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EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES
2176 RAYBURN HOUSE OFFICE BUILDING
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November 19, 2021

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

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
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

Dear Secretaries Walsh, Becerra, and Yellen:

As bipartisan leaders of the Committee on Education and Labor (Committee) and coauthors of surprise billing legislation during the 116th Congress,¹ we write to express our support for the recent Interim Final Rule (IFR) entitled *Requirements Related to Surprise Billing; Part II*.² Specifically, we are pleased that the IFR adopts an approach to independent dispute resolution (IDR) that is consistent with legislation reported by the Committee, the text of the statute, and congressional intent. In doing so, the IFR protects patients from surprise medical bills and properly balances the interests of all stakeholders while advancing our shared, bipartisan goal of minimizing administrative burdens and reducing health care spending.

As you know, the *No Surprises Act* was enacted during the 116th Congress as part of the *Consolidated Appropriations Act, 2021* (CAA).³ The *No Surprises Act* was the product of a nearly two-year process to develop a solution to the growing problem of unexpected balance bills

¹ Ban Surprise Billing Act, H.R. 5800, 116th Cong. (2020).

² Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55980 (Oct. 7, 2021).

³ Division BB, Title I, Pub. L. No. 116-260 (2020).

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by out-of-network providers, also known as “surprise” medical bills. Prior to its enactment, studies found that approximately one in five inpatient hospital admissions and one in ten elective hospital admissions resulted in surprise bills.⁴ Although many states have enacted laws to address this issue, federal legislation was necessary to ensure protections for consumers covered by self-insured group health plans subject to the *Employee Retirement Income Security Act of 1974* (ERISA).⁵ As the committee of jurisdiction over employer-sponsored health plans and ERISA,⁶ the Committee played a leading role in the development of the *No Surprises Act* and favorably reported similar legislation during the 116th Congress, the *Ban Surprise Billing Act*.⁷ We further joined with our colleagues on the other committees of jurisdiction in negotiating and publicly supporting the *No Surprises Act* compromise,⁸ and worked to ensure its inclusion in the CAA.

Consistent with other surprise billing proposals considered by Congress, the *No Surprises Act* bans balance billing by out-of-network health providers⁹ and strengthens patient protections in both the group and individual markets.¹⁰ It also establishes an IDR process to allow providers and health plans to resolve payment disputes, subject to key guardrails that encourage negotiation and ensure a fair payment amount is achieved. The IDR process allows the payment amount to be determined by a neutral third party known as an IDR entity. The law prohibits IDR entities from considering inflationary billed charges and allows for the consideration of two groups of factors: first, in all cases, an IDR entity must consider the Qualifying Payment Amount (QPA), a market-based measure of the value of an item or service that generally tracks the median in-network rate for an item or services; and second, other additional information that may be submitted voluntarily by the parties or requested by the IDR entity.¹¹ Such additional information includes the educational credentials, experience, and quality outcomes of the provider, the provider’s market share, and other ancillary factors relating to the provision of the item or service.¹²

In determining how to balance these factors, the IFR properly finds that the QPA should be the primary factor considered by IDR entities. Specifically, the preamble to the IFR states that

⁴ Christopher Garmon & Benjamin Chartock, One in Five Inpatient Emergency Department Cases May Lead To Surprise Bills, 36 Health Affairs 177 (2017), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0970>.

⁵ 29 U.S.C. § 1144.

⁶ Under House Rule X(1)(e), the jurisdiction of the Committee includes matters involving the employer-employee relationship, including: “... labor generally,” “wages and hours of labor,” and the “[o]rganization, administration, and general management of the Department of Labor.” Private sector employee benefit plans are subject to oversight by the Department of Labor and fall within the jurisdiction of the Committee. The Committee has exclusive jurisdiction over statutory requirements applying to such plans under Title I of ERISA.

⁷ H. Rep. No. 116-615 (2020).

⁸ Chairman Scott Announces Bipartisan Congressional Committee Surprise Billing Agreement (Dec. 12, 2020), <https://edlabor.house.gov/media/press-releases/icymi-chairman-scott-announces-bipartisan-congressional-committee-surprise-billing-agreement>; Congressional Committee Leaders Announce Surprise Billing Agreement (Dec. 11, 2020), <https://republicans-edlabor.house.gov/news/documentsingle.aspx?DocumentID=407111>.

⁹ 42 U.S.C. §§ 300gg–131–300gg–132.

¹⁰ 29 U.S.C. § 1185e; 42 U.S.C. § 300gg–111; I.R.C. § 9816.

¹¹ 29 U.S.C. § 1185e(c)(5)(C); 42 U.S.C. § 300gg–111(c)(5)(C); I.R.C. § 9816(c)(5)(C).

¹² 29 U.S.C. § 1185e(c)(5)(C)(ii); 42 U.S.C. § 300gg–111(c)(5)(C)(ii); I.R.C. § 9816(c)(5)(C)(ii).

“when selecting an offer, a certified IDR entity must look first to the QPA, as it represents a reasonable market-based payment for relevant items and services, and then to other considerations.”¹³ This interpretation is consistent with the plain language of the *No Surprises Act*, which makes clear the primacy of the QPA through its textual structure. By listing the QPA as the first mandatory consideration in all IDR situations followed by “such information as requested [by the IDR entity]” and “additional information,”¹⁴ the statute signals that IDR entities must look first at the QPA before considering additional circumstances, which “may” be submitted by parties. Such information includes relatively minor items (such as the experience or educational credentials of a provider) as well as certain other factors that are generally reflected in the underlying QPA (such as patient acuity or the complexity of furnishing an item or service). These factors on their face plainly have less utility in determining an appropriate payment amount other than the QPA and should not be given equal weight by IDR entities.

In addition, the statute further clarifies the centrality of the QPA by providing extensive detail regarding its calculation and application in out-of-network billing situations. The requirements with respect to the QPA are thoroughly articulated in the statute, which requires the QPA to be based on the median contracted rate for similar items and services, taking into account geographic area as well as differences between insurance markets, and to be adjusted based on the consumer price index for all urban consumers.¹⁵ It also includes substantial procedural and oversight provisions that require the Departments of Labor, Health and Human Services, and the Treasury to engage promptly in notice-and-comment rulemaking to develop the methodology for calculating the QPA,¹⁶ as well as a mandatory audit process to ensure compliance with these requirements.¹⁷ The thoroughness of the law’s treatment of the QPA reflects the importance placed on it and also ensures that the standard is fairly and transparently applied during the IDR process.

In addition to comports with the plain language of the statute, the approach adopted by the IFR is consistent with Congress’s bipartisan goal of lowering premiums and preventing inflation in health care spending. In its evaluation of legislation to end surprise billing that was considered by the committees of jurisdiction in the House, the Congressional Budget Office (CBO) determined that all three proposals would have a non-inflationary impact on health care spending because each prohibited the consideration of billed charges and emphasized the median in-network rate (or QPA) during IDR.¹⁸ In contrast, states such as New York are facing rising

¹³ Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55980, 55996 (Oct. 7, 2021).

¹⁴ 29 U.S.C. § 1185e(c)(5)(C); 42 U.S.C. § 300gg–111(c)(5)(C); I.R.C. § 9816(c)(5)(C).

¹⁵ 29 U.S.C. § 1185e(a)(3)(E); 42 U.S.C. § 300gg–111(a)(3)(E); I.R.C. § 9816(a)(3)(E).

¹⁶ 29 U.S.C. § 1185e(a)(2); 42 U.S.C. § 300gg–111(a)(2); I.R.C. § 9816(a)(2).

¹⁷ 42 U.S.C. § 300gg–111(a)(2); I.R.C. § 9816(a)(2). *See also* 29 U.S.C. §§ 1134, 1136.

¹⁸ *See* Congressional Budget Office, H.R. 5826, the Consumer Protections Against Surprise Medical Bills Act of 2020, as Introduced on February 10, 2020, Estimated Budgetary Effects (Feb. 11, 2021), <https://www.cbo.gov/system/files/2020-02/hr5826table.pdf>; Congressional Budget Office, H.R. 5800, the Ban Surprise Billing Act, as ordered reported by the House Committee on Education and Labor on February 11, 2020, Estimated Budgetary Effects (Feb. 13, 2021), <https://www.cbo.gov/system/files/2020-02/hr5800.pdf>; Congressional Budget Office, H.R. 2328, Reauthorizing and Extending America’s Community Health Act, As ordered reported by the House Committee on Energy and Commerce on July 17, 2019 (Sept. 18, 2019), <https://www.cbo.gov/system/files/2019-09/hr2328.pdf>.

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health care spending as a result of IDR processes that do not prioritize the median in-network rate.¹⁹ An IDR process at the federal level lacking such guardrails would lead to similar cost increases,²⁰ which is precisely why Congress rejected such proposals in favor of a non-inflationary IDR structure. In its final cost estimate, CBO confirmed that the approach adopted by the *No Surprises Act* would reduce premiums and federal health spending,²¹ consistent with bipartisan congressional intent.

We thank you again for your work in implementing the requirements of the *No Surprises Act*. The approach adopted in the IFR is consistent with congressional intent and will ensure that the IDR process protects patients and does not excessively raise costs for plans, providers, or taxpayers. We hope these comments are helpful as you continue your work in implementing this landmark legislation.

Sincerely,



ROBERT C. "BOBBY" SCOTT
Chairman



VIRGINIA FOXX
Ranking Member

cc: The Honorable Kiran Ahuja, Director
U.S. Office of Personnel Management

¹⁹ Loren Adler, Experience with New York's Arbitration Process for Surprise Out-of-Network Bills (Oct. 24, 2019), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/10/24/experience-with-new-yorks-arbitration-process-for-surprise-out-of-network-bills/>.

²⁰ See Loren Adler et al., Rep. Ruiz's Arbitration Proposal for Surprise Billing (H.R. 3502) Would Lead To Much Higher Costs And Deficits, Health Affairs (July 16, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190716.355260/full/>.

²¹ Congressional Budget Office Estimate for Divisions O Through FF H.R. 133, Consolidated Appropriations Act, 2021 (Jan. 14, 2021), https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf.