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U.S. House of Representatives

COMMITTEE ON WAYS AND MEANS
1139 LONGWORTH HOUSE OFFICE BUILDING
Washington, DC 20515

November 9, 2023

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

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

The Honorable Julie Su
Acting Secretary
U.S. Department of Labor
200 Constitution Ave NW
Washington, DC 20010

Dear Secretary Becerra, Secretary Yellen, and Acting Secretary Su:

We write to express serious concerns regarding the Departments of Health and Human Services, Treasury, and Labor's (the Departments) past and present efforts to implement the bipartisan *No Surprises Act*, passed into law as part of the *Consolidated Appropriations Act of 2021 (P.L. 116-260)*.

It is unacceptable that the Administration is straying from the clear letter of the law and intent of Congress, and further, failing to implement key pieces of the legislation altogether. On September 19, 2023, the Committee on Ways and Means held a hearing on the bill's implementation and heard frustrations from stakeholders across the health care delivery system about how the Departments' actions have plagued the foundation of a meaningful patient protection. Additionally, on October 18, 2023, representatives from the Departments briefed members of the Ways and Means Committee during a bipartisan roundtable where those frustrations were directly relayed and Committee members requested swift action to fully comply with the statutory language and clear Congressional intent as the Departments rework the flawed rulemaking.

In developing this critical bipartisan patient protection, Congress deliberately chose to initiate an arbitration process which was carefully constructed to balance the interests of the health plans and medical providers involved in the disputes. The *No Surprises Act* language intentionally requires arbiters to consider the unique circumstances of each billing dispute by reviewing an explicit series of considerations with no single factor to be weighed more than any other.[1] The statute explicitly lists factors for determinations without emphasis on any specific one factor:

[1] Internal Revenue Code section 9816(c)(5)(C), Employee Retirement Income Security Act section 716(c)(5)(C), and Public Health Service Act section 2799A-1(c)(5)(C), as added by Section 103 of the No Surprises Act, Title I of Division BB of the Consolidated Appropriations Act of 2021

(C) Considerations in determination.-- (i) In general.--In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR item or service shall consider—
(I) the qualifying payment amounts (as defined in subsection (a)(3)(E)) for the applicable year for items or services that are comparable to the qualified IDR item or service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR item or service; and
(II) subject to subparagraph (D), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(ii).
(ii) Additional circumstances.--For purposes of clause (i)(II), the circumstances described in this clause are, with respect to a qualified IDR item or service of a nonparticipating provider, nonparticipating emergency facility, or group health plan, the following:
(I) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act).
(II) The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided.
(III) The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual.
(IV) The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service.
(V) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

The statutory text of the law is unambiguous – despite that, the Departments failed to implement a final rule that accurately reflects the law and this inconsistency has been proven in court four times where the Departments have lost each lawsuit.[2] While we are glad the Judiciary is upholding its duties, American patients and our greater health care system should not need to rely on Federal courts to litigate what their elected representatives unquestionably wrote into law.

At our hearing, we heard specific examples of how these implementation flaws are harming patients and impacting medical providers, independent dispute resolution (IDR) entities, and health insurers. First, despite the most stringent efforts by Congress to hold them harmless, patients are still vulnerable to surprise bills. It has come to our attention that some patients are receiving the balance of a claim after a party loses an IDR. The Departments must enforce the patient protections established by Congress:

(ii) the cost-sharing requirement is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility.

The biased interpretation of the qualified payment amount (QPA) has created serious consequences for medical providers of all sizes. Small medical practices in rural and underserved communities that had been in-network with health insurers are now receiving network cancellations. Even larger providers, like hospitals, are suffering similar consequences from the downward pressure of reduced reimbursement from the skewed QPA. Worse yet, challenges when grouping IDR claims, the growing backlog of cases, and cases in which large health insurers fail to pay medical providers any amount after arbitration combine to place a significant financial burden on medical providers, forcing them to reduce available

[2] https://www.beckershospitalreview.com/finance/lawsuits-and-logjams-a-no-surprises-act-timeline.html

staff and services for patients. We ask that the Departments use their existing authority to enforce these important provisions.[3]

Simultaneously, IDR entities must adjust to multiple freezes of processing IDR cases, worsening the backlog. While many IDR entities have been settling disputes within the 30-day window provided to them under statute, the constant stop-and-go directives from the Departments due to courtroom losses and reworked guidance strains their ability to appropriately maintain staff and expertise to settle claims on behalf of medical providers and health insurers.

The unbalanced process created by Department rulemaking has fueled an astronomical amount of claims being sent to IDR. If the policy is implemented in line with the law and Congressional intent of the *No Surprises Act*, health insurers will be encouraged to expand their provider networks, increasing access to care for patients, and the "open negotiation" period will allow medical providers and health insurers to confidently resolve disputes and only require IDR as a last resort.

Furthermore, despite the statutory deadline of January 1, 2022, the Departments have not initiated rulemaking for the Advanced Explanation of Benefits (AEOB), an important advancement in patient price transparency.[4] The AEOB is a key pillar of transparency for patients to have an understanding of costs and plan requirements prior to receiving health care services. Specifically, health insurance plans are required to provide patients with an estimated price for a scheduled medical procedure within one business day (or three business days if the procedure is scheduled more than 10 days in advance). Patients deserve to know what their health care will cost before receiving care, and it is unconscionable to further delay this protection.

We are glad that millions of Americans have been protected from surprise medical bills, but we remain disappointed with the outstanding challenges that face all aspects of our health care system. We cannot emphasize strongly enough the depths of the Departments' failure to implement the *No Surprises Act* as written in statute and as Congress intended. We ask that you swiftly revisit the final rule, ensure that it aligns with the law as written, and take immediate steps to make the law's transparency provisions a reality for patients.

Sincerely,

Jason Smith
Chairman
Committee on Ways and Means

Vern Buchanan
Member of Congress

[3] Section 2723 of the Public Health Service Act, Sections 502 and 204 of the Employee Retirement Income Security Act of 1974, and Section 4980D of the Internal Revenue Code

[4] Internal Revenue Code section 9816(f), Employee Retirement Income Security Act section 716(f), and Public Health Service Act section 2799A-1(f), as added by Section 111 of the No Surprises Act, Title I of Division BB of the Consolidated Appropriations Act of 2021.

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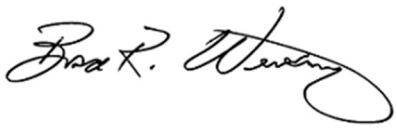

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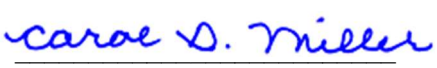

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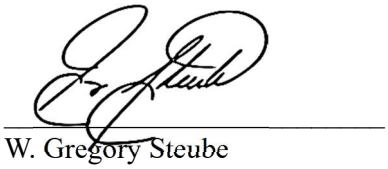

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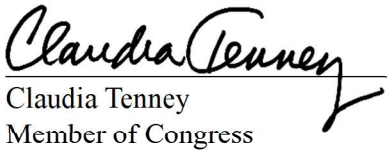

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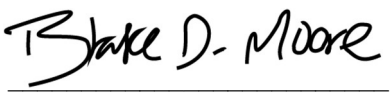

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