AAOS
American Association of Orthopaedic Surgeons

March 10, 2021

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

The Hon. Liz Richter
Acting Administrator
Centers for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Subject: Upcoming rulemaking on No Surprises Act (2020)

Dear Secretary Becerra and Acting Administrator Richter,

On behalf of over 34,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS) and the orthopaedic specialty societies that agreed to sign on, we are pleased to share our position and thoughts as you embark on rulemaking as directed by the No Surprises Act (2020).

On December 28, 2020, President Donald J. Trump signed the No Surprises Act into law. As you are aware, this statute will go into effect for plan or policy years beginning on or after January 1, 2022. This bipartisan, bicameral legislation came to fruition after two years of debates, discussions and mark-ups. It will, for the first time, remove patients from the middle of out-of-network (OoN) billing disputes between healthcare practitioners and insurers and create an independent dispute resolution (IDR) process to settle payment amounts. While many states have adopted legislation targeting unanticipated medical bills, the federal law, if implemented well, is a significant step towards finally putting an end to the frustrations of patients and physicians alike with the existing patch work approach.

Aided by consolidation in the insurance industry, health insurance plans are increasingly offering narrow, often inadequate networks of health care providers, leaving most patients with out-of-network health care bills. **These narrow networks lead to "surprise" medical bills, which most often occur when patients receive care which they thought was covered by their insurance but was unexpectedly provided by an out-of-network physician or another provider.** For example, a particular hospital may be in-network, but the surgeon providing the care may not be covered. Surprise bills can happen at any time, but they often happen during emergency care, when patients and doctors have no way of confirming who is in- or out-of-network.

Congress left many key specifics of the No Surprises Act (2020) legislation up to interpretation by the Departments of Health and Human Services, Labor and Treasury ("the Departments"). Hence, it is imperative that federal rulemaking propose a cogent set of terms (since the final rules defining qualifying final payment amounts are due by July 2021) and provide the legislated protections to the millions of patients across the country as intended by lawmakers. Below are the key principles that AAOS advocated for with Congress[1] over the last two years, and we would like to present them to you as you author the preamble to the rule:

- **Hold patients harmless.** A patient receiving emergency services from an out-of-network practitioner will be liable only for the amount they would have been charged had the practitioner been in-network.
- **Create a quick and fair process for settling disputes.** A "baseball-style" IDR process, which can be triggered by any party in the event of a dispute. The median in-network rate must be considered at the same priority level as other factors, as laid out in the legislation, and not treated as the primary factor. The physician and the insurer can negotiate and settle on a mutually agreeable number at any time.
- **Require transparency from networks.** Insurance companies would be responsible for keeping accurate records of physicians' network status and would be held liable if a patient were informed incorrectly that a practitioner was in-network.
- **Reduce out-of-network billing rates.** The New York law has succeeded in reducing the practice of out-of-network billing by 34%. The federal solution should model this effort to duplicate its success.

According to some policy thought leaders, implementation questions generally fall into three buckets. Namely these are (1) Breadth of surprise billing ban; (2) Details of the median in-network rate calculation; and (3) Mechanics of the arbitration process.[2]

Breadth of Surprise Billing Ban

AAOS urges the Departments to retain a balance billing option. In nonemergent situations, balance billing should be permitted only if the patient is adequately informed about the likelihood of out-of-network care. The patient should have every opportunity to seek care from their provider of choice regardless of network status in order to preserve choice and competition. As is evident in the legislative language below, the Congressional intent of the surprise billing ban is to empower patients with the information necessary to make the best choice for them. This means that, given adequate notification and an estimate of out-of-pocket charges, patients should retain the right to choose a physician of their choice irrespective of health plan. In these cases, when treatment is non-emergent

[1] Vivian, J. (2021). Federal Surprise Medical Billing Law Enacted Following Years of Influential AAOS Advocacy. AAOS Now. Available: https://www.aaos.org/aaosnow/2021/jan/earlyreleases/advocacy03/

[2] USC-Brookings Schaeffer on Health Policy (February 4, 2021). Understanding the No Surprises Act. Available: https://www.aaos.org/aaosnow/2021/jan/earlyreleases/advocacy03/ https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/02/04/understanding-the-no-surprises-act/

and patients have the necessary cost information, a balance billing option is clearly allowed under the law as it is written.

> *"…with respect to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer who is to be furnished items or services by a nonparticipating provider or nonparticipating facility, is a document specified by the [HHS] Secretary, in consultation with the Secretary of Labor, through guidance that shall be signed by the participant, beneficiary, or enrollee before such items or services are furnished and that—*
>
> > *"(A) acknowledges (in clear and understandable language) that the participant, beneficiary, or enrollee has been—*
> >
> > *(i) Provided with the written notice under paragraph (1)(A);*
> > *(ii) Informed that the payment of such charge by the participant, beneficiary, or enrollee may not accrue toward meeting any limitation that the plan or coverage places on cost-sharing, including an explanation that such payment may not apply to an in-network deductible applied under the plan or coverage; and*
> > *(iii) Provided the opportunity to receive the written notice under paragraph (1)(A) in the form selected by the participant, beneficiary, or enrollee; and*
> >
> > *(B) documents the date on which the participant, beneficiary, or enrollee received the written notice under paragraph (1)(A) and the date on which the individual signed such consent to be furnished such items or services by such provider or facility."*

In-network Rate Calculation

The legislation of the No Surprises Act states that the IDR entity may not consider usual and customary rates, billed charges, nor payment rates from public payers. While the legislation is written to define the qualifying payment amount as the median contracted rate for the service and insurer in question, AAOS supports using an in-network median rate that is based on the rate for all local health plans, not simply the products of the insurer in question. We believe that this will help the IDR entity understand whether the health plan is an outlier in all their products. In prior advocacy, we have supported the FAIR Health database as a metric, and we continue to believe that independent sources like this are the gold standard for in-network rate calculation during the IDR process.

Mechanics of the Arbitration Process

Though there are many details of the arbitration process which need to be clarified in rulemaking, we are suggesting that particular attention be paid to the following two areas:

1) Creating specific criteria for determining what "good faith" is defined as for the purpose of proving that physicians have adequately engaged in that aspect of the IDR process.

2) As currently written, the party which initiated the IDR process may not initiate a new IDR process with the same party and for the same services for three months. However, once that 90-day period has ended, the party may submit appropriately batched claims for that 90-day period. The legislation clearly states that "the Secretary shall provide that, in the case of items and services which are included by a provider or facility as part of a bundled payment, such items and services included in such bundled payment may be part of a single determination under this subsection." AAOS requests that, for the purposes of batching, services which are billed within a bundle but provided on multiple days be considered as a single service on the first date the first service is billed.

State Law Implications

While the intent of the Act is to not preempt existing state surprise billing laws, the statutory language retained some ambiguity that necessitates the Departments' further clarification prior to and during the rulemaking process. In particular, AAOS urges guidance on when the surprise billing protections apply to beneficiaries in self-funded ERISA plans. Several states are in the process of considering how existing laws interplay with the new federal framework. For instance, analysis by the Commonwealth Fund distinguishes between states with comprehensive balancing billing protections and those with limited or partial protections, and there remain questions as to whether such limited protections would satisfy the "specified state law" language of the statute.[3] We also request clarification regarding the distinction between the use of the Taxpayer Identification Number (TIN) and the National Provider Identifier (NPI) to define the "provider" for the purpose of the law.

Furthermore, we hope that in rulemaking you will be cognizant of the market failure that created this surprise billing problem in the first place. While patients typically can choose physicians and facilities within their own insurance network for elective care, it is sometimes impossible to avoid out-of-network practitioners and facilities. In addition, ancillary clinicians contract separately with insurance companies from principal physicians and can be out-of-network even if the principal physician is contracted with the patient's health insurance network. To the extent that HHS and CMS have legal authority, AAOS supports incorporating specific, quantitative standards that require insurance networks to maintain a minimum number of active primary and specialty physicians, accurate updated physician directories, and provide transparent out-of-network payment options for patients. We believe these remedies are essential for preventing surprise medical bills, ensuring access to care, and decreasing physician burden.

Thank you for your time and attention to the concerns of the American Association of Orthopaedic Surgeons (AAOS) on the significant statutes in the No Surprises Act (2020). The AAOS looks forward to working closely with HHS and CMS on further mitigating the impact of surprise medical bills, especially holding musculoskeletal patients harmless in the United States. Should you have questions on any of the above comments, please do not hesitate to contact Shreyasi Deb, PhD, MBA, AAOS Office of Government Relations at deb@aaos.org.

[3] The Commonwealth Fund (November 30, 2020). State Balance-Billing Protections. Available: https://www.commonwealthfund.org/publications/maps-and-interactives/2020/nov/state-balance-billing-protections

Sincerely,

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Alabama Orthopaedic Society
American Alliance of Orthopaedic Executives
American Association for Hand Surgery
American Association of Hip and Knee Surgeons
American Orthopaedic Foot and Ankle Society
American Orthopaedic Society for Sports Medicine
American Shoulder and Elbow Surgeons
American Society for Surgery of the Hand
Arkansas Orthopaedic Society
Arthroscopy Association of North America
California Orthopaedic Association
Cervical Spine Research Society
Colorado Orthopaedic Society
Connecticut Orthopaedic Society
Florida Orthopaedic Society
Georgia Orthopaedic Society
Illinois Association of Orthopedic Surgeons
Iowa Orthopaedic Society
Kansas Orthopaedic Society
Louisiana Orthopaedic Association
Maine Society of Orthopaedic Surgeons
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Massachusetts Orthopaedic Association
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Minnesota Orthopaedic Society
Mississippi Orthopaedic Society
Missouri State Orthopaedic Association
Musculoskeletal Tumor Society
Nebraska Orthopedic Society
North American Spine Society
North Carolina Orthopaedic Association
North Dakota Orthopaedic Society
Oregon Association of Orthopaedic Surgeons
OrthoForum
Orthopaedic Trauma Association
Pediatric Orthopaedic Society of North
America Pennsylvania Orthopaedic Society
Rhode Island Orthopaedic Society
Ruth Jackson Orthopaedic Society
Scoliosis Research Society
South Carolina Orthopaedic Association
South Dakota State Orthopaedic Society
Tennessee Orthopaedic Society
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