May 21, 2021

Submitted Electronically Via Email

Jeff Wu
Acting Principal Deputy Administrator
Deputy Director for Policy
Centers for Medicare & Medicaid Services
Department of Health and Human Services

RE: Comments Relating to the Surprise Medical Billing Requirements Enacted As Part of the *No Surprises Act*

Dear Mr. Wu,

The Self-Insurance Institute of America, Inc. ("SIIA") respectfully submits these comments relating to the surprise medical billing requirements enacted as part of the *No Surprises Act*. In particular, the below comments discuss matters relating to the preemption of State law in accordance with the Employee Retirement Income Security Act ("ERISA"). These comments also provide specific suggestions for developing certain terms and definitions set forth under the statute, including the "Initial Payment" and the "Qualifying Payment Amount."

SIIA is a member-based association dedicated to protecting and promoting the business interests of companies involved in the self-insurance and captive insurance marketplace. SIIA's membership includes self-insured employers, third party administrators, brokers, and stop-loss/reinsurance carriers, among other industry service providers.

I. The Federal Departments Must Give Due Consideration to Self-Insured Health Plans

SIIA recognizes that while Congress considered self-insured health plans when developing the *No Surprises Act*, much of Congress's focus centered around fully-insured health plans underwritten by commercial insurance issuers. Based on U.S. Department of Labor statistics, 67% of covered workers nationwide receive benefits through a self-insured health plan. As a result, issues impacting self-insured plans and their plan participants are just as important – if not more important – than issues impacting fully-insured plans and their policyholders. We urge the Federal Departments to carefully consider how the surprise medical billing requirements should be applied to self-insured plans when developing implementing regulations, especially how these new rules should apply to self-insured plans with unique and non-traditional plan designs, including plans that directly contract with medical providers and open-access plans with no provider networks.

It is important to emphasize that while fully-insured and self-insured health plans have many similarities, there are differences that we believe the Federal Departments must take into account during the rulemaking process. More to the point, as the Federal Departments develop rules applicable to fully-insured plans, such rules should ***not*** be routinely applied to self-insured plans without careful consideration of these differences. However, as discussed more fully below, we do believe there are instances where the statutory construct applicable to insurance issuers can be similarly applied to self-insured plans and their third-party administrators as a means to simplify the administrative burdens associated with, for example, identifying the median in-network rate in a geographic area.

II. ERISA Preemption

A. The Federal Departments Must Explicitly Clarify that ERISA Preempts State Law

Congress did not explicitly address the issue of preemption of State and/or Federal law in the statute. As a result, we believe that it is imperative that the Federal Departments specifically articulate in the regulation (and not merely the preamble) that in cases where a State law acts immediately and exclusively upon an ERISA-covered self-insured health plan – resulting in "an impermissible connection with" the ERISA-covered self-insured plan – such State law is preempted under ERISA's preemption provision.

It is well-established that ERISA preempts any State surprise medical billing law because such law acts immediately and exclusively upon an ERISA-covered self-insured health plan, thereby having an impermissible connection with the plan. We further believe that ERISA would similarly preempt any State All-Payer Model Agreement because such program would similarly have an impermissible connection with any ERISA-covered self-insured plan. As a result, the forthcoming regulatory provisions implementing the surprise medical billing requirements must explicitly provide that ERISA preempts (1) a State surprise medical billing law and (2) a State with an All-Payer Model Agreement.

B. ERISA Preemption Helps Identify the "Recognized Amount" Payable By an ERISA-Covered Self-Insured Plan Participant

According to the statute, an ERISA-covered self-insured plan participant is required to pay to an out-of-network provider the portion of the "Recognized Amount" for which the participant is responsible based on the cost-sharing requirement that would apply if the medical items or services were furnished by an in-network provider. The "Recognized Amount" is defined in the statute as being equal to one of the following three amounts:

1. If the medical item or service is furnished in a State that has in effect a surprise medical billing law, the amount shall be determined by the State surprise billing law;
2. If the medical item or service is furnished in a State that has ***no*** State surprise billing law, the amount shall equal to the "Qualifying Payment Amount";
3. If the medical item or service is furnished in a State that has an All-Payer Model Agreement, the amount shall equal an amount approved by the State under that system.

Based on the statutory definition of the "Recognized Amount" – and with a clear understanding that ERISA preempts a State surprise medical billing law and a State All-Payer Model Agreement – the ***only*** "Recognized Amount" that an ERISA-covered self-insured plan participant must pay to an out-of-network provider must equal the "Qualifying Payment Amount." Accordingly, we urge the Federal Departments to specifically state the following in the implementing regulations:

- In the case of the “Recognized Amount” that an ERISA-covered self-insured plan participant is required to pay an out-of-network provider, this “Recognized Amount” shall equal the “Qualifying Payment Amount,” meaning that the participant will pay an out-of-network provider the portion of the “Qualifying Payment Amount” for which the participant is responsible based on the cost-sharing requirement that would apply if the medical items or services were furnished by an in-network provider.

Note, some State surprise medical billing laws allow ERISA-covered self-insured plans to “opt in” to the law’s payment requirements. While ERISA-covered self-insured plans rarely ever voluntarily “opt in” to a State surprise billing law, the Federal Departments may choose to afford these self-insured plans a choice: (1) “opt in” to the State surprise billing law or (2) follow the Federal requirements. However, in such a case, the regulations must make clear that a State surprise medical billing law does ***not*** apply to an ERISA-covered self-insured plan unless and until a plan voluntarily “opts in” to a State’s surprise billing requirements.

C. ERISA Preemption Helps Identify the Amount an ERISA-Covered Self-Insured Plan Must Pay to an Out-of-Network Provider After Making an “Initial Payment” or Denying the Payment

According to the statute, not later than 30 days after a bill for furnishing medical items or services is sent by a provider to an ERISA-covered self-insured plan, the plan must either choose to send to the provider (1) an “Initial Payment” or (2) a denial of the payment.

Within the next 30 days after the ERISA-covered self-insured plan decided to either send (1) an “Initial Payment” or (2) a denial of the payment, the plan or the provider may initiate open negotiations for purposes of determining an appropriate payment for amounts that may exceed the portion of the “Recognized Amount” for which the participant is responsible based on the cost-sharing requirement that would apply if the medical items or services were furnished by an in-network provider.[1]

If the plan and provider agree to a negotiated amount within a subsequent 30-day period that begins on the date of the initiation of the open negotiations, then such negotiated amount (which shall include the “Initial Payment” if paid by the plan to the provider) must be paid by the plan to the provider, and any disputed payments shall be deemed to have been resolved.

However, if the plan and the provider do not so agree on a negotiated amount, the statute indicates that the plan will pay the out-of-network provider one of the following three amounts:[2]

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[1] The statute refers to the excess amount that the self-insured plan must pay the provider as the “Total Plan Payment,” which is defined as being equal to the amount by which the “Out-of-Network Rate” for such services exceeds the portion of the “Recognized Amount” for which the participant is responsible based on the cost-sharing requirement that would apply if the medical items or services were furnished by an in-network provider.

[2] In cases where the plan and provider cannot agree on a negotiated amount, the “Total Plan Payment” shall equal the amount by which the “Out-of-Network Rate” exceeds the portion of the “Recognized Amount” for which the participant is responsible based on the cost-sharing requirement that would apply if the medical items or services were furnished by an in-network provider. The statute defines “Out-of-Network Rate” as equaling one of the three amounts listed above. As noted in this Section II.C. of the comment letter, because ERISA preempts a State surprise medical billing law and a State All-Payer Model Agreement, the “Out-of-Network Rate” for a self-insured plan must equal the amount determined by an arbiter through the Federally-developed arbitration/independent dispute resolution (“IDR”) process, unless the plan and provider can come to an agreement on their own outside of the arbitration/IDR process or the Federal Departments allow a self-insured plan to voluntarily “opt in” to a State’s arbitration/IDR process.

1. If the medical item or service is furnished in a State that has in effect a surprise medical billing law, the amount payable shall be determined by the State surprise billing law;
2. If the medical item or service is furnished in a State that has ***no*** State surprise medical billing law, the amount payable shall equal an amount (which shall include the "Initial Payment" if paid by the plan to the provider) that is determined by an arbiter through the Federally-developed arbitration/independent dispute resolution ("IDR") process;[3]
3. If the medical item or service is furnished in a State that has an All-Payer Model Agreement, the amount payable shall equal an amount approved by the State under that system.

Based on this statutory requirement – and with a clear understanding that ERISA preempts a State surprise medical billing law and a State All-Payer Model Agreement – in cases where an ERISA-covered self-insured plan and the provider do not so agree on a negotiated amount, the ERISA-covered self-insured plan will ***only*** be required pay the final payment amount determined by an arbiter through the Federally-developed arbitration/IDR process (hereinafter referred to as "the arbitration process"). We urge the Federal Departments to specifically clarify in the implementing regulations the following:

- In the case an ERISA-covered self-insured plan and an out-of-network provider cannot agree on a negotiated amount, the amount payable by the self-insured plan to the out-of-network provider ***must*** equal the final payment amount determined by an arbiter through the Federally-developed arbitration process.

As previously stated, while an ERISA-covered self-insured plan may "opt in" to a State surprise medical billing law's payment requirements, the regulations must make clear that a State surprise medical billing law does ***not*** apply to an ERISA-covered self-insured plan unless and until a plan voluntarily "opts in" to a State's surprise billing rules.

D. ERISA Preemption and the Arbitration Process

The primary focus of this comment letter is not on the arbitration process itself, which we intend to provide specific and detailed comments on later in the year when the Federal Departments begin drafting regulations describing how the Federally-developed arbitration process will work. However, due to the importance of ERISA preemption, we wanted to lay down a marker on how we believe ERISA preemption will impact an arbiter's decision during this Federally-developed arbitration process.

In short, on account of ERISA preemption, an arbiter should *not* be permitted to look to State-specific decisions as precedent when making a final payment determination. More specifically, because ERISA preempts a State surprise billing law, including a State's own arbitration process, ERISA should similarly preclude an arbiter – during the Federally-developed arbitration process – from considering any decision produced through a State law or through the State's arbitration process. Further, in many instances, State surprise billing laws use different determining factors during the arbitration process, such as billed charges and Usual and Customary Rates, which as discussed below, the statute prohibits an arbiter from relying on during the Federally-developed arbitration process.

[3] According to the statute, not later than 30 days after the date of the selection of the arbiter (defined as the "certified IDR entity"), the arbiter shall make a final payment determination and notify the plan and the provider of the final payment amount payable by the plan to the provider.

III. Statutory Terms and Definitions

A. "Initial Payment"

The term "Initial Payment" is ***not*** defined in the statute. Various stakeholders have suggested that the Federal Departments should leave the term "Initial Payment" undefined and let private-sector market forces determine what that payment should be, if any. SIIA is supportive of this suggestion.

However, if the Federal Departments are of the opinion that some sort of definition of "Initial Payment" is necessary, SIIA believes that the "Initial Payment" should be defined by the ERISA plan document (in the case of a self-insured plan) or the insurance contract (in the case of a fully-insured plan). In other words, the manner in which the ERISA plan document or the insurance contract defines the payment amount that the self-insured plan or insurance issuer will pay to an out-of-network provider prior to (1) agreeing to a negotiated amount or (2) utilizing an arbitration process should govern how the "Initial Payment" is defined.

It is important to note that in the context of an ERISA-covered self-insured plan, the plan sponsor has a fiduciary duty to act in accordance with the plan document. Thus, in cases where the ERISA plan document specifically sets forth an "Initial Payment" that is payable to an out-of-network provider, the plan document should govern, and the "Initial Payment" should equal the payment amount set forth in the plan document. However, in cases where the plan document is silent, an argument can be made the "Initial Payment" should remain undefined, consistent with the suggestion above.

B. "Qualifying Payment Amount"

1. *The Importance of the "Qualifying Payment Amount"*

For self-insured health plans, the "Qualifying Payment Amount" is the most important aspect of the surprise medical billing payment requirements. As discussed above, the "Recognized Amount" for a self-insured plan participant is the "Qualifying Payment Amount" (on account of ERISA preemption), which means that an ERISA-covered self-insured plan participant will pay an out-of-network provider the portion of the "Qualifying Payment Amount" for which the participant is responsible based on the cost-sharing requirement that would apply if the medical items or services were furnished by an in-network provider.

ERISA preemption also tells us that the amount an ERISA-covered self-insured plan must pay to an out-of-network provider ***must*** equal the final payment amount determined by an arbiter through the Federally-developed arbitration process (unless the plan and provider can agree to a negotiated amount or the Federal Departments allow a self-insured plan to voluntarily "opt in" to a State's arbitration process). Importantly, the statute specifically articulates that during the Federally-developed arbitration process, the arbiter ***must consider*** the "Qualifying Payment Amount" when determining a final payment amount that the self-insured plan must pay to the provider,[4] underscoring the importance of how the "Qualifying Payment Amount" should be determined, especially for self-insured plans.

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[4] The statute specifically uses the terms "shall consider" when explaining what an arbiter is required to consider in making a final determination during the arbitration/IDR process, hence our use of, and emphasis on, the words "must consider."

Related to this latter point, questions have been raised as to whether an arbiter must, relative to the "Qualifying Payment Amount," give equal weight to the "additional circumstances" set forth in the statute when making a final payment determination (these "additional circumstances" represent additional factors for consideration during the arbitration process). SIIA acknowledges that, according to the statute, an arbiter must also consider "information on any [additional] circumstances."[5]

However, if Congress intended for an arbiter to give equal weight to "information on any [additional] circumstances," we believe Congress would have included this language in the same statutory sub-clause where Congress articulates that the arbiter ***must consider*** the "Qualifying Payment Amount."[6] In addition, the Congressional Budget Office gave greater weight to the "Qualifying Payment Amount" when scoring the *No Surprises Act*, confirming that Congress intended that the "Qualifying Payment Amount" represents the base-line and primary arbitration factor relative to the "additional circumstances."

As a result, we believe that "information on any [additional] circumstances" is secondary to the consideration of the "Qualifying Payment Amount," meaning that the "information on any [additional] circumstances" merely influences whether this base-line "Qualifying Payment Amount" should be increased or decreased when a final payment determination is ultimately made.

Regarding how these "additional circumstances" may influence the final payment determination, it is important to emphasize the following: The underlying negotiated in-network rate (and associated procedure codes) traditionally include costs associated with many of the arbitration factors enumerated as an "additional circumstance." More specifically, in-network rates already include costs associated with a provider operating as a teaching hospital/institution. In addition, the level of training and experience of a particular provider is often times reflected in the rates, and depending on the type of medical item or service that is being furnished, the complexity of furnishing such item or service is typically a part of the underlying negotiated rate as well. Even in cases where a provider has a dominant market-share, the fact that the provider holds such a dominant position, in-network rates are primarily higher relative to providers that have a minority stake in a particular market.

Based on how rates are negotiated in practice, a strong argument can be made that not only should the "additional circumstances" *not* be given equal weight relative to the weight given to the "Qualifying Payment Amount," but an arbiter *must* take into account the fact that these additional arbitration factors may already be included in the in-network rates that are used to ultimately determine the "Qualifying Payment Amount." If an arbiter does choose to, for example, increase the "Qualifying Payment Amount" based on these "additional circumstances," such an action may double count these costs, effectively amounting to double-dipping.

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[5] According to the statute, these "additional circumstances" include: The level of training or experience of the provider; Quality and outcome measures adopted by the provider; Market-share held by the provider OR the payor in the geographic area; Patient acuity and complexity of services provided; Teaching status of the provider; Efforts by the provider to join the payor's network; Any contracted rates over the prior four years.

[6] For example, new Public Health Services Act ("PHSA") section 2799A-1(c)(5)(C)(i)(I) (and parallel ERISA section 716(c)(5)(C)(i)(I)) states that the arbiter shall consider the "Qualifying Payment Amount," while section 2799A-1(c)(5)(C)(i)(II) (and ERISA section 716(c)(5)(C)(i)(II)) follows-on by stating that the arbiter shall consider "information on any [additional] circumstances"…

2. *The Median In-Network Rate for a Particular Medical Item or Service Furnished In a Particular Geographic Area*

a. Identifying the Median In-Network Rate "Within" Self-Insured Health Plans and Insurance Issuers

Importantly, the statute provides that the term "Qualifying Payment Amount" means: "[T]he median of the contracted rates recognized by ***the*** plan or issuer, respectively (determined with respect to ***all such plans of such sponsor*** or ***all such coverage offered by such issuer that are offered within the same insurance market***)…for the same or similar item or service that is…provided in the geographic region in which the item or service is furnished."

SIIA believes that a clear reading of the statute, coupled with Congressional intent, indicates that the median of the in-network rates charged by the various plan designs offered by a self-insured plan represents the median in-network (i.e., contracted) rate for that self-insured plan for a particular medical item or service furnished in a particular geographic area.

Similarly, we believe that the median in-network rate for each insurance issuer operating in a geographic area shall be determined by identifying the median of all of the in-network rates charged among a specific insurance issuer's individual market plans, small group market plans, and/or large group market plans, respectively.

Based on the foregoing, the median in-network should be determined by identifying the median rate "within" the various plan designs offered by a self-insured plan, and separately, the median in-network rate "within" an insurance issuer's respective lines of insurance business.

b. The Identification of the Median In-Network Rate for Self-Insured Plans Should Be Determined "Within" the Plans' Third-Party Administrator

With respect to self-insured plans, SIIA believes that the Federal Departments can simplify the process for determining the median in-network rate in the following way: As the Federal Departments know, virtually all self-insured plans are administered by a third-party (while some self-insured, self-administered plans exist, there are very few). In cases where a self-insured plan is administered by a third-party, we recommend that the median in-network rate for this self-insured plan should be determined by identifying the median of all of the in-network rates charged by all of the self-insured plans "within" this particular third-party administrator's book of business (grouped by specified categories of self-insured plan-type or self-insured provider network, as discussed more fully below).

Similar to how the statute requires the identification of the median in-network rate for insurance issuers (i.e., the median rate is identified by looking at all of the in-network rates charged among an insurance issuer's fully-insured plans offered in a particular line of business), self-insured plans should be able to look to all of the in-network rates charged among all of the self-insured plans administered by a particular third-party to identify the median of these rates.

SIIA believes that determining the median of the in-network rate charged by all of the self-insured plans administered by a particular third-party is not only consistent with the statute, as articulated above, but such a rule eases much of the administrative burden associated the process of identifying the median in-network (i.e., contracted) rate for a particular medical item or service

furnished in a particular geographic area. In addition, such a rule is consistent with other areas of law such as the Affordable Care Act's "single risk pool" requirement, which pools all of the lives insured by an individual (or small group) market plan by the particular insurance issuer underwriting the respective plans. Here, all of the in-network rates charged by the self-insured plans administered by a third-party would be pooled together for purposes of identifying the median of these rates.

c. The Identification of the Median In-Network Rate Should Also Be Determined "Within" a Group of Similarly Situated Plan Designs

Insurance issuers often times offer fully-insured plans with varied structures and provider networks, such as high-performance networks; tiered networks; narrow networks; and other value-based insurance designs. Similarly, self-insured plans offer varying structures with different provider networks, such as self-insured plans that "rent" provider networks that were developed and maintained by an insurance issuer or other service provider offering access to provider networks; self-insured plans that directly contract with providers; self-insured plans that only base their payments on a percentage or multiplier of Medicare (e.g., a Medicare-plus arrangement); and open-access plans that have no provider networks, such as Reference Based Pricing ("RBP models").

In these instances, the in-network rates that are charged by similarly situated self-insured plans typically differ from the rates charged by other self-insured plan designs, but such rates are usually the same as their similarly situated plans. In other words, the in-network rates charged by a particular group of similarly situated plan designs may be higher or lower relative to other non-similarly situated arrangements, but such rates will be similar to their like-kind plans. As a result, it is reasonable to develop specific "categories" of plan designs through which the median of the in-network rates charged by those similarly situated plans can be identified. SIIA believes that if these similarly situated plans are not categorized together for purposes of identifying the median in-network rate, the median of the rates for these similarly situated plans may be skewed.

Based on the foregoing, SIIA recommends that the Federal Departments develop the following rules:

- All self-insured plans that "rent" a provider network that was developed and is maintained by an insurance issuer or other service provider offering access to provider networks should be grouped together into one category for purposes of identifying the median of the in-network rates charged by these types of self-insured plans. These groups of self-insured plan-types should further be categorized by the insurance issuer or service provider that maintains the provider network that the plan is "renting."
- All self-insured plans that directly contract with a provider should be grouped together into one category for purposes of identifying the median of the in-network rates charged by these types of self-insured plans.
- All open-access plans that have no provider networks should be grouped together into one category for purposes of identifying the median of an in-network rate "equivalent" charged by these types of arrangements.
- Any other like-kind self-insured plan design (such as, for example, Medicare-plus arrangements and others not specifically listed here) should be grouped together, respectively, for purposes of identifying the median of the in-network rates charged by these types of arrangements.

Such grouping can be accomplished "within" a particular third-party that administers these varying types of self-insured arrangements by requiring the third-party to develop such categories among the similarly situated plan designs in their book of business. Again, this is consistent with the statute, as noted above, and it is similar to other areas of the law (e.g., the Affordable Care Act).

d. The Federal Departments Must Confirm That Health Care Providers and Insurance Issuers Must Share Pricing and Health Claims Data

In public comments on the "Transparency In Coverage" regulations, SIIA explained that a self-insured plan will be unable to comply with the new transparency requirements in cases where a health care provider or an insurance issuer that "rents" its provider network to the plan refuses to share pricing and health claims data with the plan sponsor and its service providers (e.g., the plan's third-party administrator). SIIA raises this issue once again due to concerns that if health care providers and insurance issuers continue to refuse to share pricing and health claims data with plan sponsors and their service providers, these sponsors and their third-party administrators will be unable to comply with the surprise medical billing requirements. For example, a sponsor and third-party will not be able to identify a median in-network rate for a particular medical item or service.

In our comments on the "Transparency In Coverage" regulations, we asked the Federal Departments to mandate that providers and insurance issuers must share pricing and health claims data with plan sponsors and their service providers as a means to enabling self-insured plans to comply with the new transparency rules. Unfortunately, the Federal Departments did not accommodate this request, believing that private-sector market forces would resolve the ongoing problem of data-sharing. In particular, the Federal Departments noted that a contract agreement between the self-insured health plan and the provider or insurance issuer typically includes a provision stating that any contract term that conflicts with a Federal law requirement is null and void, and the Departments opined that any contractual provision prohibiting the sharing of pricing and health claims data that prevents the plan sponsor and/or its service providers from complying with the "Transparency In Coverage" requirements would conflict with Federal law, and thus, this contractual provision would be rendered null and void. This legal theory has yet to be proven in practice.

Congress, however, decided to address this particular issue in the *No Surprises Act*. Specifically, Congress added new ERISA section 724, which prohibits the addition of contractual "gag clauses" that preclude a "group health plan" (and its plan sponsor) from accessing pricing information, as well as health claims-related data, from health care providers and insurance issuers that maintain provider networks. SIIA believes that ERISA section 724 is the key to enabling self-insured plan sponsors and their service providers to comply not only with the surprise medical billing requirements, but this change in the law will also enable plan sponsors and their third-party administrators to comply with the "Transparency In Coverage" regulations.

SIIA believes that it is imperative that the Federal Departments confirm that ERISA section 724 does indeed require health care providers and insurance issuers to share pricing and health claims data with a self-insured plan sponsor and its service providers, thus enabling the sponsor and third-party administrator to comply with the surprise medical billing requirements. Remaining silent on this particular issue will cause continued confusion and confrontation.

3. *Appropriate Data To Identify the Median In-Network Rate In a Geographic Area*

a. Identifying the Median In-Network Rate "Within" Self-Insured Plan Administrators and Insurance Issuers Negates the Need for an "Approved" Database

SIIA recognizes that the statute does ***not*** give the Federal Departments concrete instructions on how to appropriately and accurately aggregate data relating to the rates both self-insured plans and insurance issuers charge for particular medical items and services to identify the median in-network rate in a particular geographic area. The statute does provide that for purposes of identifying the median in-network rate based on charges for medical items and services as of January 31, 2019 (for the 2022 plan year), a plan/issuer may identify the median rate by using: "[A]ny database that is determined, in accordance with rulemaking…to not have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic area (such as a State all-payer claims database)."

Notwithstanding this statutory language, SIIA believes that if the Federal Departments require the identification of the median in-network (i.e., contracted) rate to be determined "within" a third-party administrator's book of business (in the case of a self-insured plan) and "within" and insurance issuer's lines of insurance business (in the case of fully-insured plans), such a requirement negates the need to rely on a "database" for purposes of, for example, identifying the median in-network rate charged for a particular medical item or service as of January 31, 2019. We similarly believe that going forward (in plan years after 2022), the median in-network rate can be appropriately and accurately identified by looking "within" the third-party administrator and insurance issuer to identify the median in-network rate, even in cases of new coverage offerings or coverage newly offered in a particular geographic area.

b. Guardrails for "Approving" Private-Sector Databases

Notwithstanding our belief that a database for identifying the median in-network rate in a geographic area is unnecessary, if the Federal Departments move forward with developing rules for "approving" a database, we recommend that the Federal Departments develop specific criteria that private-sector third-parties should meet in order to be "certified" or "approved" as a reliable database.

For example, as the statute indicates, the Federal Departments ***cannot*** "approve" databases that have been – or can be – shown to have a conflict of interest. This *must* be a prerequisite to any Federal "approval" of any said database, and we believe the burden of proof is on the private-sector third-party seeking Federal "approval." More specifically, this third-party must affirmatively prove to the Departments that the private-sector entity does not have any conflicts of interest (e.g., the entity cannot be funded by a medical provider(s) or a private equity firm(s)). A simple "attestation" that the entity has no conflicts of interest is ***not*** sufficient.

In addition, if a self-insured plan or insurance issuer provides the Federal Departments with evidence that any third-party seeking "approval" as a reliable database does indeed have a conflict of interest that was not properly disclosed to the Federal Departments, the Departments should adopt a rebuttable presumption reliance on this evidence, meaning the third-party seeking "approval" must affirmatively provide the Departments with evidence that shows that no conflict of interest is present.

SIIA also believes that the Federal Departments must prohibit the use of any database that develops their "data set" based on billed charges and/or Usual and Customary Rates. To do otherwise would not only be inconsistent with the statutory prohibition against arbiters relying on billed charges and Usual and Customary Rates during the Federally-developed arbitration process, but this would be inconsistent with the statutory language noted above. Again, proving to the Federal Departments that billed charges and/or Usual and Customary Rates are not baked into the algorithm for compiling the "data set" *must* be a prerequisite for "approval," and the burden of proof must be on the private-sector third-party seeking "approval." Self-insured plans and insurance issuers may also present evidence that billed charges and/or Usual and Customary Rates are being used to develop the rates in the "data set" and the burden must be on the third-party to rebut this evidence.

c. Additional Considerations Related to "Approving" a Database

As explained above, looking "within" a self-insured plan administrator and an insurance issuer to identify the median in-network rate charged by a self-insured plan/issuer in a geographic area negates the need for the type of database that the statute suggests for the 2022 plan year and in cases of coverage that is newly made available and/or coverage offered in a particular geographic area for the first time.

However, if the Federal Departments feel compelled that the Departments are required to establish some sort of "certification" process for approving private-sector databases (as also discussed above), it is reasonable to suggest that the reliance on any private-sector database – especially if payors can choose from multiple private-sector databases that receive Federal Department "approval" – may result in a fragmented set of "data sets" with inconsistencies and bias.

As a result, the Federal Departments may consider developing a Federally-maintained database that aggregates all of the publicly available in-network rates that must be disclosed in accordance with the "Transparency In Coverage" regulations (but such Federally-maintained database should only be made available in 2023 or 2024, considering the fact that self-insured plans and insurance issuers are not required to publicly disclose their in-network rates until January 1, 2022).

If the Federal Departments choose to develop this type of Federally-maintained database, the Federal Departments could also develop a publicly accessible standards-based application program interface ("API") through which third-party developers could create mobile applications that could connect directly with the API which – when accessed by a plan administrator and/or insurance issuer – could assist the third-party and/or issuer in ensuring that the median in-network rate that was identified "within" their book of business/lines of insurance business is accurate. In addition, the API could further assist an arbiter in appropriately and adequately identifying the "Qualifying Payment Amount" (i.e., the median in-network rate) during the Federally-developed arbitration process. And, such an API – linked to a Federally-maintained database – could aid in meeting the broader policy goals of (1) increasing the transparency of health claims data through the "Interoperability Rules" and (2) increasing the transparency of medical prices through the "Hospital Price Transparency" and the "Transparency In Coverage" regulations.

4. *The Median In-Network Rate In a Geographic Area Should Be Allowed to Be Based on a Percentage of Medicare*

When developing the "methodologies" for identifying the median in-network rate, the statute directs the Federal Departments to take into account "payments that are made by the insurer or plan that are not on a fee-for-service basis." In our opinion, this language is referring to payments made under value-based plan designs and other unique and non-traditional plans such as open-access plans with no networks and other Medicare-plus and RBP models. In the case of these types of plans, a percentage of Medicare is often times used to determine the payment rate for a particular medical item or service.

SIIA believes that the Federal Departments should develop rules that take into account payments based on a percentage of Medicare, and we believe the Departments should allow self-insured plans and insurance issuers to identify the median in-network rate based on a percentage of Medicare formula. We believe that this can be done in a manner similar to what we see in the "Transparency In Coverage" regulations, where self-insured plans and insurance issuers can base their in-network rates on a percentage of Medicare and convert the amounts paid for the medical items or services into real dollar amounts.

We also believe that identifying the median in-network rate by taking into account payments that are based on a percentage of Medicare will resolve issues relating to the Federally-developed arbitration process. As the Federal Departments know, the statute prohibits an arbiter from taking into account "public health plan" rates (like Medicare) when determining a final payment amount during the Federally-developed arbitration process. This language has prompted a number of stakeholders – including SIIA – to wonder whether the arbiter can take into account rates based on a percentage of Medicare in arbitration.

In our opinion, if self-insured plans and insurance issuers are permitted to take into account payments based on a percentage or multiplier of Medicare when identifying the median in-network rate, the arbiter will by definition – and operation of the law – be permitted to take into account rates based on a percentage of Medicare during the arbitration process (because, as explained above, the arbiter ***<u>must consider</u>*** the "Qualifying Payment Amount" during the Federally-developed arbitration process, and if the "Qualifying Payment Amount" (i.e., the median in-network rate in a geographic area) can be based on a percentage of Medicare, then the arbiter must consider this percentage of Medicare formula).

5. *Identifying the "Geographic Area"*

For purposes of identifying the median in-network rate in a geographic area, SIIA believes that a reasonable "methodology" for determining the appropriate geographic areas is mirroring Medicare's geographic payment map, or utilizing the Metropolitan Statistical Areas or the Core-Based Statistical Area (which are used by the U.S. Census as well as Medicare), or even the Affordable Care Act's "rating areas" (i.e., zip codes). However, SIIA does believe there is merit to considering "geographic areas" based on population density, as well as provider density. For example, we believe Congress intended the Federal Departments to consider both population and provider density when directing the Federal Departments to "tak[e] into account access to items and services in rural and underserved areas."

IV. <u>The Federal Departments Should Develop a "Good Faith" Compliance Safe Harbor Applicable to the 2022 and 2023 Plan Years</u>

As the Federal Departments are well-aware, complying with the requirements set forth in the *No Surprises Act* will <u>*not*</u> be easy for both the providers and the payors (i.e., self-insured plans and insurance issuers). As a result, SIIA recommends that the Federal Departments develop a "good faith" compliance safe harbor for the 2022 and 2023 plan years for <u>*all*</u> of the requirements set forth under the *No Surprises Act*, not just the requirements that are slated to be included in the first set of regulations that are due by July 1st.

More specifically, SIIA recognizes that the effective dates for the surprise medical billing requirements are hard-wired into the statute, and as a result, we are not asking for a delay in these effective dates. But, based on the complexities and administrative burdens associated with complying with the specific changes Congress made to the law, we believe that there is ample good cause – and it is certainly in the public's best interest – to develop a "good faith" compliance safe harbor in which the Federal Departments will *not* impose any penalties on any payor or provider if they undertake good faith efforts to comply with applicable law.

There are countless instances in which the Federal Departments have developed and implemented a "good faith" compliance safe harbor for multiple years. Two noteworthy instances include (1) a "good faith" safe harbor for 2014 and 2015 for compliance with the certification standards for insurance issuers seeking to participate in HealthCare.gov (this "good faith" safe harbor was implemented again in 2018) and (2) a "good faith" safe harbor for compliance with the employer reporting requirements related to the Affordable Care Act's "employer mandate" for both issuers and self-insured health plan sponsors, first announced for the 2015 tax year, and extended each year through 2020.

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Thank you in advance for considering these comments. Please do not hesitate to contact me should you have questions or if members of SIIA can serve as a resource on these very important matters.

Sincerely,

Michael W. Ferguson
President and Chief Executive Officer
Self-Insurance Institute of America, Inc.