June 21, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

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

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

Dear Secretaries Becerra, Walsh, and Yellen:

On behalf of our members, the American College of Emergency Physicians (ACEP) and the Emergency Department Practice Management Association (EDPMA), we would like to follow-up on a letter that we wrote on April 25, 2022 that laid out issues emergency physicians are having obtaining the required information from plans and issuers as articulated under the *Requirements Related to Surprise Billing; Part I Interim Final Rule* (First IFR).[1]

As background, ACEP is the national medical society representing emergency medicine. Through continuing education, research, public education and advocacy, ACEP advances emergency care on behalf of its 40,000 emergency physician members, and the nearly 150 million Americans we treat on an annual basis. EDPMA is the nation's largest professional physician trade association focused on the sustainable delivery of high-quality, cost-effective care in the emergency department (ED), and its members handle over half of the visits to U.S. emergency departments

[1] Requirements Related to Surprise Billing; Part I. 86 FR. 36898-36899 (July 13, 2021).

each year. Together, ACEP and EDPMA members provide a large majority of emergency care in our country, including rural and urban settings, in all fifty states and the District of Columbia.

After ACEP and EDPMA wrote the letter on April 25, we had a follow-up meeting with staff at the Center for Consumer Information and Insurance Oversight (CCIIO) within the Centers for Medicare & Medicaid Services (CMS) on May 25. During this meeting, we discussed specific group health plan and health insurance issuer (collectively referred to in this letter has "health plans") non-compliance issues our members are experiencing, provided policy recommendations to address non-compliance, and also requested additional guidance on how our members should proceed with the federal Open Negotiations and independent dispute resolution (IDR) processes when there is limited or missing information from insurers (information that was required by the first IFR). We also emphasized the critical need for stronger, swifter enforcement of the regulatory requirements when health plans are not meeting them.

ACEP and EDPMA sincerely thank CCIIO staff for the meeting, and we found the meeting to be productive. CCIIO staff stated during the meeting that they were acutely aware of the non-compliance issues we raised and were addressing them on a case-by-case basis. Less than two weeks after our meeting, on June 6, CMS released a checklist of requirements for insurers during the Open Negotiations and federal IDR processes. In the introduction to the checklist, CMS states that it has received numerous complaints that health plans have not been complying with the requirements in the areas that we specifically raised in our letter and follow-up meeting with CCIIO.

The checklist spells out the requirements laid out in the *No Surprises Act* and in the first IFR in a clear and comprehensive way, and ACEP and EDPMA believe that it is a ***good first step*** in helping to increase the level of compliance among health plans. However, we believe that the Departments of Health and Human Services (HHS), Labor, and Treasury (the Departments) must take ***additional actions*** to ensure that patients are truly taken out of the middle of billing disputes as the *No Surprises Act* intended and that health care providers have the clarity they need to accurately request reimbursement from patients for furnished services and, if necessary, engage in the federal IDR process as laid out in statute and regulation. We appreciate the Departments' movement toward enforcement of requirements already in place. In the meantime, we have the following additional specific requests:

1. ***Release Frequently Asked Questions (FAQs):*** ACEP and EDPMA recommend that the Departments release a set of FAQs, found in Appendix 1, that serve as stakeholder guidance to reduce ambiguity around the *No Surprises Act* requirements and to better understand how to proceed in cases of health plan non-compliance.

2. ***Hold providers who mistakenly bill patients incorrectly harmless from any penalties:*** As noted in our letter from April 25, in numerous documented cases where the federal *No Surprises Act* provisions apply, health plans are not providing the qualifying payment

amount (QPA) for the item or service billed nor the certifying statement that the QPA was calculated properly and that the QPA serves as the recognized amount for the purposes of calculating patient cost-sharing. Thus, health plans are not properly notifying providers whether the cost sharing amount identified by the health plans for out-of-network items and services is in compliance with the *No Surprises Act* patient cost-sharing protections. This lack of information can cause confusion for both providers and patients and could result in patients being billed the incorrect amount—which consequentially puts patients back in the middle of billing disputes.

Our members always strive to bill patients accurately, but this lack of information makes it difficult or even impossible to do so. *Providers should not be punished for something that is beyond their control.* Therefore, the Departments should make it clear going forward that providers who request the reimbursement amounts from patients identified by the health plan as the patient cost-sharing responsibility be held harmless from any penalties.

3. ***Increase transparency about non-compliance cases and provide follow-up for concerned parties:*** ACEP and EDPMA understand and appreciate that the primary way of addressing non-compliance issues is on a case-by-case basis through the submission and resolution of individual complaints. Disputing parties (health plans or providers) can submit billing complaints online or by contacting the No Surprises Help Desk at 1-800-985-3059. During our meeting with CCIIO staff on May 25, we were informed that the Departments have resolved around a quarter of the complaints, but that there is a *significant backlog of unresolved complaints.* Further, when the Departments resolve a specific complaint, they request documentation from the health plan and work with the health plan to rectify the specific non-compliance issue for similar claims going forward.

   We were also told during our meeting that providers are allowed to "batch" complaints against one health plan. In other words, instead of having to submit a complaint for each individual claim, providers are allowed to collectively submit all of the complaints related to one health plan. This is important as it may help save time and speed up the time in which complaints are processed and adjudicated by the Departments.

   Given that the complaint system is currently the main mechanism for addressing cases of non-compliance, ACEP and EDPMA recommend that the Departments release information about these cases (to the extent possible), including:
   - The total number of cases
   - The total number of cases that are resolved
   - The total number of cases that are unresolved
   - The most common issues raised and how these issues were addressed
   - Best practices to avoid issues that are commonly leading to complaints

Releasing information about the complaints and increasing transparency around the issues that are driving the complaints could reduce the total amount of complaints and increase compliance of all *No Surprises Act* requirements.

Furthermore, ACEP and EDMPA request that the Departments provide specific communication with the party that initiated the complaint once findings are complete. Our members have made a significant investment of time, energy, and resources in service of advising and improving processes related to implementation of the *No Surprises Act.* In addition to the lack of transparency about the overall process (including key findings and conclusions as noted above), we are concerned that individual parties have had little or no feedback about how their issue was addressed, or whether it has been resolved.

Providing information to individual parties could also reduce the total number of complaints and increase clarity and compliance around *No Surprises Act* requirements.

4. ***Ensure that states have the checklist and distribute it directly to health plans:*** While ACEP and EDPMA again appreciate that CMS has released a helpful checklist of *No Surprises Act* requirements to health plans, it is critical that health plans actually access the checklist and use it. To ensure that the checklist is disseminated to all insurers, we believe that states should take an active role in both the dissemination of the checklist and follow-up enforcement that must take place to ensure that health plans are adhering to the requirements outlined in the checklist. As you are aware, in some states where the federal IDR process is accessible, the state department of insurance or another state agency is the enforcement entity. Even if a state is not responsible for enforcement, every state plays an active role in regulating specific health plans. Therefore, most insurers are accustomed to looking to their state's department of insurance for guidance around regulatory compliance.

   Since states play a critical role in regulating insurers, it is essential that the Departments engage the states and urge those responsible for enforcement to help educate insurers about all the *No Surprises Act* requirements.

Overall, ACEP and EDPMA strongly believe that taking these additional steps is absolutely necessary to achieve the main goal of the No Surprises Act: to protect patients and keep them out of the middle of payment disputes. As clinicians and experts in coding and billing, *we are available* to serve as a resource to help resolve these operational issues. However, until a longer-term solution can be formulated, we urge the Departments to provide guidance and support for providers who are navigating all the billing processes established by the *No Surprises Act* with incomplete information from health plans**.**

If you have any questions, please contact Laura Wooster, ACEP's Senior Vice President of Advocacy and Practice Affairs at lwooster@acep.org, or Cathey Wise, EDPMA's Executive Director at cathey.wise@edpma.org.

Sincerely,

Gillian Schmitz, MD, FACEP

Gillian R. Schmitz, MD, FACEP
ACEP President

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Don Powell, DO
Chair of the Board, EDPMA

Appendix 1

Potential FAQs for Stakeholder Guidance on *No Surprises Act* Compliance Issues

Q1. What steps should providers take to meet the Open Negotiation and Federal IDR timelines when group health plans and health insurance issuers do not "provide the QPA for each item or service involved" with the initial payment or notice of denial of payment or the additional information as required under regulation (including the phone number and email information of the plan/issuer representative to contact to begin Open Negotiation)?

ACEP and EDPMA Comments on Q1. In ACEP and EDPMA discussions about health plan non-compliance, it was suggested that the outlet for this was the *Request for an Extension of Federal IDR Process Time Periods Due to Extenuating Circumstances*. While we appreciate this option exists, we respectfully reply that this is unworkable.

The volume of claims to which this issue applies is overwhelming. To add a one-off time extension request meant for "extenuating circumstances" for what is right now the majority of claims covered by the federal law is affecting our operations and unfairly benefits the health plans by overwhelming providers and facilities with non-compliance.

As the guidance in the request provides in its example, "An extension may be necessary if, for example, a natural disaster impedes efforts by plans, issuers, FEHB carriers, providers, providers of air ambulance services, and facilities to comply with the terms of the interim final rules," this type of accommodation is not suitable for broad non-compliance with the provision of required information.

For these reasons we urge the Departments to provide guidance and a solution that ensures that the health plans are meeting their obligations under the rules and that it creates a fair playing field/market rather than allowing the health plans to unilaterally dictate the terms and information under which both parties are operating.

Q2. Are the new RARCs relevant to the *No Surprises Act* required to be included by group health plans and health insurance issuers in payment and denial remittance communications? In the absence of a RARC signaling whether the claim for the item or service is governed by state or Federal law, how will recipients of the initial payment or denial of payment know what rules govern a potential dispute that arises out of the payment for the claim?

ACEP and EDPMA Comments on Q2. As ACEP and EDPMA understand it, these RARCs are *not* required. Without this information, our members do not know what resolution mechanisms to pursue in the event of inadequate health plan payments for rendered services. This has become particularly acute in the face of health plans' lack of inclusion of the QPA on the remittance advice or Open Negotiation contact information (which would inform the provider/facility that the claim is governed by the Federal provisions).

Under the tight timelines associated with the *No Surprises Act* (and some state provisions), this lack of utilization of the RARCs to inform the governing policies serves to give health plans the upper hand as the clock ticks and providers are left without adequate information about cost-sharing and dispute resolution options. Mandatory use of the RARCs would serve to correct these problems.

Q3. The regulations state that the rules are applicable to "plan years (in the individual market, policy years) beginning on or after January 1, 2022." Does this mean that there are plans or coverage that would otherwise be subject to the *No Surprises Act* but to which the rules do not yet apply because the plan or coverage year has not renewed and patients could be subject to a balance bill? How are group health plans and health insurance issuers required to communicate this to patients? How will patients know when the *No Surprises Act* protections apply to them? What if there is a plan or coverage that has a multi-year renewal cycle?

ACEP and EDPMA Comments on Q3. Our members have received correspondence in some instances where the health plan states that it is not subject to the *No Surprises Act* yet because the plan year has not renewed. This has happened frequently enough that we are concerned that the Departments have underestimated the number of lives covered by plans that were believed to be meeting the NSA requirements but are not yet (and regardless, patients do not understand this nuance). This is also making it more difficult to administer the requirements given that providers and facilities are not in a position to know when plan/coverage year renewal dates are and there is no method for obtaining this information, thus the need for additional guidance and clarification.