating upward pressure on costs.

Possible actions by Par providers

If Par providers are contracted at lower-than-median rates, they may demand increases to median rate levels or may leave the network to receive higher Non-Par payment. If contracted at higher-than-median levels, high-volume or high-prestige providers may leverage their status to contract at rates higher than median, increasing costs.

Some providers may contract for certain services and not for others. These providers may wish to renegotiate payments for contracted services to make up for lower payment on non-contracted services due to the Act.

Possible actions by payers

Payers might renegotiate to reduce unjustifiably high payments to Par providers or terminate contracts. Payers will need to consider regulatory requirements of adequate provider networks as well as market and customer needs and preferences.

Payers may begin contracting with Non-Par providers near median payment levels because out-of-network payments likely will be cut to median payment levels. This may result in broader provider networks, or payers replacing existing Par providers that will not lower their contracted rates. Payers will act to protect against provider cost-shifting to other covered services less affected by the Act.

Payers likely will adjust benefit designs as utilization patterns between Par and Non-Par networks change to maintain cost competitiveness. It is possible that the protections from the Act will increase Non-Par utilization. If the Act drives more providers in-network, payers may find different value in Non-Par benefits.

It is unclear how the Act might affect the market's move toward value-based contracting with providers.

Other considerations

For each surprise bill that goes to the IDR process, the secretary of Health and Human Services must post information about the nature and geographic location of the service provided, the payment amounts offered by each party, which party prevailed, and the length of time involved in making the determination. The impact on provider contracting and network configuration over time is unknown.

A national IDR system could result in very disparate effects, state to state and market to market, depending on underlying conditions. Drivers are likely to include a level of state involvement, existing state laws, variances in provider and payer markets and level of competitiveness, and plan sponsor and patient knowledge.

State Experience for States with Surprise Billing Laws

How will states with existing surprise billing laws work with the Act? The Act calls for state payment determination processes to be used where they exist—which apply to fully insured policies. State payment mechanisms will apply for these state-regulated insurance plans, but not to federally regulated self-funded plans as required by the Act. States will have to decide whether to maintain their approaches or switch to the federal system.

According to the Commonwealth Fund, as of February 5, 2021, there are 18 states with a comprehensive approach and 15 states with a limited approach to balance billing provisions.⁵

⁵ [“State Balance-Billing Protections”](#); The Commonwealth Fund; last updated Feb. 5, 2021.

Of those that are comprehensive, the payment provisions vary:

- Four have a payment standard only;
- Seven have a dispute resolution process; and
- The remaining seven have both a payment standard and a dispute resolution process.⁶

Of the states with a limited approach:

- Cover emergency services at in-network and out-of-network facilities or non-emergency care in an in-network hospital with no additional protections;
- May apply balance billing provisions to either health maintenance organization (HMO) or PPO plans;
- Cannot prohibit providers from balance billing the member; and
- Cannot have a payment standard or dispute resolution process.⁷

California has a payment standard and a dispute resolution process in place.

- For out-of-network care in an in-network facility, dispute resolution can only be used if the payment standard cannot be applied.⁸
- The emergency services dispute resolution process is non-binding and has never been used.⁹
- The payment standard for out-of-network providers working at in-network facilities pays the greater of
 - the average in-network cost of the same service in the region, or
 - 125% of Medicare.
- The payment standard for emergency services is less specific, and is based on reasonable and customary values, updated annually, that take several factors into consideration.¹⁰

The California Medical Association has said the payment standard gives too much negotiating leverage to payers, causing rate reductions and contract cancellations, leading to network shrinkage and patient access issues.^{11,12} Critics of the payment standard are concerned that provider groups may consolidate to gain negotiating leverage. America's Health Insurance Plans (AHIP) reports a 16% increase in in-network physicians, but the values reported are not member-weighted and may not reflect network reductions at the local level.¹³

⁶ Ibid.

⁷ [“Balance Billing by Health Care Providers: Assessing Consumer Protections Across States”](#); The Commonwealth Fund; June 2017.

⁸ “State Balance-Billing Protections,” op. cit.

⁹ Ibid.

¹⁰ [“State Balance-Billing Protections—Maps and Interactives”](#); The Commonwealth Fund; Feb. 5, 2021.

¹¹ [“California Surprise-Billing Law Protects Patients But Aggravates Many Doctors”](#); California Healthline; Dec. 4, 2019.

¹² [“California saw reduction in out-of-network care from affected specialties after 2017 surprise billing law”](#); Brookings Institution; Sept. 26, 2019.

¹³ Ibid.

As mentioned previously, 14 of the 18 states with a comprehensive approach to balance billing have an IDR process. There are several factors that determine how many claims go through the IDR process:

- Four states require a minimum dollar threshold (\$700-\$1,000) to allow IDR.¹⁴
 - Some, like New Jersey, allow providers to group all claims for an enrollee.
 - Others like Colorado, prohibit batching.^{15,16}
- How the arbitration fees are paid also impacts how often the parties will initiate IDR.
 - Fees can be split evenly, or loser pays all.
 - In a loser-pays-all scenario, both parties are deterred from initiating IDR unless they believe they have a strong case.¹⁷
- Both Colorado and Washington state have minimum initial payments in place that providers feel are not enough to make it worth the effort to initiate IDR.¹⁸
- New Jersey and Texas resolutions have typically favored providers, so providers in those states are more likely to initiate IDR.¹⁹

The factors that an independent arbitrator is allowed to take into consideration will impact the final result of the IDR:

- Some states allow factors such as case complexity and provider experience.
- Others also rely on payment levels.²⁰
 - New Jersey, New York, Alaska and Connecticut allow the arbitrator to consider the 80th percentile of billed charges.²¹
 - Allowing arbitrators to review billed charges as a reasonable charge for services causes rulings in favor of charges much greater than the original payment or in-network rates.
 - Texas arbitration awards have been 4.7 times higher than the average original payment.
 - New Jersey arbitration awards have been 5.7 times the median in-network price.²²

¹⁴ [“How States Are Using Independent Dispute Resolution to Resolve Out-of-Network Payments in Surprise Billing”](#); The Commonwealth Fund; Feb. 27, 2020.

¹⁵ [“Taking the Disputes Out of Dispute Resolution: Lessons from State Balance Billing Laws”](#); Robert Wood Johnson Foundation; March 15, 2021.

¹⁶ [“Arbitration Over Out-Of-Network Medical Bills: Evidence From New Jersey Payment Disputes”](#); *Health Affairs*; January 2021.

¹⁷ “How States Are Using Independent Dispute Resolution to Resolve Out-of-Network Payments in Surprise Billing,” op. cit.

¹⁸ “Taking the Disputes out of Dispute Resolution: Lessons from State Balance Billing Laws,” op. cit.

¹⁹ Ibid.

²⁰ “How States Are Using Independent Dispute Resolution to Resolve Out-of-Network Payments in Surprise Billing,” op. cit.

²¹ “Taking the Disputes out of Dispute Resolution: Lessons from State Balance Billing Laws,” op. cit.; [“Surprise Medical Bills: How to Protect Patients and Make Care More Affordable”](#); *The Georgetown Law Journal*; Vol. 108.

²² “Taking the Disputes out of Dispute Resolution: Lessons from State Balance Billing Laws,” op. cit.; “Arbitration Over Out-Of-Network Medical Bills: Evidence From New Jersey Payment Disputes,” op. cit.

Finally, there are concerns that high awards and resolutions favoring providers increase the leverage of emergency and ancillary service providers, resulting in higher negotiated in-network rates which are passed along to the enrollees in premiums.²³

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As you move forward with developing proposed rules implementing the *No Surprises Act*, we would be happy to discuss any of these issues further with you. If you have any questions or would like to discuss further, please contact Matthew Williams, senior health policy analyst, at williams@actuary.org.

Sincerely,

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Chairperson
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Karin M. Swenson-Moore, MAAA, FSA
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²³ “Surprise Medical Bills: How to Protect Patients and Make Care More Affordable,” op. cit.