November 17, 2021

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

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

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

Re: Concerns with Interim Final Rule Requirements Related to Surprise Billing: Part II implementing the No Surprises Act (NSA)

Dear Secretaries, Becerra, Walsh, and Yellen:

On behalf of the undersigned organizations representing physicians across the country, we write to urge you to reconsider the requirements in the Interim Final Rule (IFR), entitled "Requirements Related to Surprise Billing; Part II," 86 Fed. Reg. 55,980 (Oct. 7, 2021), implementing the No Surprises Act (NSA) that directs Independent Dispute Resolution (IDR) entities to consider the qualifying payment amount (QPA) a rebuttable presumptive reasonable payment for out-of-network physicians engaging in the IDR process and, in turn, places a thumb on the scale in favor of health insurers in contract negotiations.

The American Medical Association, state medical associations, and national medical specialty societies strongly support protecting patients from surprise medical bills and continue to support the patient protections in the NSA that do just that. To be clear, our request is not to unravel the NSA or delay implementation of any of its patient protections. Instead, **we ask that you revise the most recent IFR to conform with the NSA's statutory language to allow an IDR entity the discretion to consider all the relevant information submitted by the parties to determine a fair out-of-network payment to physicians, without creating a rebuttable presumption that directs an IDR entity to consider the offer closest to the QPA as the appropriate payment amount.**

With patients protected, we acknowledge that our concerns are now centered on ensuring fair payments to physicians and a balanced IDR process. This is, of course, relevant at an individual physician level, as physicians should be able to negotiate reasonable payment for their services. But more importantly, a skewed IDR process that restricts physicians' ability to make their case for a reasonable out-of-network payment removes a critical remaining incentive for insurers to negotiate fair contracts with physicians.

As the NSA is implemented, a remaining force pushing health insurers to negotiate with physicians—the demands of patients and employers for in-network care—is being significantly reduced. While we strongly support removing patients from the middle, we also appreciate that Congress recognized an additional check on health plans was needed to replace this market force—a meaningful IDR process. While none of our organizations anticipated a high volume of claims going all the way through the dispute process to IDR when the NSA was enacted, we knew that the possibility of a physician successfully making the case for a fair out-of-network payment to an IDR entity could help influence a health insurer to come to the negotiating table in the first place, offer a reasonable initial payment when a surprise bill happens, and settle most disputes in the open negotiations process.

But, in implementing the IDR process in a way that essentially predetermines the outcome to be at the 50th percentile of contract rates, that important check on negotiating incentives established by Congress has largely been stripped away.

We agree with the analysis that *insurers* will likely pay many in-network physicians much less in the coming years as they negotiate contracts (and renegotiate current contracts) under the QPA's ceiling. Whether that will translate to a reduction in health care premiums for patients is not known, but it is certain to put an additional financial strain on many independent practices that are working to make ends meet and pay their staff, many just regaining their footing lost over the last 18 months due to the pandemic. While financial strain often forces independent practices to close, others make tough decisions to accept outside funding, join hospital systems, or consolidate with other provider groups. We suggest none of these options necessarily increase access to quality, lower-cost care.

We also anticipate a significant reduction in contracts being offered to many physicians in the coming years, especially those hospital-based physicians targeted by the NSA's surprise billing provisions. Without the existing lack of pressure of network adequacy enforcement, and now the reduced demand for in-network hospital care from patients and employers, insurers are not likely to expand their networks or renew those contracts with payment rates above the QPA. While protections from surprise billing that results from these network inadequacies will shield patients from some of the financial impact, we believe that a long-term reduction in network breadth is not good for patients who still benefit from in-network coverage when it falls outside of the NSA protections. Additionally, meaningful negotiations that lead to contracting create efficiencies in

the health care system including, but not limited to, reduced administrative waste, value-based arrangements, billing efficiencies, and, importantly for this effort, reduced use of the dispute resolution process including the IDR process.

In conclusion, we believe that the NSA was drafted in a purposeful way to meaningfully protect patients from surprise billing while ensuring important checks and balances on the provider-insurer contracting process. We urge you to correct the IFR's deviation from that congressional balance and issue a final rule that does not include a rebuttable presumption that directs an IDR entity to consider the offer closest to the QPA as the appropriate payment amount, and confirms that an IDR entity has the discretion to consider all the relevant information submitted by the parties, as provided in the statute, to determine a fair out-of-network payment to physicians.

Thank you for your consideration,

American Medical Association
AMDA – The Society for PALTC Medicine
American Academy of Allergy, Asthma & Immunology
American Academy of Dermatology Association
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology- Head and Neck Surgery
American Academy of Physical Medicine & Rehabilitation
American Association of Clinical Endocrinology
American Association of Clinical Urologists
American Association of Neurological Surgeons
American College of Allergy, Asthma and Immunology
American College of Cardiology
American College of Emergency Physicians
American College of Gastroenterology
American College of Obstetricians and Gynecologists
American College of Osteopathic Internists
American College of Osteopathic Surgeons
American College of Radiology
American Gastroenterological Association
American Geriatrics Society
American Medical Group Association
American Orthopaedic Foot & Ankle Society
American Osteopathic Association
American Psychiatric Association

American Society for Clinical Pathology
American Society for Dermatologic Surgery Association
American Society for Gastrointestinal Endoscopy
American Society for Laser Medicine and Surgery
American Society for Surgery of the Hand
American Society of Addiction Medicine
American Society of Anesthesiologists
American Society of Cataract & Refractive Surgery
American Society of Dermatopathology
American Society of Echocardiography
American Society of Hematology
American Society of Neuroradiology
American Urological Association
American Venous Forum
Association for Clinical Oncology
College of American Pathologists
Congress of Neurological Surgeons
International Society for the Advancement of Spine Surgery
Medical Group Management Association
Renal Physicians Association
Society for Vascular Surgery
Society of Interventional Radiology
Society of Thoracic Surgeons
Spine Intervention Society

Medical Association of the State of Alabama
Alaska State Medical Association
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association Inc
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society

Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society
Wyoming Medical Society