

September 3, 2021

Laurie Bodenheimer
Associate Director
Healthcare and Insurance
Office of Personnel Management

Douglas W. O'Donnell
Deputy Commissioner for Services and
Enforcement
Internal Revenue Service

Xavier Becerra
Secretary
Department of Health and Human
Services

Ali Khawar
Assistant Secretary
Department of Labor

Mark J. Mazur
Acting Assistant Secretary
Department of the Treasury

Re: Requirements Related to Surprise Billing; Part 1 (CMS-9909-IFC)

Dear Ms. Bodenheimer, Mr. O'Donnell, Mr. Becerra, Mr. Khawar and Mr. Mazur:

On behalf of our more than 200 member hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment on the Requirements Related to Surprise Billing; Part I interim final rule with comment period (IFC). IHA values the opportunity to engage the Office of Personnel Management, Internal Revenue Services, and U.S. Departments of Health and Human Services, Labor and Treasury (the departments) in developing clear, impactful surprise billing guidelines to assist consumers and reduce barriers to healthcare.

IHA and the departments share the same goals: to protect patients from surprise medical bills in applicable situations and remove patients from billing disputes between payers and providers. Illinois passed a balance billing law to protect patients, and Illinois hospitals have been at the forefront of attempting to simplify patient bills and lessen patient financial burden. We empathize with patients, as the current billing system can be confusing and intimidating.

IHA and our members are committed to implementing the No Surprises Act (NSA) as effectively and transparently as possible. As demonstrated by the Hospital Price Transparency (CMS-1717-F2) and Transparency in Coverage (CMS-9915-F) final rules, devising, implementing and enforcing sweeping healthcare pricing regulations is difficult. Just last month, the Centers for Medicare & Medicaid Services (CMS) proposed changes and requested operational feedback on the Hospital Price Transparency final rule, demonstrating the complexity of both the current system and the changes stakeholders are attempting to make. Relatedly, the departments recently deferred enforcement of several requirements under the Affordable Care Act

TRUSTEES & OFFICERS

Chair
Karen Teitelbaum
Sinai Chicago

Chair-Elect
Ted Rogalski
Genesis Medical Center

Immediate Past Chair
Phillip Kambic
Riverside Healthcare

Treasurer
J.P. Gallagher
NorthShore University HealthSystem

Secretary
Mary Lou Mastro
Edward-Elmhurst Health

President
A.J. Wilhelmi
Illinois Health and Hospital Association

Steven Airhart
Hartgrove Behavioral Health System and Garfield Park Behavioral Hospital

Damond W. Boatwright
Hospital Sisters Health System

Jeremy Bradford
SSM Good Samaritan Hospital

Katherine Bunting
Fairfield Memorial Hospital

Ruth Colby
Silver Cross Hospital

M. Edward Cunningham
Heartland Regional Medical Center

William Dorsey, MD
Jackson Park Hospital and Medical Center

Dean M. Harrison
Northwestern Memorial HealthCare

Maureen Kahn
Blessing Health System

Omar B. Lateef, DO
Rush University Medical Center

James Leonard, MD
Carle Health

Michael McManus
Memorial Regional Health Services

George Miller
The Loretto Hospital

Keith Parrott
AMITA Health

José R. Sánchez
Humboldt Park Health

William Santulli
Advocate Aurora Health

David Schreiner
Katherine Shaw Bethea Hospital

Robert Sehring
OSF HealthCare

Allan M. Spooner
Franciscan Health Olympia Fields

Steven D. Tenhouse
Kirby Medical Center

Shawn P. Vincent
Loyola Medicine

Brenda J. Wolf
La Rabida Children's Hospital

(ACA) and the Consolidated Appropriations Act, 2021 (CAA) that affect the No Surprises Act (NSA) and Transparency in Coverage final rule, acknowledging that stakeholders need additional time to fully understand and comply with certain requirements.

To that end, IHA urges the departments to defer enforcement of the requirements under the NSA for the reasons outlined below. The departments acknowledged the difficulty stakeholders will have providing good faith estimates and the advanced explanations of benefit required by the NSA, deferring enforcement of both requirements for insured patients until they are addressed via the notice and comment rulemaking process.¹ The requirements outlined in this IFC and forthcoming regulations will require staff education, new policies and workflow adjustments. Notably, many of the requirements introduced in this IFC have not been fully developed, including the details of the independent dispute resolution (IDR) process. Additionally, many NSA policies will require information exchange across payers (i.e., plans and issuers), providers (i.e., providers and facilities)² and patients. There is currently no established standard for these transactions, and it is understandable that the policies outlined today may require revision as new hurdles and barriers arise. **Thus, we urge the departments to plan on evaluating and revising the requirements detailed in this IFC and forthcoming NSA regulations to ensure the processes and documents outlined by the departments function as envisioned.**

IHA looks forward to working with the departments, our national and state partners, and our members to implement the NSA. Our comments focus on the need for additional clarity and guidance, as well as increased transparency across NSA stakeholders and processes.

Ongoing Clarification and Technical Assistance

IHA appreciates the recent FAQ document created by the departments addressing outstanding questions on the ACA and certain provisions of the CAA that implement the NSA and the Transparency in Coverage final rule. IHA urges the departments to update this document as additional questions arise.

Additionally, IHA urges the departments to develop and execute educational programs and technical assistance to help providers and payers achieve compliance. As we have seen time and again, noncompliance is often the result of ambiguous or confusing implementing regulations. Fostering an environment that helps providers and payers understand where to invest resources and how to overhaul processes will result in a better experience for everyone, particularly patients who are often the main casualty when sweeping reforms are hastily implemented.

¹<https://www.hhs.gov/guidance/document/faqs-about-affordable-care-act-and-consolidated-appropriations-act-2021-implementation>

²Throughout this comment letter, we will refer to plans and issuers as payers and providers and facilities as providers unless otherwise specified.

State Surprise Billing Laws

One area that IHA believes necessitates immediate clarification and enhanced guidance involves the interaction between the NSA and state surprise billing laws. The IFC states: “the Departments interpret that language to also include, for example, state laws that require or permit a plan or issuer and a provider or facility to negotiate, and then to engage in a state arbitration process to determine the out-of-network rate.” In Illinois, we have a law that bans surprise billing for certain items and services: Public Act 96-1523³(215 ILCS 5/356z.3a).⁴ Similar to the NSA, Public Act 96-1523 bans balance billing for out-of-network anesthesiology, emergency, neonatology, pathology and radiology services provided at in-network hospitals or ambulatory surgery centers. Patient cost sharing must mirror in-network cost sharing, and the payer (health plan or issuer) may pay either the billed amount or attempt to negotiate reimbursement with the provider. If negotiations do not result in an agreed-upon payment amount, then the payer or the provider may initiate a binding arbitration process by filing a request with the Illinois Department of Insurance.

The NSA is more expansive than Public Act 96-1523, banning balance billing for additional services, under a wider range of health plans, and covering more provider types as well as emergency services at out-of-network facilities. As the regulations indicate that Illinois’ state law takes precedent for the services it covers, it appears that there are two separate processes for determining out-of-network reimbursement for protected services, one governed by Public Act 96-1523 and one governed by the NSA. **We ask the departments to confirm that they intend for Illinois providers and payers to navigate two different out-of-network reimbursement processes.**

Assuming our interpretation is correct, we ask the departments to develop additional guidance to assist providers, payers and patients in navigating these parallel processes. Payers are in the best position to determine whether state or federal requirements govern the reimbursement process for a given item or service because payers have more information than providers on the type of plan a patient has (e.g., a self-insured or fully-insured group health plan, individual health plan, etc.), and requiring the provider to ascertain this information is burdensome. **Therefore, IHA requests the departments require payers to communicate the applicable process for negotiation and arbitration when they submit the initial payment amount via a remittance advice or a notice of denial. Further, we request the departments establish appropriate oversight of payers to ensure they communicate accurate plan information to providers in a timely manner.**

Additionally, IHA strongly urges state and federal oversight bodies to use discretion in enforcing state and NSA surprise billing requirements, particularly in the early months following NSA implementation. Even with enhanced communication regarding whether the state or federal process governs out-of-network reimbursement determinations, there is bound

³<https://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=096-1523>

⁴<https://www.ilga.gov/legislation/ilcs/ilcs4.asp?DocName=021500050HArt%2E+XX&ActID=1249&ChapterID=22&SeqStart=99300000&SeqEnd=114800000>

to be confusion across stakeholders. Both payers and providers will undoubtedly require assistance determining appropriate timelines for negotiations, navigating the state arbitration or federal IDR processes, and complying with varying document retention requirements. Premature enforcement and punitive actions or penalties would only slow progress, hurting patients, providers and payers in the process.

Qualifying Payment Amount (QPA)

IHA appreciates the departments' thoughtful approach to patient cost sharing and reimbursement arbitration. The departments established the QPA for two purposes: (1) to serve as the payment amount from which patient cost sharing is determined, and (2) to serve as one of several factors used by arbiters to determine final reimbursement during the IDR process. The QPA methodology is relatively simple: using contracted rates as of Jan. 31, 2019, the QPA is a plan or issuer's median contracted rate for the same or similar service, provider, specialty and facility in the same or similar insurance market and geographic region. The departments also present alternative methodologies for when there is not enough information available to calculate a median contracted rate, through dependence on independent claims databases or the use of Medicare rates (in the case of new items or services). While relatively simple, we are concerned that the QPA methodology overwhelmingly favors payers, and will adversely impact some providers initially, and virtually all providers as time goes on.

Deflating Reimbursement

Our chief concern regarding the QPA methodology is that it disproportionately favors payers, potentially leading to unintended consequences that narrow provider networks and restrict access to care. Because the methodology relies on the median, by definition the QPA will be underpaying providers represented by half of the negotiated contracts. This is particularly troublesome should the IDR process rely heavily on the QPA, something that many members of Congress and patient advocacy groups have been pushing for. IHA agrees that the QPA should represent an amount that does not result in egregious cost sharing for the patient. However, if the IDR arbiters are required to strongly consider the QPA in the IDR process, then the QPA must also ensure adequate reimbursement for providers. Unfortunately, the departments have not allowed for reimbursement differentiation based on provider type. By this we mean that differences in providers are weighted equally. In reality, facility costs vary dramatically based on facility type. For example, the overhead costs for academic medical centers (AMC) are more than ten times higher, on average, than non-AMCs in Illinois,⁵ yet all three of these facility-types may be included in the same QPA calculation. If the QPA is favored in the IDR process, then providers with higher costs and presumably higher negotiated contract rates will lose money over time. This may result in cuts to service lines, limiting access to breakthrough procedures and technologies and reduced investment in addressing social and structural determinants of health.

⁵Figures based on 2019 HCRIS data.

Additionally, we are concerned that heavy reliance on the QPA during the IDR process will result in narrower provider networks over time. Specifically, should arbiters decide that the median contracted rate amount is the appropriate reimbursement for items or services covered under the NSA, then payers will realize that they pay less for items or services provided out-of-network. This may cause payers to narrow their networks, which in turn negatively impacts patient access to medical care, particularly in small and rural communities. Patients who prefer to remain in-network will have to travel longer distances to reach in-network providers, and narrower networks may make it even more difficult to transfer patients after they are stabilized (see notice and consent section below). **We believe Congress and the departments intend for the NSA to improve patient access to medical care, not restrict it. Thus, we respectfully request that the departments revisit the current QPA methodology.**

Potential QPA Methodology Alternatives

There are several alternatives to the current QPA methodology that would address the concerns of the provider community. One such alternative is to rely on usual, customary and reasonable (UCR) reimbursement for items or services furnished by out-of-network providers at in-network facilities (or out-of-network emergency facilities for emergency services) because UCR reimbursement is the de facto industry standard dictating adequate reimbursement from both the provider and payer perspectives.

Additionally, IHA believes that special reimbursement arrangements or single case agreements provide a good representation of an acceptable reimbursement rate for out-of-network providers. Unfortunately, the departments specifically require payers to remove such reimbursement agreements from the current QPA methodology. **At a minimum, IHA urges the departments to include special or single case reimbursement agreements in the QPA methodology.** We also recommend the use of such agreements as an alternative to the current QPA methodology, as they represent a reasonable reimbursement arrangement for both payers and providers when a network is insufficient for the medical needs of a patient.

Term Ambiguity and Calculation Transparency

The departments require the QPA to reflect a payer's median contracted rate for the same or similar service, provider, specialty and facility in the same or similar insurance market and geographic region. However, from IHA's perspective these terms are not strictly defined, leaving a wide opening for confusion and variation in interpretation across stakeholders. This is problematic because payers must calculate the QPA within these guidelines, and yet the information payers are required to communicate to providers regarding the QPA calculation is limited. While providers are allowed to request several QPA calculation factors, the lack of transparency around QPA calculations is not within the spirit of this administration. **We request the departments revise the information sharing policy within the IFC, and require complete transparency in how payers calculate the QPA. All relevant factors, including risk-adjustment, bonus payments, etc. should be communicated to the relevant providers upfront.**

Inflation Adjustment

The departments require payers to inflate the QPA, based on 2019 contracted rates, using the consumer price index for all urban consumers (CPI-U). However, medical costs follow a much steeper inflation trajectory than the overall economy. Thus, **IHA requests the departments consider adjusting the QPA using the consumer price index for medical care (CPI-M). The CPI-M is a strictly composed index accounting for medical care commodities and services, and adjusting the QPA by the CPI-M will more accurately reflect the economic reality providers and payers face.**

Additional Clarification

While we provide details on some of our concerns with the QPA above, we cannot fully assess the QPA methodology without first understanding how the departments intend for arbiters to use the QPA in the IDR process. As outlined above, we have significant concerns that heavy reliance on the QPA during the IDR process would significantly favor payers and result in inadequate reimbursement to providers, leading to narrower networks over time. **Thus, we request the departments to clarify that arbiters are not to default to the QPA during the IDR process. We also request the departments consider comments specific to the calculation of the QPA in future notice and comment rulemaking that provides additional guidance to stakeholders on the IDR process.**

Post-Stabilization Services

In the IFC, the departments clearly explain that the NSA definition of emergency services goes beyond the Emergency Medical Treatment and Labor Act (EMTALA). In this IFC, the definition of emergency services includes services provided by a freestanding emergency department as well as services provided after stabilization unless certain conditions are met. We discuss our questions regarding post-stabilization services and the Notice and Consent section below. Our comments in this section pertain to post-stabilization services that continue to meet balance billing protection criteria under the NSA.

Coverage of Post-Stabilization Services

The IFC includes post-stabilization services in the definition of emergency services, extending NSA protections until the patient is transferred to an in-network facility or until the patient consents to be balance billed. However, the departments do not provide guidance for situations where the patient does not meet transfer criteria and does not consent to be balance billed, in which case we expect that the out-of-network facility and providers will care for the patient through discharge. **We ask the departments to provide guidance specifying that payers are responsible for either covering or issuing a notice of denial for all post-stabilization items and services through the point of transfer, consent, or discharge.**

Patient Transfers

In situations when the patient does meet transfer criteria post-stabilization, we ask the departments to clarify that payers must work in a timely manner to arrange transfer. In other words, the departments must ensure that payers cannot delay finding or authorizing patient transfer to an in-network provider or facility to the point where such a transfer is no longer medically appropriate. Hospitals and health systems frequently report that payers will wait days before responding to requests for transfer. Such a delay directly affects quality of care, as the patient's condition could deteriorate during this time necessitating the out-of-network provider to resume treatment.

Additionally, we ask the departments to specify the payer is obligated to reimburse the provider for the services provided once patient transfer is complete. We believe such an obligation will encourage payers to facilitate timely patient transfer, ultimately improving the patient experience.

Provider Recourse

Finally, we can envision limited scenarios in which a patient declines transfer to an in-network provider or facility but also does not consent to be balance billed. The departments make clear that patients have these rights under the NSA. However, we are unclear as to the departments' intent for providers in such cases. **IHA requests the departments provide additional guidance around provider obligations should a patient meeting transfer criteria decline both a transfer and consent to be balance billed. Specifically, we request the departments clarify that providers will not be penalized should they decline to provide treatment in such instances.**

Notice and Consent

As explained in the IFC, patients may waive balance-billing protections under certain circumstances, including for post-stabilization services should certain criteria be met. IHA has several concerns about the notice and consent documents and the process providers must go through to comply with requirements outlined by the departments.

Notice and Consent Responsibilities

The guidance explaining which healthcare entity is responsible for completing the notice and consent process is ambiguous, particularly in instances where post-stabilization services are provided by an out-of-network provider at an out-of-network emergency facility. The departments write (emphasis added): "HHS is of the view that an individual cannot consent to waive balance billing and cost-sharing protections unless they have been informed of their potential liability with respect to both the facility and provider charges related to receiving post-stabilization services at a nonparticipating emergency facility. Therefore, nonparticipating emergency facilities must include in the written notice the good faith estimated amount that the participant, beneficiary, or enrollee may be charged for items or services furnished by the nonparticipating emergency facility or by nonparticipating providers with respect to the visit at

such facility (including any item or service that is reasonably expected to be furnished by the nonparticipating emergency facility or nonparticipating providers in conjunction with such items or services). HHS seeks comment regarding potential challenges nonparticipating emergency facilities may have *in coordinating the development of a good faith estimate on behalf of both the facility and providers.*

This language suggests that the out-of-network *facility* is responsible for coordinating the delivery of the standard notice on behalf of out-of-network providers working in said facility, regardless of employment status. The departments also write (emphasis added): “To the extent that the nonparticipating facility omits from the good faith estimate information about items and services provided by a nonparticipating provider, the notice and consent criteria *will be not be considered met for items and services furnished by that provider*, and the requirements in 45 CFR 149.410(a) (and the corresponding requirements on plans and issuers) would apply.”

Across these two excerpts, the departments appear to acknowledge the difficulty facilities (i.e., hospitals) may have in gathering and ensuring the accuracy of good faith estimates on behalf of out-of-network providers. Such difficulty is exacerbated in circumstances where the out-of-network providers are also not employed by the facility, with billing procedures operating completely outside of the facility’s billing department. Many Illinois hospitals do not employ the majority of hospital-based providers directly. According to the American Hospital Association’s 2019 Annual Survey, 82% of Illinois hospitals that submitted data employ less than half of their hospital-based physicians. In such situations, hospitals will have to coordinate with external entities to obtain the information necessary for the notice and consent. Illinois providers often cite communication difficulties with payers, and making facilities responsible for facilitating the notice and consent process on behalf of out-of-network providers will undoubtedly cause delays and confusion. **Therefore, we ask the departments to amend this provision and require all out-of-network facilities and providers to be responsible for their own notice and consent processes. Facilities should not be responsible for creating, distributing, and ensuring the accuracy of notice and consent documents on behalf of non-employed, out-of-network providers.**

If the departments do in fact intend for facilities to govern the notice and consent process on behalf of all out-of-network providers, we believe this additional administrative burden is inappropriate. It is unlikely that a facility will have immediate access to information necessary to provide patients with a good faith estimate of the costs of an out-of-network provider if that provider is not employed by the facility. Facilities will need time to change workflow processes, establish communication between facility and non-employed provider billing departments to produce good faith estimates, and technical assistance when troubleshooting the myriad unexpected issues that may arise when first implementing the notice and consent process. **We appreciate that the process of providing insured patients with a good faith estimate has yet to go through the notice and comment rulemaking process, and that the departments have delayed enforcement of this requirement until that rulemaking process is complete. However, the departments have not announced an enforcement delay regarding provision of**

the notice and securing the patient's consent to balance bill. Holding facilities responsible for this process beginning Jan. 1, 2022 is inappropriate given the delayed enforcement of providing good faith estimates, and we urge the departments to delay enforcement of this requirement until they issue additional guidance on responsibilities.

We also suggest the departments consider outlining a policy that mirrors the special rule to prevent unnecessary duplication with respect to the disclosure of patient protections under the NSA and applicable state laws. Under this special rule, the departments allow facilities to provide the disclosure on behalf of providers to the extent that the provider furnishes an item or service covered under the plan or coverage at a healthcare facility. Both the facility and the provider must agree to this arrangement via an amended existing contract or a new written agreement specifically outlining the disclosure requirements regarding balance-billing protections. We suggest the departments develop a similar special rule for the standard notice and consent process. Certainly, many facilities and providers may enter into such agreements, particularly because it will be easier to coordinate documentation requirements for the patient. However, facilities that provide admitting privileges to independent providers should have the choice of declining to take responsibility for ensuring compliance with notice and consent requirements on behalf of those providers.

Notice and Consent for Same-Day Services

We are also concerned about the timing requirements for the standard notice and consent documents. Specifically, the timing requirements for same-day scheduled appointments pose logistical problems and could endanger the patient. Presumably, providers schedule an item or service for the same day because provision of the item or service is relatively urgent (though perhaps not emergent). The departments require providers to furnish the standard notice and consent to patients three hours before the appointment. The intent behind this requirement is to allow the patient enough time to consent to a balance bill without feeling coerced by the provider or facility.

Considering the notice must include a variety of situationally-specific modifications including a good faith estimate of costs and a description of potential care management limitations, it is reasonable to assume that creating the standard notice and consent will take significant time. In particular, if the facility is required to produce a good faith estimate on behalf of non-employed providers, producing the appropriate information could take several hours. Thus, it would be nearly impossible for a facility to provide a compliant standard notice and consent in the required timeframe for same-day scheduled appointments. The policy as written will ultimately prevent out-of-network providers from obtaining consent to balance bill, forcing them to enter into negotiations and arbitration/IDR for post-stabilization services in particular. This will be particularly burdensome for out-of-network emergency facilities that may be best situated to provide post-stabilization services.

Additionally, the required same-day notice and consent timeline may result in lower quality care for patients. While not emergent, there are situations where providing non-urgent items or services as quickly as possible could lead to better patient outcomes. For example, there

may be situations where a patient requires an outpatient drug infusion post-stabilization. While the patient may meet the transfer criteria outlined in this IFC, it is often advantageous for patients to receive drug infusion therapy as soon as possible. Should this patient be seeking care in a remote area, transfer may simply not be the patient's preferred choice, and in fact the patient may want to obtain the drug infusion prior to completion of the three-hour required wait time. Additionally, there may be instances where a patient's condition deteriorates during the required three-hour wait time. **Thus, we urge the departments to reconsider the same day notice and consent timeframe. At the very least, we ask the departments to make exceptions in cases where the patient unexpectedly deteriorates, and also to allow patients to opt out of the three-hour waiting requirement.**

In-Network Providers

A required element of the standard notice is the provision of a list of in-network providers at the in-network facility that would be able to provide the scheduled item or service. Payers are in the best position to provide updated lists of providers participating in a given plan network. As acknowledged by the departments and Congress, payers are notoriously bad at keeping provider directories current. For example, a 2018 CMS study found that 52% of physician listings in Medicare Advantage provider directories contained at least one inaccuracy, including omission of in-network providers.⁶ Thus, it does not make sense for the departments to require providers to furnish a list of in-network providers as part of the notice and consent process. **IHA urges the departments to modify the notice and consent requirements with standard language on the notice document, directing patients to their health plan for a list of alternative providers that participate in their plan's network.**

Providing the Notice and Consent in the 15 Most Common Languages

IHA agrees with the departments that patients should receive the notice and consent documents in the language they are most comfortable reading or hearing. Thus, we agree with the requirement for these documents to be provided in the 15 most common languages spoken in the geographic location of the provider. **We request that the departments assist with this requirement by making the standard notice and consent documents available to providers in the 15 most common languages spoken nationwide.** Providing such documentation will go a long way in alleviating upfront administrative burden, and better ensure that translations of the standard notice and consent are accurate.

Provider-Payer Communication

The departments require providers to alert payers when a service is protected from balance billing, and when a patient consents to being balance billed for items or services furnished by an out-of-network provider. These communication responsibilities present administrative burdens for providers including significant changes in information systems, patient processes, staffing and provider management. Payers will also experience some administrative burden, as

⁶<https://www.commonwealthfund.org/publications/journal-article/2019/jun/improving-accuracy-health-plan-provider-directories>

they too will have to adapt to receive and appropriately act on this information. Therefore, **we once again request the departments delay enforcement of these communications beyond Jan. 1, 2022, and to provide education and technical assistance in the several months following implementation. Additionally, we encourage the departments to adopt a standard electronic process to ensure consistency and minimize the burden of alternate forms of communication and document transmission.**

Document Retention Policy

The departments require providers to retain standard notice and consent documents for at least seven years. Presumably, this requirement is to ensure providers have the documentation necessary should they be the subject of a compliance audit.

Additionally, the departments declined to enact a statute of limitations for complaints of noncompliance against providers or payers. In other words, under the current rule a patient could allege noncompliance against a payer or provider decades after the item or service in question. **IHA requests the departments revise this policy, implementing a statute of limitations on noncompliance complaints that aligns with the seven-year document retention policy.** Failing to do so will either result in providers retaining records indefinitely, or inefficient audits where stakeholders are unable produce the necessary documentation to resolve disputes. It is unreasonable for providers to be expected to retain notice and consent documents indefinitely, and we urge the departments to outline a defined statute of limitations for the complaint process.

Health Plans with Out-of-Network Coverage

IHA appreciates that the NSA applies to a wide range of payers. We also recognize that many health plans include out-of-network coverage. It is our interpretation that when a plan provides out-of-network coverage, the plan's terms supersede the NSA. In other words, patients would not be limited to in-network cost sharing for NSA-covered services; rather, the patient would have to comply with the out-of-network cost-sharing amount stipulated by their plan. **IHA requests the departments provide specific guidance on how providers and payers should treat health plans with out-of-network coverage to avoid future confusion and potentially inappropriate complaints regarding perceived surprise medical bills.**

Additionally, IHA asks the departments to issue guidance on whether providers must provide a notice and consent to patients seeking items or services from out-of-network providers at in-network facilities if their health plan includes out-of-network coverage provisions.

Payer Loopholes

IHA appreciates that the departments utilized this IFC to reiterate requirements under the Prudent Layperson Standard established by the Affordable Care Act (ACA). Specifically, the IFC discusses recent actions by some commercial payers to restrict coverage for emergency services. The departments unequivocally state that such policies are inconsistent with the requirements of the No Surprises Act as well as the Prudent Layperson Standard, and payers cannot require prior authorization for emergency services, nor can they limit coverage for emergency services to certain diagnosis codes.

Unfortunately, payers continue to find and exploit loopholes to evade the surprise billing protections afforded under the NSA.⁷ For example, UnitedHealthcare (UHC) recently changed outpatient diagnostic laboratory services from a “network” to “designated” benefit for its fully insured small and large group health plans. Outpatient diagnostic lab tests will be denied as non-covered when performed by an in-network freestanding or outpatient hospital laboratory that is not enrolled in UHC’s Designated Diagnostic Provider (DDP) program, with the patient held responsible for payment in full. Fundamentally, UHC is attempting to alter the concept of a network plan by carving out specific services from network coverage. In addition to misleading patients, this policy effectively circumvents NSA protections by creating a new form of surprise billing for in-network care. We anticipate that diagnostic laboratory services are the first of many such service-specific carve outs as UHC already announced plans to add major imaging services in 2022.⁸ **IHA urges the departments to produce guidance speaking to how the NSA interacts with payer practices such as DPP networks.**

NSA Oversight

The departments state that they will rely on existing state and federal oversight bodies and mechanisms to ensure payer and provider compliance with NSA requirements, a plan that deeply concerns IHA and our members. Almost every process required by the NSA necessitates timely and thorough cooperation from payers. We appreciate that the departments plan to address several payer-specific NSA requirements in future notice and comment rulemaking. **We strongly urge the departments to ensure there are tight guardrails for all stakeholders involved in this process, particularly payers.** Existing oversight mechanisms have already exposed numerous issues regarding private payer compliance with coverage requirements. These same mechanisms struggle to enforce future compliance or corrective actions. For example, a 2018 study conducted by the Office of Inspector General, Office of Evaluation and Inspections (OEI) found that Medicare Advantage Organizations overturned 75% of their own denials when beneficiaries and providers appealed preauthorization and payment denials.⁹ As

⁷ <https://www.uhcprovider.com/content/dam/provider/docs/public/reports/dpp/designated-diagnostic-provider-outpatient-lab-services-FAQ.pdf> (Revised August 16, 2021)

⁸ <https://www.uhcprovider.com/content/dam/provider/docs/public/reports/dpp/designated-diagnostic-provider-major-imaging-services-faq.pdf> (Revised July 15, 2021)

⁹ <https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp>

stated by OEI, this finding is especially concerning because beneficiaries and providers rarely use the appeals process, suggesting that a large number of inappropriate prior authorization and payment denials are never addressed.

The NSA introduces additional payer requirements that existing oversight mechanisms may not be positioned to oversee in a timely manner. For example, payers are required to provide the initial payment amount within 30 days of receiving a clean claim. However, in Illinois, our members often experience extreme delays in claims adjudications with private payers. The typical claim adjudication timeline cited by our members is 30-45 days, with members indicating they do not consider a payment to be “late” unless it has been more than 45 days since the claim was sent. Thus, it is not typical for payers to provide payment in the timeframe required by this IFC. Considering the importance of the NSA and how burdened our state and federal oversight bodies already are, it seems unreasonable to assume these entities can oversee and enforce the NSA with status quo resources.

IHA strongly urges the departments to reconsider their reliance on existing oversight mechanisms and entities in overseeing and enforcing NSA requirements. There are simply too many new processes and requirements for both providers and payers for existing state and federal oversight bodies to take on, particularly as we know all stakeholders will have a steep learning curve over the next several months and years to fully comply with NSA requirements.

Ms. Bodenheimer, Mr. O’Donnell, Mr. Becerra, Mr. Khawar and Mr. Mazur, thank you again for the opportunity to comment on the first of several rules implementing the No Surprises Act. Please direct questions or [comments to IHA](#).

Sincerely,

A.J. Wilhelmi,
President & CEO
Illinois Health and Hospital Association