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Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Via email: https://www.regulations.gov

December 6, 2021

Subject: RIN 1210-AB00 – Requirements Related to Surprise Billing; Part II

The California Public Employees' Retirement System (CalPERS) applauds the passage of the *No Surprises Act* which ends the practice of surprise medical billing among medical providers. We also appreciate the opportunity to comment on the latest regulation package, *Requirements Related to Surprise Billing; Part II (RIN 1210-AB00*). This important law and regulatory framework will help protect patients who are unknowingly exposed to out-of-network charges resulting from provider/insurer contract disputes which have been on the rise in recent years and will help ensure health insurance premiums and out-of-pocket costs are affordable and sustainable for consumers.

CalPERS is the largest purchaser of public employee health benefits in California, and second largest purchaser in the nation, after the federal government. Our high quality, comprehensive health plan offerings include health maintenance, preferred provider, and exclusive provider organization (HMO, PPO, and EPO) plans. In 2020, CalPERS spent over $9.7 billion purchasing health benefits for our 1.5 million members and employers. We are grateful that the approximately 267,000 CalPERS members enrolled in our self-funded plans will now be protected by federal law. Historically, in cases where self-funded plan members received emergency room care from non-participating providers, CalPERS paid a higher in-network percentage based on allowed amounts and we were powerless to stop our members from receiving surprise bills for in-patient care. In order to meet our fiduciary responsibility to provide high quality health care at a reasonable cost for all our members, CalPERS must ensure that we do not overpay for health care. Our self-insured health plans cover the entire cost of care for our participants and we understand firsthand the challenges of continuing to cover the cost of care when prices keep rising. For decades, healthcare price increases have outpaced inflation creating a spending growth trend that is unsustainable.

The following are comments intended to address the *Requirements Related to Surprise Billing; Part II* regulations published October 7, 2021:

(1) We have an interest in having any arbitrated payment amount be as close to the contracted rate as possible in order to remove any disparities or perverse incentives which can drive health care prices higher. We are hopeful the independent dispute resolution process outlined in regulation will have the effect of setting disputed payment amounts reasonably close to those we already experience as it should mitigate future increases in prices.

(2) We are also strong advocates for consumer protections and are encouraged to see that the regulations provide patient/provider complaint, appeal, and dispute resolution processes.

In 2020, prior to the passage of the *No Surprises Act* and as a member of the Public Sector HealthCare Roundtable and the Pacific Business Group on Health, we advocated for a federal solution to the issue of surprise billing that would include linking out-of-network reimbursement to the median in-network rate. In addition, we encouraged lawmakers to consider a default payment-first, dispute resolution-second arrangement similar to what is used here in California. While we would have preferred a national model like our state model over an arbitration-centric model, we encouraged action to protect all patients and are grateful that the regulatory framework's definition of a qualifying payment amount takes into consideration the median in-network rate with a geographic region component and will be a primary factor for determining reimbursement amounts.

Additionally, we enthusiastically support the earlier *Requirements Related to Surprise Billing, Part I* regulations that recognize the applicability of existing state laws. Our members and employers have directly benefitted from California's enactment of legislation to protect California-regulated plan participants from surprise billing (Assembly Bill (AB) 72, Chapter 492, Statutes of 2016). Specifically, AB 72 requires health plans, not patients, to reimburse out-of-network providers at an "Average Contracted Rate" which is defined as 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered, whichever is greater. In addition, if the non-contracting provider wishes to reject the default payment amount, the provider is able to participate in a fixed-cost Independent Dispute Resolution Process (IDRP). Here in California, there have been only 22 cases where a dispute has risen to the IDRP level since the program launched at the end of 2017. During that time, we have not noted any decrease in the number of individual providers contracting with health plans, nor have we observed a discernable drop in patient access to care.

We understand that additional regulatory changes may occur in the future as the new processes are implemented, but as they currently stand, we are appreciative as they seem to provide long-needed protections. In the coming years we will be watching how federal and state laws interact, will closely review any future regulations or guidance, and will monitor how often and in what circumstances payment determinations land significantly above or below the qualifying payment amount.

We look forward to providing continued support for implementation of the *No Surprises Act*. Please contact Donald B. Moulds, Ph.D., Chief Health Director, at donald.moulds@calpers.ca.gov if you have any questions or would like to discuss our response.

Sincerely,

Marcie Frost
Chief Executive Officer

Cc: Donald B. Moulds