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August 31, 2021

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

The Honorable Martin Walsh  
Secretary  
U.S. Department of the 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

***Re: Requirements Related to Surprise Billing, Part 1***

Dear Secretary Becerra, Secretary Walsh, and Secretary Yellen:

The Association of American Medical Colleges (AAMC or the Association) is pleased to submit comments in response to the interim final rule with request for comments entitled, “Requirements Related to Surprise Billing, Part 1” 86 *Fed. Reg.* 36872 (July 13, 2021), issued by the Department of Health and Human Services, the Department of the Treasury, and the Department of Labor (the Departments). We appreciate the effort that went into this interim final rule (IFC) and the Departments’ desire to seek feedback through listening sessions and comment letters. The nation’s teaching hospitals are often the institutions that care for the most vulnerable and medically complex patients through investments in specialized emergency standby services and cutting-edge technologies. The AAMC and our members support safeguards that protect patients from surprise medical bills and promote price transparency. This goal can be achieved while also taking into account the uniqueness of teaching hospitals and their patient populations when implementing the No Surprises Act.<sup>1</sup>

The AAMC is a nonprofit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America’s medical schools and teaching hospitals and the millions of individuals employed across academic medicine, including more than 186,000 full-time faculty members,

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<sup>1</sup> Consolidated Appropriations Act, 2021. (Pub.L. 116-260). Division BB, Title I.

94,000 medical students, 145,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The unique role that teaching hospitals and their associated physicians and other providers play in the provision of healthcare to their communities must be considered when determining network adequacy and median contracted rates regardless of whether these institutions are in the insurer's network. Teaching hospitals are sometimes excluded from insurer networks because their rates may be higher than non-teaching hospitals. These hospitals and their associated providers deliver highly specialized items and services, including subspecialty care, that are often unavailable at other institutions. In many communities, these services, such as trauma centers, burn units, and neonatal services, are only available at teaching hospitals. In addition, academic medical centers have highly trained subspecialty physicians – such as subspecialists in pediatric and oncology medicine – on their staff who are called upon for care by the wider health care community. Further, the patients cared for by these providers may be medically complex and often cannot access needed care elsewhere.

Many AAMC members already have made substantial investments to protect patients from surprise medical bills and promote price transparency, including having dedicated staff to assist patients in navigating the complex health insurance system and educate them as it relates to their benefits and cost-sharing liabilities. Some members have developed online calculators that provide patient-specific cost estimates for scheduled services. Additionally, hospitals are required to have financial assistance programs in place to help patients unable to afford needed care.

Even with these measures in place, there are times when patients receive services from an out-of-network provider. For example, when experiencing an emergency, it is common for individuals to seek care at the nearest facility, which may not be part of the patient's insurance plan's network. As the IFC notes, hospital emergency departments are held to EMTALA<sup>2</sup> standards without regard to a patient's insurance status. Because some individuals are treated by hospitals or providers at hospitals that do not participate in the patient's insurance plan, these patients may receive an unexpected bill for services not covered by their insurance company. This may also be true for patients needing specialized care furnished at select facilities or by certain providers that do not participate in their insurance plan.

Navigating the maze of health insurance coverage can be daunting for patients. Understanding cost-sharing liabilities and network limitations can add to this confusion. In addition, insurance plans that do not provide adequate minimal coverage have been allowed to be marketed and sold. Unfortunately, the general public, when looking for affordable health insurance options, may not always recognize the consequences of these types of plans. Complicating matters are certain health plans, such as short-term, limited-duration plans, that provide inadequate coverage, leaving many consumers exposed to significant out-of-pocket cost sharing. Consumers may be attracted to plans that offer lower premiums without fully understanding that coverage may be

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<sup>2</sup> Emergency Medical Treatment and Labor Act (EMTALA). 42 U.S.C. 1395dd.

inadequate to meet their basic health needs and have limited provider networks. We hope that in the future the Administration will limit the use of short-term limited-duration health plans to protect patients from having inadequate coverage and providers from receiving inadequate payment for services provided to members of these plans.

When consumers enrolled in these plans are faced with a sudden major unexpected illness or injury, they are often surprised and angered to find that their plan does not provide access to specialized care and does not protect them from high medical bills. Under the No Surprises Act, providers, rather than their insurers, will now shoulder the burden to inform patients that their insurance coverage is inadequate. Insurers are best positioned to know a patient's coverage. It should be incumbent upon them to inform the patient about their coverage, or lack thereof, and any patient cost-sharing liabilities. This responsibility should not fall to the provider. Further, requiring insurance plans to provide minimum coverage that includes essential health benefits and meets network adequacy requirements would help to achieve the goal of the No Surprises Act to reduce surprise medical bills. Plan transparency and oversight will be important as the surprise billing regulations are implemented to safeguard patients access to needed medical care and to ensure provider reimbursement is sufficient.

Many states have enacted laws or provided guidance to protect consumers from unexpected health care bills. Additional clarification from the Departments on the interaction of the No Surprises Act and state laws governing surprise medical bills is necessary to bring a clearer understanding of how balance billing laws impact both consumers and providers. For example, the No Surprises Act allows self-insured plans to opt-in or opt-out of state law; many consumers are likely unaware what type of health plan they are enrolled in. Some state laws may have narrower or broader surprise billing requirements. Without sufficient clarity from federal regulators, this patchwork of rules will lead to greater misunderstanding of consumer safeguards and provider requirements.

We continue to be concerned with the tight implementation timelines and urge the Departments to consider delaying implementation to provide sufficient time to implement many of the system changes that both providers and insurers will have to make to allow for a seamless transition. Given the complexity of implementation, we recommend that the implementation date be delayed by one year; alternatively, the enforcement date should be no sooner than January 1, 2023. We appreciate the Departments' acknowledgement of the complexity of developing the technical infrastructure to transmit data – good faith estimates and advanced explanation of benefits – and the decision to delay rulemaking and enforcement of the requirements.<sup>3</sup>

#### **QUALIFYING PAYMENT AMOUNT (QPA) AND MEDIAN CONTRACTED RATE**

The No Surprises Act directs the Departments to establish a methodology for determining the QPA. The QPA is defined as the median contracted rate recognized by the plan or issuer in 2019

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<sup>3</sup> <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf>

for the same or similar item or service that is provided by a provider in the same or similar specialty in a geographic region, increased annually for inflation. As described below, the AAMC believes that there are several factors that should be considered in calculating the median contracted rate.

***The Qualifying Payment Amount and Median Contracted Rate Must Account for the Highly Specialized Care Provided by Teaching Hospitals and Their Associated Providers***

The QPA must account for the role of teaching hospitals and their associated providers in their communities. It is teaching hospitals that furnish specialized care, that treat all patients, and that are essential to maintaining the services that communities expect. Due to these factors and a myriad of others, rates paid to teaching hospitals may be higher than those paid to other providers, but those rates must be taken into account when calculating the median contracted rates that will ultimately determine the QPA. Accounting for these higher payments would align with the legislative requirements for payment determinations under the independent dispute resolution (IDR) process.

Under the IDR, the No Surprises Act directs arbiters to consider a number of factors when making their payment selection such as the level of training, experience, quality and outcomes of the provider; patient acuity; teaching status, case mix, and scope of services of the provider. For teaching hospitals and teaching physicians, rates are likely to be different when compared to community providers due to higher patient complexity, and the infrastructure needed to support the research, education, clinical, and community and global health missions. These teaching hospitals and physicians deliver care to the most complex and vulnerable patient populations, many of whom require highly specialized care which often is not available elsewhere. It is essential plans' payments to providers recognize the important role and value that teaching hospitals play in the health care system and the need for reimbursement to reflect the resources required to provide and maintain these services, including the availability of specialty and subspecialty care.

The level of patient acuity seen at teaching hospitals is higher when compared to other facilities and necessitates teaching hospitals to maintain services that frequently are not available elsewhere. These hospitals are relied upon by their communities to care for a greater number of uninsured and underinsured individuals. Finally, teaching hospitals remain committed to their mission of training the next generation of physicians and allied personnel and must finance a substantial amount of the costs of training from their operating funds. Each of these factors contributes to higher costs. Medicare and many state Medicaid programs have long recognized the need to support teaching hospitals' missions as evidenced by payment adjustments for graduate medical education payments and uncompensated care. These and other payments must be factored into the calculation of the QPA and median contracted rates.

The IFC states that certain payment adjustments to providers – risk sharing or other incentive-based payments – would be excluded when calculating the median contracted rate. (p. 36894). While these payment adjustments may be excluded from the calculation of patient cost-sharing

amounts (*i.e.*, recognized amount), we believe they should be included when calculating the QPA and determining what is ultimately paid to the provider. These adjustments are important factors in contracting and should not be excluded from determining median contracted rates. Providers often accept lower reimbursement rates in exchange for higher volume or additional payments based on quality. Therefore, calculation of the median contracted rates should reflect all forms of reimbursement, not just base payments.

### ***Out-of-Network Rates Should be Factored into the Calculation of the Median Contracted Rate***

The IFC establishes the methodology that plans and issuers must use to calculate the median contracted rate. This includes the contracted rates of all plans of the plan sponsors, or all coverage offered by the issuer in the same insurance market for the same or similar item or service that is provided by a provider in the same or similar specialty or facility in the same geographic region. The IFC notes that “the term ‘contracted rate’ refers only to the rate negotiated with providers and facilities that are contracted to participate in any of the networks.” (p. 36889). As defined in the regulation, the median contracted rate would not include rates paid to nonparticipating providers for similar items and services in the same geographic region. In other words, the rates currently paid to out-of-network providers and facilities for services will not be included which will lead to a much lower rate under the IFC. Rates paid to nonparticipating providers should be included in the calculation of the median contracted rate to ensure that the QPA is truly representative of the rates paid to different facilities and providers within a geographic region. To exclude these rates would severely disadvantage out-of-network facilities that are excluded because of the plan’s narrow network design even though patients in the insurers’ plan receive highly specialized care from those facilities and would incent insurers to contract only with low-cost providers. The legislation is meant to protect patients from surprise billing and its implementation should not inadvertently provide a competitive advantage to insurers in their contract negotiations with providers.

### ***Single Case Arrangement Rates Should Be Included in the QPA Calculation***

Non-contracted services such as ad hoc or single case agreements are not included in the definition of a contracted rate under the IFC, but they are provided the same consumer protections as would apply had the services been provided in-network. (p. 36889). The Departments recognize that a single case constitutes a contracted rate, thus creating an in-network relationship between the health plan and a provider or facility for the purposes of identifying situations where the balance billing protections apply and resulting in an in-network cost-sharing amount. Nonetheless, under the IFC these single case rates would not be included in the calculation of the median contracted rate despite the fact that the IFC notes that all contracted rates for items and services would be factored into the calculation of the median contracted rates. We believe that this inconsistent treatment of single case agreements is contrary to the definition of the QPA. Rates for items and services that are covered under single case agreements should be included when calculating the median contracted rates. This would align with the Departments’ interpretation that a facility that has a single case agreement should be considered as a participating health plan. (p. 36882). Further, omitting single case rates from

the QPA calculation may encourage health plans to establish narrower networks to exclude certain specialists and facilities from their networks and, instead, use single case arrangements to furnish some care.

***Clarify that the Recognized Amount Is Not the Same as the Nonparticipating Provider Payment***

Under the No Surprises Act, patient cost sharing for emergency and non-emergency services furnished by a nonparticipating facility or provider would be based on the recognized amount. (p. 36883). The QPA may be used to determine the recognized amount that will be used to calculate patients' cost sharing for out-of-network items and services. We support patient protections that would use the recognized amount which may be lower than the amount the plan ultimately pays the nonparticipating provider. However, we ask the Departments to clarify that the recognized amount is not the same as the initial payment amount a plan pays nonparticipating providers. The IFC acknowledges that the amount ultimately paid to the provider generally does not affect the cost-sharing amount the individual must pay. (p. 36884). Reducing patient cost sharing should not negatively impact ensuring sufficient provider reimbursement. The recognized amount used to calculate patient cost sharing would likely not reflect the true costs associated with furnishing the items and services and thus underpay providers if the recognized amount is the amount the insurer pays the provider. We are concerned that without a definitive statement from the Departments insurers may consider the recognized amount as the reimbursement amount for services furnished by the nonparticipating provider.

***Ensure Patients' Access to Tertiary and Quaternary Care Provided by Out-of-Network Facilities***

Teaching hospitals routinely provide specialized services including care at Level 1 Trauma Centers, that cannot be furnished in other hospitals. There are few Level 1 Trauma Centers in the country, with some states only having one. These trauma centers receive patients that require specialized care and incur significant "standby costs" so that all services and personnel are available at the time of an injury. Some health plans, however, exclude hospitals with trauma units from their networks. If a patient is transferred to a nonparticipating hospital to receive specialized emergency care not offered at the facility to which they were initially taken, we ask that the Departments encourage the health plan to work with the receiving nonparticipating hospital to determine coverage and payment rates, rather than simply defaulting to the QPA.

***Calculate Rates to Physicians or Providers Based on the Same Specialty***

The proposed rule identifies a "provider in the same or similar specialty" based on the plan or issuer's usual business practice. (p. 36891). We urge the Departments to calculate median contracted rates based only on those items and services provided by physicians or providers in the *same* specialty or subspecialty. Education, level of training, and specialty type are important factors that should be recognized in contracting and determining payment amounts. Academic medical centers often include faculty physicians from more than 70 adult and pediatric specialties, and numerous subspecialties, such as burn and cardiac surgery. It is important to

distinguish among the different specialties and subspecialties and the scope of conditions they treat when calculating rates.

***Require Transparency of the Methodology and Data Used to Calculate the QPA and Median Contracted Rates***

The IFC requires plans and issuers to make certain disclosures with each initial payment or notice of denial of payment and to provide additional information upon request of the provider or facility. (p. 36898). A plan or issuer must provide, *in a timely manner*, (emphasis added) certain information requested by the plan. (p. 46899). In order to ensure that all stakeholders have access to the calculation of the QPA, plans should be required to publicly post on their websites the methodology used to calculate the QPA. Plans and issuers should be required to give providers the specific data points used in the calculations including the number of rates used to determine the median contracted rate and the names of the facilities and providers whose rates were used to determine the median amounts to ensure the rates used are comparable. In addition, insurers that have many plans with the same facilities and providers should be required to include multiple data points and not be allowed to skew the analysis towards the lowest rate with each provider. This level of transparency will help to ensure a fair initial payment and, when necessary, create a productive basis from which health plans and providers can negotiate the appropriate payment, thus reducing the volume of claims submitted to the IDR process.

**NOTICE AND CONSENT**

Under the No Surprises Act, a patient must receive written notice and consent within 72 hours of the item or service being furnished, or at the time the appointment is made, depending on when the item or service was scheduled. The notice can be in paper or electronic form based on patient preference and must contain the following information: notification that the provider is out-of-network for their health plan; a good faith estimate of the charges for the items and services; a list of in-network providers at the facility (if the facility is in-network) to which the patient can be referred; information on any prior authorization or other care management requirements; and a clear statement that consent is optional and the patient can instead choose to seek care from an in-network provider. The notice must be available in the 15 most common languages spoken in the provider's area. The notice and consent form must include a space to obtain the patient's signature agreeing that they were provided with appropriate notice, including a cost estimate, as well as the date on which notice was provided and consent obtained.

***Providers Should Only Be Responsible for the Notice and Consent and Good Faith Estimate for the Items and Services They Will Provide***

The requirement to obtain notice and consent for all out-of-network items and services could be burdensome for some providers. Participating facilities should not be required to obtain notice and consent for nonparticipating providers and should be held harmless for out-of-network charges when ancillary services are provided by nonparticipating providers. The Departments

should clarify that the nonparticipating providers in the facility should be responsible for obtaining the notice and consent for the items and services they provide.

The Departments seek feedback on the potential challenges out-of-network emergency facilities may have in developing a good faith estimate for both the facility and the provider as part of the notice and consent process. Requiring a good faith estimate to incorporate both facility and provider charges will be challenging. For example, facilities and providers may use different billing systems that could complicate the ability to provide an accurate good faith estimate. Requiring facilities to provide a good faith estimate for providers they do not employ may be impossible. It is sometimes difficult to access patients' insurance information, including patient-specific cost sharing even for in-network providers; if payers do not maintain real-time enrollment and coverage information online, this would delay access to this information. Moreover, out-of-network facilities and providers should not be required to provide patient-specific cost sharing for future services at the time of the initial ED visit as plans will likely not have access to patient-specific insurance information.

In calculating the good faith estimated amount for purposes of notice and consent, the provider or facility is expected to apply the same process and considerations used to calculate that estimate that is required under section 2799B-6(2) of the Public Health Service Act. HHS seeks comment regarding the method by which this should be calculated. Specifically, the statute (section 2799B-6) requires providers to include "...expected charges for furnishing such item or service (including any item or service that is reasonably expected to be provided in conjunction with such scheduled item or service and such an item or service reasonably expected to be so provided by another health care provider or health care facility), with the expected billing and diagnostic codes for any such item of service." (p. 36908). We request that the rules clarify that "in conjunction with" refers to the obligation to furnish good faith estimates for items or services provided at the time of the scheduled service. We do not believe Congress intended for providers to include estimates for items or services, such as post-acute care, that are provided after the scheduled service.

***Flexibility Is Essential When Defining "unforeseen, urgent medical needs"***

The IFC states that the notice and consent process will not cover items and services that are furnished as a result of unforeseen, urgent medical needs that arise at the time such covered item or service is furnished. (p. 36911). We feel that the scope of treatment that can be furnished during an intervention should not be limited to what is listed on the notice and consent form. There may be a need for subsequent interventions to address anomalies not found during the initial evaluation or procedure. Further, the IFC extends this limitation to post-stabilization services that may be totally unrelated to the medical intervention. There must be a recognition that in medical care unexpected events happen and providers should not be expected to capture all potential postoperative sequelae to ensure that the required treatment is not considered "unforeseen."



***The 3-Hour Requirement for Notice and Consent May be Unattainable and Could Delay Necessary Care***

Under the IFC, nonparticipating providers will be required to provide patients with notice and consent documentation no later than 3 hours prior to furnishing the items or services subject to the No Surprises Act. (p. 36907). This timeframe may be unattainable and could delay needed care for some patients. For example, a patient is seen by a participating physician who refers the patient to a nonparticipating provider and the nonparticipating provider can see the patient the same day. However, because of the time of day, the nonparticipating provider is unable to provide notice and obtain consent within the 3-hour limitation. As a result, the patient may have to postpone the evaluation by the nonparticipating physician which could delay care. There should be flexibility within and beyond the timeframe to accommodate for these types of situations and also the ability to waive the 3-hour requirement.

***Ancillary Services List Should Not Be Expanded***

Out-of-network providers that obtain notice and consent from the patient for out-of-network items and services may balance bill the patient. However, the Act specifies that certain out-of-network ancillary services are excluded from obtaining notice and consent and therefore are prohibited from balance billing the patient for these ancillary services furnished. Ancillary services are an important part of delivering health care and additional services should not be added to the list without stakeholder input.

***Monitor Patient Access to Out-of-Network Specialists When Receiving Care at In-Network Facilities***

The Departments should monitor patient access to out-of-network providers when treated at an in-network facility. Out-of-network providers that furnish services in an in-network facility will be subject to the No Surprises Act unless they provide notice and receive consent from the patient to treat them who also agrees to be balance billed. As a result, out-of-network providers may be reluctant to treat patients at an in-network facility. For example, a patient presents to the ED with a non-life-threatening condition that could require treatment by a specialist. After a discussion of treatment options, the patient decides to have an evaluation for treatment by the specialist. However, the specialist is out-of-network and may choose instead to see the patient in their office. Depending on availability, the patient may have to wait to be seen by the provider, delaying needed care. Also of concern is access to specialty services in rural and underserved areas. These areas often cannot support a full-time specialist; instead, specialists visit the areas on a regular basis (*e.g.*, weekly or monthly). However, if the specialists' services would be considered out-of-network or ancillary, they may be less likely to agree to provide services, resulting in reduced access to needed care in rural and underserved areas.

Moreover, these providers should not be considered under the definition of "ancillary services" which would limit their ability to balance bill. As defined in the IFC, items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or services at such facility would be considered ancillary. (p. 36982). This provision would

limit the community or rural facility from establishing subspecialty care with out-of-network providers. Often the ability to find and provide consistent subspecialty care for a rural population is difficult. The burden of the insurance plan not having an adequate network of providers should not become a reason to deny adequate compensation for these providers. Providers who choose to deliver care in underserved areas should be excluded from the definition of ancillary services if they are the only provider who can provide certain services. We ask the Departments to consider the unintended consequences that may affect the equity of access to care as they finalize these rules. Excluding these providers from the definition of ancillary would maintain or even increase access to care in underserved areas. The Departments should clarify that these types of providers are excluded from the definition of ancillary.

***Nonparticipating Providers Should Not Be Required to Provide Plan-Specific Prior Authorization / Care Management Information***

The notice must provide information about whether prior authorization or other care management limitations may be required in advance of receiving such items or services at the nonparticipating facility or provider. The IFC acknowledges that requiring nonparticipating providers and facilities to obtain specific information related to prior authorization or care management imposed by the insurer could be burdensome. (p. 36908). We agree. Nonparticipating providers and facilities typically do not have access to these requirements. We believe that insurers have the specific information and, therefore, should be responsible for providing plan-specific information to patients.

***The Departments Should Provide Notice and Consent Templates in Other Languages***

Nonparticipating providers will be required to make the notice and consent documents available in the 15 most common languages in the geographic region in which the applicable facility is located. If an individual's preferred language is not among the 15 most common languages made available a qualified interpreter must be provided. (p. 36937). HHS assumes that of the 17,647 health care facilities and emergency departments that will be subject to these requirements, 16,992 will incur burden to develop the notice and consent documents. HHS also assumes that the facilities will provide the notice and receive consent on behalf of nonparticipating providers, as well as retain records and notify plans. HHS estimates the total one-time first-year burden (in 2021) to develop and prepare final versions of the documents, translate and make those documents accessible to the providers within the facility is estimated at roughly \$22.6 million. (p. 36938).

Starting in 2022, for all emergency and health care facilities, HHS estimates hospitals' total annual, ongoing burden related to the notice and consent, recordkeeping, and notification to plans will be 3,104,001 hours and the total cost, including printing and materials, will be approximately \$117 million. For individuals receiving the notice, there is an estimated annual burden of approximately \$99 million starting in 2022. (p. 36939).

These significant financial liabilities will further stress hospitals and providers who currently struggle with lost revenue due to the COVID-19 public health emergency. It will require scarce

resources to be redirected to comply with these requirements in both the short-term and long-term. In an effort to decrease the financial impact on providers and to ensure that translated materials are uniform and correct, HHS should develop and disseminate translated notice and consent documents into the languages that it currently supports under the Medicare program<sup>4</sup> that providers can opt to use if they do not want to create their own. Further, there should be standards in place for hospitals to transmit information, such as good faith estimates and notice and consent documents, to plans to decrease burden for both the providers and plans.

### **NOTICE AND CONSENT: POST STABILIZATION**

When a patient receives emergency services from an out-of-network facility or provider, the Act requires that once stabilized the patient should be moved to an in-network facility. The patient would be permitted to stay in the out-of-network facility and the provider may balance bill the patient if the patient is informed that they are in an out-of-network facility and gives consent to remain at the facility and acknowledges they understand that they may be balance billed. In other words, unless the patient is transferred or consents to stay in the out-of-network facility, the patient cannot be balance billed for services provided after stabilization.

We appreciate the Departments' clarification that post-stabilization services are considered emergency services that include outpatient observation or an inpatient stay as part of the emergency services furnished. (p. 36880). This will decrease confusion over which services are included in the consumer protections and limit denials if patients require additional observation or inpatient treatment. We ask that the Departments clarify that hospitals will be held harmless if a patient cannot be transferred to another facility in a timely manner due to a lack of provider or bed availability. Health plans should not be allowed to deny coverage of post-stabilization services because out-of-network hospitals are unable to transfer patients to an in-network facility due to circumstances beyond their control.

Health plans, however, should be required to assist the hospital and patient to secure a bed in an in-network facility and should not be able to deny finding or authorizing placement at an in-network hospital to the point where transfer is no longer relevant because the patient no longer requires inpatient or post-acute care. Health plans should also be required to inform the patient or the patient's authorized representative of the need for the transfer and keep them updated on when and where the transfer will occur.

Post-stabilization transfer would occur when a provider determines the patient is able to travel using nonmedical transportation or nonemergency medical transportation. We agree with the Departments that the decision to transfer a patient should be based on the evaluation by the treating health care provider. The IFC goes on to say that if it is determined that the individual cannot travel using nonmedical or nonemergency medical transportation or that the participating facility or provider is not located within a reasonable travel distance, the patient cannot freely

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<sup>4</sup> <https://www.cms.gov/About-CMS/Agency-Information/OMH/resource-center/resources-by-language>

provide notice and consent and therefore, the provider cannot balance bill the patient. (p. 36880).

Moreover, securing a provider willing to take a patient to provide subsequent treated for a staged procedure could be difficult. For example, a patient with a jaw fracture may seek initial emergency care at an out-of-network facility. The initial facility stabilizes the fracture, but the patient will require subsequent care that likely includes surgery after facial swelling is substantially decreased. If the patient was initially seen at an out-of-network facility, the patient would be required to seek subsequent care from an in-network provider. Providers are often reluctant to accept patients in the middle of a two-step procedure for safety reasons. This would mean that the patient may need to continue treatment at the out-of-network facility. However, the out-of-network facility would have to provide notice and obtain consent for the patient to continue treatment, putting the provider in the position of informing the patient of his/her insurance benefit. Even if the provider agrees to treat the patient without obtaining notice and consent, the provider could be reimbursed by the plan a much lower rate or be subject to the IDR process according to the No Surprises Act.

### ***Travel and Distance Requirements Should be Consistent with Current Rules***

The Departments seek comment on the definition of reasonable travel distance. The distance a patient must travel to seek medical care may be related to network adequacy. If a patient is enrolled in a plan that utilizes a narrow network of providers, then depending on the services needed, access to care could be challenging. A sufficient number of qualified health care providers is necessary to ensure members have access to covered services within a reasonable travel distance. When plans do not have sufficient numbers or types of providers, patients are forced to forego care, wait, or travel long distances. This can result in consumers seeking care at local, out-of-network providers that are close to their home.

The Medicare Advantage guidelines for time and distance<sup>5</sup> could be used as a source for determining an outer limit about whether the distance a patient must travel for post-stabilization care is reasonable. Additionally, plans should be required to have a sufficient number of providers and facilities to allow adequate access for patients. A minimum number requirement ensures that plans have a contracted network that is broad enough to provide beneficiaries access to covered services.

## **INTERACTION WITH STATE LAW AND REGULATIONS**

The intent of the No Surprises Act is to provide clear protections for patients and to ensure that there is a method available to resolve reimbursement issues between plans and providers for all non-contracted services. Many states have enacted laws to prevent balance billing and the No

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<sup>5</sup> Medicare Program; Contract Year 2021 Policy and Technical Changes to Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program. Final Rule 85 FR 33905. <https://www.govinfo.gov/content/pkg/FR-2020-06-02/pdf/2020-11342.pdf>.

Surprises Act defers to state law where applicable. However, without clear direction as to whether a state or federal standard applies there is likely to be significant confusion for both patients and providers.

***Self-Funded Plans Should Not be Allowed to Opt-In or Opt-Out of State Law***

Currently, some states allow self-funded plans to opt-in to the state's consumer protections. The interim final rule will allow self-insured plans to voluntarily opt-in to state laws that provide a method to determine the cost-sharing amount or total amount payable to providers under such plans. Further, a group health plan that opts into a state law is required to do so for all items and services to which the state law applies. (p. 36886). Allowing self-funded plans to choose (*e.g.*, opt-in, opt-out) between state and federal consumer protections will be confusing to both patients and providers. Navigating insurance coverage can be a daunting task for many consumers. Now consumers could be faced with additional challenges of understanding what laws could potentially impact their access to care and their cost-sharing liability for certain items and services. To decrease confusion and limit provider burden, all self-funded plans should be subject to the provisions of the No Surprises Act and these plans should not be allowed to choose between federal and state regulations.

***Require Health Plan Sponsors to Identify the Type of Plan the Consumer is Enrolled In***

There will be operational challenges for providers to determine whether a self-insured plan is governed by state or federal law. Ascertaining this information will increase provider burden. Providers will now be required to determine if the employee is covered under an ERISA plan, the scope of the coverage, and whether state or federal law applies.

The IFC states that it will be incumbent upon the self-insured plan that chooses to opt into a state law to prominently display coverage of out-of-network services, including a general description of the items and services provided by nonparticipating facilities and providers covered by the specified state law. (p. 36886). Health plans also should be required to provide information on the type of plan upon a provider's initial query for eligibility and coverage, including up-to-date online information. The patient's insurance card should identify the type of plan (*e.g.*, ERISA) to assist providers in complying with state and federal balance billing requirements, including consumer protections.

**GOOD FAITH ESTIMATE**

We appreciate the Departments' acknowledgement of the complexity for payers and providers to operationalize the transfer of the good faith estimate and advanced explanation of benefits (EOB) to satisfy the requirements of the No Surprises Act. We support the Departments' decision to delay rulemaking until the intricacies of such a system are better understood and support the decision to delay enforcement of the requirements.

As the Departments contemplate how to successfully operationalize this system, we ask the Departments to consider whether every patient should receive a good faith estimate and advanced EOB. For example, a good faith estimate should not be necessary for patients that expect to pay a fixed copayment. The good faith estimate is to inform patients about their cost-sharing liabilities; patients with a fixed copayment amount already know what their out-of-pocket costs will be. Consideration should be given to whether the good faith estimate should be limited to only out-of-network patients. When a good faith estimate is generated, a copy of the advanced EOB should be shared with the provider to ensure the provider understands what information the patient has received. Finally, we have heard from our members that to ensure success of this complex system, a standard language for transmission of this information between the provider and the payer is essential.

### ***Provide a Good Faith Estimate Only Upon Patient Request***

We recommend that regulations issued in the future regarding the good faith estimate clarify that providers are only required to provide a good faith estimate when there is a scheduled appointment, and the patient requests the good faith estimate. Providing a good faith estimate for scheduled services when the patient does not request it would be unnecessary and a significant administrative burden on providers. Teaching hospitals and teaching physicians provide a large volume of patient visits, surgeries, procedures, and ancillary services. It would be very difficult to produce good faith estimates for all the services that they provide (especially in the timelines set), to transmit them to health plans, and then for the plans to get the advanced EOBs timely to their enrollees. If providers were required to provide good faith estimates for all services, this would result in unnecessary cost to the system and divert important resources away from patient care. Instead, we recommend that providers inform patients of their right to make a request. It also is not unusual that an estimate from a provider differs from the estimate provided by the plan because of benefit changes under the plan. This would cause confusion for both the patient and the provider. The Departments should require that health plans provide the advanced EOB to providers at the same time that it is provided to patients.

### ***Align Consumer Price Comparison Tools***

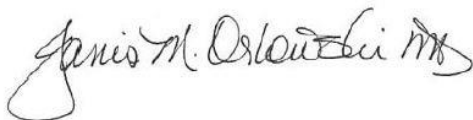
We support the Departments' recognition that many of the price transparency requirements are duplicative and their desire to align transparency of information, including providing this information over the telephone. Both payers and hospitals are required to post consumer cost-sharing information. Effective January 1, 2021, hospitals are required to post standard charges for at least 300 "shoppable" services. Many hospitals have placed price estimation tools on their websites to provide this information. Hospitals are also required to publicly post online, in a machine-readable format, price information for all items and services offered by that hospital. Similarly, beginning January 1, 2022, health plans must provide detailed price information in machine-readable files to the public, and in 2023 will be required to make personalized out-of-pocket cost information for 500 shoppable services available on the Internet. We urge the Departments to streamline and harmonize the requirements under the price transparency program with the good faith estimate requirement. To avoid patient confusion, it is important that

providers and health plans provide consistent information to their patients about the charges and costs associated with providing items and services.

## CONCLUSION

Thank you for the opportunity to provide input as you develop regulations that protect patients from surprise medical bills and ensure appropriate payment to providers. We would be happy to work with you on any of the issues discussed above or other topics that involve the academic health center community. If you have questions regarding our comments, please feel free to contact Mary Mullaney at [mmullaney@aamc.org](mailto:mmullaney@aamc.org) and Gayle Lee at [galee@aamc.org](mailto:galee@aamc.org).

Sincerely,

A handwritten signature in black ink that reads "Janis M. Orłowski M.D.". The signature is written in a cursive style with a large initial "J" and a stylized "M" at the end.

Janis M. Orłowski, M.D., M.A.C.P.  
Chief Health Care Officer, AAMC