NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

September 7, 2021

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9909-IFC
P.O. Box 8016
Baltimore, MD 21244-8016.

Via Regulations.gov

To Whom It May Concern:

The National Association of Insurance Commissioners (NAIC) submits the following comments on the *Requirements Related to Surprise Billing; Part I*, as published in the *Federal Register* on July 13, 2021. The NAIC represents the chief insurance regulators in the 50 states, the District of Columbia, and the United States territories and we submit these comments on behalf of our members.

Definitions

Definition of Covered Item or Service

We recommend the Departments amend the rule to specify a definition for "covered item or service." Such a definition would complement the existing definitions of "nonparticipating provider" and "visit" to clarify that consumers are not subject to balance bills if a plan or issuer uses provider type or network classification to define an item or service as not covered. Ideally, the definition of "covered item or service" would clarify that if an item or service is covered for in-network providers, it is considered a covered item or service. There is a history of litigation over the definition of "covered services" in other contexts. See, for example, *Iowa Dental Ass'n v. Iowa Ins. Div*. 831 N.W.2d 138 (Iowa 2013). The definition of "covered item or service" should be resolved by regulation to avoid anticipated disputes.

Balance billing protections apply to covered items and services delivered by nonparticipating providers at participating health care facilities. Nonparticipating providers are defined by the lack of a direct or indirect contractual relationship with a plan or issuer. State regulators are concerned that consumers may lack protections

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if a plan or issuer has a contract with a provider or facility, but that contract or the insured's policy specifies that some items or services offered by the provider or facility are not covered services, even if the plan or issuer would cover the same items or services provided by another provider who is in-network or in a different network tier. For example, an issuer could establish a contract with a participating hospital or a policy that defines the services provided by the hospital's laboratory as not covered services. Because they are not covered services, a consumer may face a surprise bill from laboratory services at this participating facility. State regulators also see a possibility of exclusions in the policies issued to insureds as a possible source for an insurer's argument that the item or service is excluded when provided by this type of provider, and therefore, the item or service is not "covered."

The Interim Final Rule's definition of "visit" to include "equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is at the facility" will help to ameliorate this concern in some instances. However, the visit definition seems intended to address differences in coverage due to the location services are performed, not due to the network status or tier of the provider. We urge the Departments to adopt a definition of covered items or services that defines them as the health care items and services that would be covered under the terms of the plan or coverage without regard to a provider's network tier or whether the provider is a participating provider. This would help ensure that plans and issuers do not avoid the designation of a nonparticipating provider, and thus balance billing protections, through policy or contract terms.

Definition of Participating Health Care Facilities

State regulators support including single-case agreements in the definition of participating health care facilities. This definition will allow providers and facilities to informally negotiate payment services with out-of-network carriers. However, we recommend that the definition of single-case agreement applies only to out-of-network services with prior authorization. If this provision applies retrospectively to out-of-network services without prior authorization, it will create parallel and potentially unequal systems for resolving surprise medical bills. A provider could choose to either seek a single-case agreement or negotiate and resolve disputes under the terms of the No Surprises Act (NSA). Any single case agreements executed after a service is provided may serve as a disincentive to network participation by

providers who feel they can get a better deal negotiating single case agreements than accepting surprise billing reimbursement rates or joining an insurer's network.

Definition of Non-Participating Providers

State regulators request that the Departments clarify that a provider in a network tier or classification more costly to the consumer than that of the facility (whether emergency or non-emergency) in which the provider operates is a "nonparticipating provider" for purposes of the NSA. State regulators have seen surprise balance billing situations where providers, who may be participating providers but are in a different network tier than the facilities in which the providers operate, bill consumers at a rate far in excess of what the consumers would pay for a provider whose network tier matched that of the facility. To allow such a surprise balance bill would effectively allow providers to defeat the clear intent of the NSA. State regulators do not believe providers who contract with issuers at higher tier "network" rates should retain their ability to balance bill unsuspecting consumers without complying with the notice and consent procedures laid out in the NSA and the Interim Final Rule. Defining higher tier providers as participating providers would result in far less protection for consumers than if those providers had no contract at all and were defined as nonparticipating providers. Altering the definition of nonparticipating provider to be inclusive of providers in less favorable tiers than their facilities would help ensure that plans, issuers, and providers do not circumvent the designation of a nonparticipating provider, and thus balance billing protections, through contract terms.

State regulators support the definition of ancillary services as including physician and non-physician services. We suggest explicitly clarifying that these services include psychiatry and psychology services. Some states have received consumer complaints about out-of-network behavioral health care received by hospitalized patients. A treating provider may suggest a psychological consultation for a consumer who is hospitalized, either after emergency stabilization or for a planned procedure. Consumers in need of such services may not be in the best position to fully understand a request to waive their balance billing protections – even if the "3-hour prior" standard is met.

Definition of Emergency Facility

State regulators request that urgent care centers be considered for inclusion as an emergency facility. A consumer's choice to use an urgent care center should not expose them to balance bills given the prudent layperson standard. Further, health plan benefit designs may incentivize the use of urgent care centers as an alternative to emergency departments. From a consumer perspective, two consumers could have the same symptoms that would meet the prudent layperson standard. The consumer who went to a hospital ED would be protected from balance bills, but the other consumer who went to an urgent care clinic because their cost-sharing might be substantially lower would not be.

Also, in some states, "urgent care clinics" and other retail clinics are not licensed as such. Instead, the practitioners providing services in those facilities are licensed. State regulators and other stakeholders would benefit from guidance as to how those facilities would be identified by the states if the Departments choose to include those facilities as emergency facilities.

Definitions of Emergency Medicine

State regulators request that the Departments clarify whether the listing of "emergency medicine" as a possible non-emergency ancillary service means that any health care service rendered by a physician or other health care professional at an emergency department or emergency facility would be considered "emergency medicine" for purposes of the No Surprises Act (NSA). If that is not the case, then we request that the Departments clarify what the term "emergency medicine" means when it is provided as a non-emergency ancillary service.

Emergency Care

State regulators support the language in the Interim Final Rule which makes it clear that carriers should not determine whether services constitute an emergency solely based on the resulting diagnosis code. The eventual diagnosis code may not reflect the justifiable reason the covered person sought emergency care. The rule's explicit inclusion of this provision will ensure consumers are protected against second guessing by insurance carriers of their reasonable decision to seek emergency care.

Also, we support the statement that emergency services performed outside of the emergency department to stabilize the patient are included in the NSA's protections.

Air Ambulance

State regulators generally support the definitions in the Interim Final Rule related to air ambulances services. We request that future regulations on enforcement consider and respond to the ways that federal law both empowers and limits state authority over providers of air ambulance services.

We support the Interim Final Rule's approach of considering all providers of air ambulance services to be a single provider specialty. This will allow consumer cost sharing based on the qualifying payment amount to reflect a broad-based median, rather than potentially higher costs if the median were calculated separately across different types of air ambulance providers. The intent of the NSA is to limit cost-sharing when consumers cannot reasonably choose their providers. Consumers have no choice of air ambulance provider and should not face higher cost-sharing amounts due to being transported by one type of air ambulance provider rather than another. Providers who can justify payments higher than the median across all air ambulance services in the relevant geographic region can present evidence for the appropriateness of their costs in negotiation with plans and issuers or to independent dispute resolution entities.

Air ambulance services raise unique issues regarding payment and balance billing, so we appreciate the special attention the Departments gave to air ambulance issues in the Interim Final Rule. One important consideration that complicates the regulation of air ambulances services is the interaction of the NSA with the Airline Deregulation Act. We encourage the Departments to use coming regulations to provide further definition to the enforcement authority Congress identified for states in Section 2799B-4 of the Public Health Service Act:

> *Each State may require a provider or health care facility (including a provider of air ambulance services) subject to the requirements of this part to satisfy such requirements*

Careful definition of this authority is needed due to the limits on state authority resulting from judicial interpretations of the Airline Deregulation Act. By explicitly

referencing providers of air ambulance services, Congress clearly intended states' enforcement authority to extend to them. We therefore ask that the Departments outline in regulation the ways that states may enforce the provisions of the NSA on providers of air ambulance services without violating the preemption provisions of the Airline Deregulation Act. We suggest that regulations specify that any enforcement action taken under the relevant part of the Public Health Service Act would not be considered to relate to the rates, routes, or services of air carriers. We hope to engage with the Departments as they develop enforcement regulations that uphold all applicable federal laws while protecting consumers.

Geographic Regions

State insurance regulators recognize that the Departments considered NAIC's input in setting the definition of geographic region for the purposes of calculating the qualifying payment amount. The Departments cite the large number of rating areas in some states as the reason not to establish individual and small group market rating areas as the applicable geographic regions. While recognizing the Departments' authority to define geographic regions, we reiterate our request for state flexibility in this area. States may wish to propose alternative regions to align the geographic regions used under state balance billing laws with those used for determining cost-sharing and resolving payment disputes under the NSA. Such alignment could reduce the complexity for plans and issuers in ensuring their payments meet the requirements of both state and federal law. We ask the Departments to establish a process by which states may propose alternative geographic regions for use in their states. The Departments would review state proposals and allow an alternative set of regions proposed by a state if they find the state's proposal would not lead to unreasonable burden for issuers or to qualifying payment amounts being biased by outliers.

Enforcement Assistance

States' experience and authority with respect to balance billing protections varies—many states are implementing their own laws to prevent balance bills while others do not have experience in this area. We appreciate the Departments' engagement with states and efforts to gather individualized information about each state's laws, regulations, and capacity for enforcement.

To effectively enforce the NSA, all states will need assistance from federal sources, though the level of needed assistance will vary from state to state. Appropriate assistance can take the form of clear and comprehensive guidance; access to federal data; templates for consumer, provider, and payer education materials; and financial resources, among others. We urge the Departments to make all these types of assistance available to states. In particular, grants to support state investments in personnel and information technology will be most needed as states take on new responsibilities under the NSA. We urge the Departments to identify funding that can be used for this purpose and establish grants for states.

Clarity on Preservation of State Laws

The NSA appropriately defers to state law in a number of ways and the Interim Final Rule generally takes a reasonable implementation approach in allowing the continued application of state laws when they do not prevent the application of federal law. Nonetheless, greater clarification is needed so that states and other stakeholders can understand how state laws will be judged "more protective of consumers," particularly in the context of consumers' opportunity to waive balance billing protections and related disclosures.

The Interim Final Rule's preamble discusses the possibility of more protective state laws, provides one example of laws that prohibit consumer consent for balance billing, and states that providers and facilities are exempt from required disclosures of inapplicable provisions. To operationalize these provisions and the rule text that allows consent for balance billing "unless prohibited by State law," states and other stakeholders need to better understand which state laws take precedence over the federal requirements in this area. Covered providers and facilities may be unaware that a state law has been deemed more protective or to which enrollees the state law applies. We urge the Departments to analyze state laws, collaboratively with states, and to publish a list of state laws that are more protective of consumers. The Departments should also make available resources to increase stakeholders' awareness of how to identify enrollees protected by state law since some enrollees in a state may be covered by a more-protective state law while others are not, depending on how the plan or insurance coverage of the enrollee is regulated.

Complaints

State regulators support the extension of the complaints process beyond issues relating to the qualifying payment amount and to providers and facilities in addition to plans and issuers. There is great value to consumers and other stakeholders in having a single system for taking complaints when many different agencies at the state and federal level may have some authority over the payers, providers, and facilities involved in a transaction.

State insurance regulators request that state authorities be integrated into the complaint processing, investigation, and enforcement system to the greatest degree possible. Because states will be the primary enforcers of NSA provisions, many complaints are likely to be referred to states. If states are involved in the processing of complaints received by HHS, state officials will be less likely to need to start the investigation process over when they receive a referral. To avoid states requesting information consumers have already submitted or repeating investigatory steps already performed by federal officials, states should have full access to the federal complaint system. We further anticipate that many complaints will involve the intersection and applicability of state and federal provisions, so establishing a system through which state and federal officials can investigate cases together will facilitate timely and appropriate resolution.

However, state regulators have raised some timing concerns. The Interim Final Rule says CMS will acknowledge receipt of a surprise medical billing complaint to a consumer within 60 days. In this acknowledgement, it will include next steps such as whether the complaint was filed with the wrong department or needs to be dealt with at the state level. This is a long period of time to allow a consumer to wait and wonder about next steps. This wait time invites potentially unnecessary worry on consumers about the state of their medical bills. State regulators recommend instituting a quicker initial review for jurisdiction to curb this wait time.

Notice of Consent to Waive Protections

State regulators appreciate the effort that the agencies went to ensure that consumers knowingly and purposefully make a choice on waiving their rights to balance billing protections. However, some concerns remain.

The IFR allows a provider to refuse to treat a patient if the patient is not willing to waive their rights to be protected from balance billing (see pp. 126-127 of the IFR). For some services, especially those of a primary surgeon for a specialized procedure where there is a limited number of surgeons who can provide the service, consumers are essentially forced to choose between receiving what they perceive to be the highest quality care and having balance billing protections. This is an untenable position to put a consumer in, especially when they're choosing care for a child or family member.

Given the difficult decision that consumers need to make regarding waivers of their rights, the notice should be provided to consumers within 72 hours of *scheduling* the procedure, rather than *receiving* the procedure. A surgery could be scheduled weeks, if not months in advance. Allowing a provider to wait until three days prior to the procedure puts the consumer in the very difficult position of having to decide whether they should restart the whole process with a different provider, potentially resulting in weeks or months of delays in receipt of care.

The NAIC has been engaged in efforts to address equity in access to care and coverage. While we appreciate the IFR's requirement that the consumer notice/consent form must be available in the top 15 languages and that interpreters be available in some circumstances (see pp. 138-140), we are concerned about only requiring a qualified interpreter after a self-report of limited understanding by an individual who speaks one of the 15 most common languages. Given the complexity of the information contained in the notice, it would seem that almost any individual, regardless of their proficiency in English, would have questions prior to consenting to be balance billed. Thus, any consumer who desires an interpreter should have access to one.

From a regulator's perspective, the entity enforcing these provisions would find it extremely difficult to assess the facts surrounding a consumer's waiver of their rights, i.e., was there pressure applied or were interpreter services appropriately offered/available?

Disclosure Requirements

With respect to the timing of disclosure to individuals of their balance billing protections, the notice must be provided at a meaningful time to consumers. While receiving the notice at the time the facility or provider requests payment from the

individual is important, it also is critical that the consumer be aware of their balance billing protections at the time they schedule a non-emergency procedure/appointment or very soon following their receipt of emergency services. Having this information up front, and then reinforcing it when the consumer actually receives a bill, will provide multiple opportunities for consumers to assess whether they will be or have been properly billed.

Thank you for considering these comments and for your continued engagement with state insurance regulators as the Departments work to implement the No Surprises Act.

Sincerely,

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