January 29, 2020

Submitted Electronically via: ***www.regulations.gov***

Attention: CMS–9915–P
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244–8010

RE: Comments on the Proposed Transparency In Coverage Regulations

To Whom It May Concern:

The Self-Insurance Institute of America, Inc. ("SIIA") respectfully submits these comments in response to the Notice of Proposed Rulemaking ("NPRM"), setting forth proposed requirements for group health plans and health insurance carriers in the individual and group markets to disclose information about (1) specific cost-sharing information for plan- and policy-holders, (2) the health plan's and policy's negotiated in-network rates, and (3) health plan's and policy's "historical" payments to out-of-network providers.

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

A. SIIA Supports Increasing the Transparency of Medical Prices and Cost-Sharing Information

SIIA supports the Administration's efforts to increase the transparency of medical prices and cost-sharing information. For far too long, our health care system has been opaque, to the detriment of employers who are committed to keeping their employees healthy and productive, and to the detriment of employees who are finding it more and more difficult to pay for their own health care.

More specifically, SIIA supports efforts to move our health care system toward a value-based health care system. We believe that one of the more potent value-based care strategies is increasing the transparency of medical prices and cost-sharing information. There are other effective strategies like value-based contracting and risk-sharing between a medical provider and a self-insured health plan (as the payer). In these cases, the provider must meet certain "quality" metrics and benchmarks, and in some cases, agree to bundled payments for certain medical episodes. But again, we believe that the most powerful way of transforming our health care system into a private, market-based system is through the disclosure of a plan's and policy's negotiated in-network rates and the plan's and policy's payments to out-of-network providers (referred to under the proposed regulations as "allowed amounts").

We further believe that the continued increases in health care costs are unsustainable,[1] and based on this fact, we believe that stakeholders in the health care industry have a choice: (1) Accept changes in the law that would move our health care system toward a value-based, market-driven health care system or (2) Be forced to accept system-wide government price controls. In our opinion, the choice is that stark in contrast.

Despite our support for increasing the transparency of medical prices and cost-sharing information, we are concerned about the difficulties sponsors of self-insured health plans and their designated agents will experience when it comes to complying with the proposed regulations, specifically accessing the required data. In particular, if plan sponsors and their designated agents cannot access the plan's negotiated in-network rates and/or the "allowed amount" payments to out-of-network providers, it will be impossible for self-insured plans to comply with the proposed requirements. In addition, we are concerned about the administrative costs that self-insured health plans (especially small self-insured plans) and their designated agents will have to bear as they attempt to comply with the proposed requirements.

Notwithstanding these concerns, SIIA is committed to working with the Administration to strike the right balance between increasing the transparency of medical prices and cost-sharing information and the administrative burdens and costs associated with effectuating this policy goal.

B. For True Transparency, Insurance Carriers and Medical Providers Must Be Required to Share Plan Data With the Plan Sponsor and Its Designated Agents In a Timely Manner

Employers that employ 10,000 or more employees (often times referred to as "jumbo employers") are best positioned to directly negotiate with medical providers to establish the particular prices their self-insured health plan will pay for medical items and services covered under the plan. However, the vast majority of employers that sponsor a self-insured health plan employ fewer than 10,000 employees. Some self-insured employer sponsors employ less than 100 employees, while the bulk of self-insured employers range from 500 to 9,999 employees.

In many cases, these small-, mid-sized, and large-employer sponsors of a self-insured plan health plan do not negotiate directly with medical providers to establish the particular prices the plan will pay. Rather, these plan sponsors contract with an insurance carrier (1) that already has a medical provider network in place in a particular geographic area and (2) that already negotiated the prices for the medical items and services that will be covered under the self-insured plan. In other words, the self-insured plan sponsor "rents" the insurance carrier's provider network, and the self-insured plan sponsor relies on the insurance carrier's negotiated prices with the providers in the carrier's network.

[1] The Kaiser Family Foundation ("Kaiser") recently revealed that the cost of a "family" employer-sponsored health plan is now close to $20,000 ($19,616 to be exact). Kaiser also indicated that the average deductible for an employer-sponsored plan has doubled since 2008. Premiums also went up 55% since 2008, even though during the past five years, premiums for employer plans have only gone up by 3% to 4%t. For 2018, premiums for employer plans went up by 5%. *See* Kaiser Family Foundation, *2018 Employer Health Benefits Survey* at https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/.

In this case, the insurance carrier possesses all of the information relating to the self-insured plan's negotiated in-network rates and payments to out-of-network providers (i.e., the "allowed amounts"). Historically, insurance carriers that possess all of the information on the plan's negotiated in-network rates and "allowed amounts" have refused to share this information with the self-insured plan sponsor and any of the plan sponsor's designated agents, such as third-party administrators ("TPAs").[2]

If TPAs and plan sponsors have *no* access to the self-insured plan's negotiated in-network rates and "allowed amounts," it makes it impossible for the plan sponsor to comply with the proposed regulations. For example, the plan sponsor will be unable to provide participants with accurate cost-sharing liability information if the plan sponsor does not have information on the plan's negotiated in-network rate for the medical item or service the participant is inquiring about. In addition, the plan sponsor cannot even begin to develop the "machine-readable" files disclosing all of the plan's negotiated in-network rates and "allowed amounts" paid to out-of-network providers.

As a result, if the Departments expect self-insured health plans to comply with the proposed regulations, the Departments must require insurance carriers (and any other medical provider) that possess information on the plans' negotiated in-network rates and "allowed amounts" to provide this information to plan sponsors and their TPAs. The Departments must also require that this information is provided in a timely manner. For example, any information relating to a plan's negotiated in-network rates and "allowed amounts" must be transmitted to the plan sponsor and its TPA within 3 days of any request for information by the plan sponsor and/or its TPA, and within 7 days of any new information that the insurance carrier (or medical provider) may obtain. In addition, the Departments must prohibit insurance carriers (and medical providers) from placing anti-competitive conditions that limit – or prevent – the sharing and use of the plan's negotiated in-network rates and "allowed amounts."

C. Plan Sponsors Should Not Be Held Liable In Cases Where the Plan Data Is Not Shared With the Plan Sponsor and Its Designated Agents In a Timely Manner

As discussed, if an insurance carrier (or any other medical provider) that possesses information about a self-insured plan's negotiated in-network rates and "allowed amounts" does not share this information with the plan sponsor and its TPA, the plan sponsor *cannot* comply with the proposed regulations. As a result, in cases where the necessary information is not shared in a timely manner, the plan sponsor should *not* be liable for its failure to comply with the proposed requirements.

More specifically, the proposed regulations currently provide that in cases where a plan sponsor contracts with a third-party (e.g., the plan sponsor "rents" an insurance carrier's provider network), any liability that results from non-compliance with the proposed regulations rests with the plan sponsor, not the third-party. It is imperative that the Departments modify this rule to provide that in cases where a plan sponsor tries – but is unable – to gain access to the plan's negotiated in-network rates and "allowed amounts," the plan sponsor shall *not* be held liable for failing to disclose the plan's

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[2] Although some plan sponsors of a self-insured plan may use an insurance carrier as its third-party administrator ("TPA"), many other plan sponsors work with an "independent" TPA (i.e., a non-carrier TPA) to, among other things, adjudicate health claims and appeals, facilitate enrollment and premium payments, perform certain plan administration functions, and respond to inquiries from members regarding their health coverage. These independent TPAs – like the plan sponsor – can only access the plan's negotiated in-network rates and "allowed amounts" if the insurance carrier (or any other medical provider) shares this information with the TPA.

negotiated in-network rates and "allowed amounts" through the on-line cost-sharing liability self-service tool and the public websites that the plan must establish.

In addition, the Departments must make clear that in cases where a plan sponsor can reasonably show that a contracted third-party (e.g., an insurance carrier or medical provider) withholds specific information or fails to timely transmit the information to the plan sponsor, any resulting liability for failure to comply with the proposed regulations rests with the third-party, not the plan sponsor acting in good faith. This would also include instances where a medical provider or other entity that is not subject to the Departments' authority refuses to share the necessary information with the plan sponsor and/or its TPA. Here, the plan sponsor should not be held liable for these non-compliant entities' failure to the disclose the necessary information.

D. Relying on "Clearinghouses" to Hold Plan Data Does Not Guarantee Compliance With the Proposed Regulations

The Departments suggest that self-insured health plans can use "clearinghouses" to store all of the necessary information that must be disclosed under the proposed regulations. While we agree that "clearinghouses" can indeed be used to store most if not all of the information that the plan needs to draw on to comply with the proposed requirements, compliance with the proposed regulations is contingent on these "clearinghouses" receiving the necessary plan data from those entities that possess the data (i.e., the insurance carriers and/or medical providers). Consistent with the points made above, the Departments *must* require the insurance carriers (or any medical providers) that possess the necessary data to share this information – in a timely manner – with those "clearinghouses" that plans choose to partner with. Failing to do so would corrupt the policy goal that the Departments are trying to achieve by making it impossible for self-insured plan sponsors to comply with these new requirements.

Despite our belief that self-insured plans can use "clearinghouses" to store plan data, we do have concerns about the cost of data-storage, which could be significant. We believe that any services that a "clearinghouse" provides to a self-insured plan must be reasonably priced and non-discriminatory (i.e., higher prices cannot be charged to smaller plans and discounts cannot be afforded to plans based on their size).

E. Open Access Self-Insured Health Plans

Another issue that is unique to self-insured health plans is that an increasing number of plans do not have any traditional provider network at all. In these cases, the plan sponsor does not "rent" a provider network from an insurance carrier, nor do they directly negotiate payments with providers. Instead, the plan sponsor permits its plan participants to procure health care services from any medical provider a participant chooses. Then, a third-party – on behalf of the plan – will pay the provider a percentage of the Medicare rate that is charged for a particular medical item or service (e.g., the payment may be 150% of the Medicare rate).

In cases where there is no appropriate Medicare rate for a particular medical item or service that can be used as a benchmark for determining a payment amount, the third-party may base the payment on other benchmarks such as the Usual, Customary, and Reasonable ("UCR") amount or Medicaid rates, or the provider will negotiate a payment amount based on an alternative benchmark such as a percentage of billed charges. In very limited cases, the third-party – on behalf of the plan – may negotiate prospective agreements (before services are rendered) with providers to pay these

providers a certain rate (e.g., a percentage of Medicare or a percentage of billed charges). In virtually all cases, however, the determination of the payment amount to providers is made *after* a particular medical item or service has been utilized by the patient.

The proposed regulations define an "in-network provider" as "a provider that is a member of the network of contracted providers established or recognized under a participant's or beneficiary's group health plan or health insurance coverage." The proposed regulations also define a "negotiated rate" as "the amount a group health plan or health insurance issuer, or a third party on behalf of a group health plan or health insurance issuer, has contractually agreed to pay an in-network provider for covered items and services, pursuant to the terms of an agreement between the provider and the group health plan or health insurance issuer, or a third party on behalf of a group health plan or health insurance issuer."

It would appear that a self-insured plan with no provider network (i.e., an "open access self-insured plan") will never include in-network providers and never have negotiated in-network rates. As a result, it would appear that the requirement to disclose negotiated in-network rates would not apply to this open access self-insured plan. Rather, the plan would only have information on the "out-of-network allowed amounts," which the proposed regulations define as "the maximum amount a group health plan or health insurance issuer would pay for a covered item or service furnished by an out-of-network provider."

However, the Departments could define an "in-network provider" as a provider that accepts payment amounts from a self-insured health plan that is based on a percentage of Medicare rates charged for a particular item or service, or an alternative benchmark rate. In this case, *all* of the providers that participants in an open access self-insured plan may receive medical services from would be considered "in-network providers." Here, the "negotiated in-network rate" would equal the percentage of Medicare rates (or an alternative benchmark rate) charged for a particular item or service. In this case, an open access self-insured plan would *not* be required to disclose the "allowed amounts" paid to out-of-network providers because the plan would never make payments to an out-of-network provider (which is defined as "a provider that does not have a contract under a participant's or beneficiary's group health plan or health insurance coverage to provide items or services").

Despite the unique nature – and operation – of an open access self-insured plan, we believe that the policy goal of disclosing the amounts that the plan will pay on behalf of a participant for a particular medical item or service will still be achieved, along with the policy goal of providing participants with information on their cost-sharing liability.

F. Converting the Cost of a Medical Item or Service Based on a Percentage of Medicare Rates to a Dollar Amount Will Be Difficult

The proposed regulations provide that to the extent a plan reimburses providers for medical items or services based a percentage of Medicare rates, the plan would be required to convert the amounts paid for the medical items or services into real dollar amounts. We understand the Departments' interest in this conversion (because participants understand dollar amounts as opposed to an arbitrary formula). However, self-insured plans that pay providers based on a percentage of Medicare rates typically do not have the actual Medicare rate of the particular medical item or service in advance of the participant utilizing the item or service. As a result, plan sponsors will *not* have the necessary information to provide participants with estimates of their cost-sharing liability through the on-line cost-sharing information tool until *after* the participant utilizes the medical item or service.

The Departments could address this problem by creating a publicly accessible application program interface ("API") that can transmit any and all information on Medicare rates for the medical items and services covered under Medicare in real-time. This way, if a participant requests cost-sharing information on a particular medical treatment (e.g., chemotherapy treatment), the plan sponsor (and their designated agents) could retrieve the Medicare rate for the chemotherapy treatment through the API at the time of the participant's request. Then, the plan sponsor could convert the percentage the plan will pay for the chemotherapy treatment into real dollar amounts.

Without this publicly available API that can provide plan sponsors (and their designated agents) with the Medicare rates in real-time, we believe that it will be impossible for plan sponsors to provide participants with estimates of their cost-sharing liability for a particular medical item or service in advance of their utilizing the medical item or service.

G. Disclosing the Negotiated In-Network Rate When No Cost-Sharing Is Required

The Departments requested comments on whether a plan sponsor should be required to disclose the negotiated in-network rates in cases where the rate is irrelevant to a participant's request for cost-sharing liability information. This situation arises if the medical item or service does not have any cost-sharing associated with it, or in cases where the participant has already met their deductible and there is no co-pay or co-insurance for the requested medical item or service.

We believe that if the plan sponsor already has information on the negotiated in-network rate for a particular medical item or service, the plan should disclose the negotiated in-network rate even if the rate is irrelevant to the participant's request for cost-sharing liability information. We further believe that disclosing the amount of the negotiated in-network rate is extremely valuable regardless of whether the disclosure of this information impacts a participant's cost-sharing liability. In our opinion, exposing participants to the negotiated in-network rate for particular medical items and services will inform them of how much these particular items and services may cost overall. And, if the plan has different negotiated in-network rates with different providers furnishing the same medical item or service, participants will have the opportunity to compare the different rates among the different providers, in addition to important factors such as quality of care and outcome metrics.

H. It Is Imperative That Participants Are Informed That Their Cost-Sharing Liability Is An Estimate

The proposed regulations require self-insured plans and insurance carriers to inform the participant that the cost-sharing information provided through the on-line self-service tool is simply an estimate (and that there may be other factors not considered at the time of the participant's request that may impact the participant's cost-sharing liability, such as pertinent policy provisions regarding eligibility, medical necessity, and experimental/investigational treatments). This disclosure is of extreme importance not only for participants – but also for the plan sponsor – and we urge the Departments to finalize this proposal.

In short – similar to the Departments – SIIA wants participants to receive the most accurate information about their cost-sharing liability. However, we recognize that there will be a number of instances where a plan sponsor does not know the specific cost for a medical item or service until *after* the medical item or service is utilized. As discussed, this situation arises in cases where payments to an in-network and/or out-of-network provider are based on a percentage of Medicare. This situation

also arises if payments are based on a discounted percentage of billed charges (e.g., a negotiated 40% discount on the billed charges for an MRI). This is most acute in cases where an out-of-network provider is furnishing the medical item or service.

In addition, certain negotiated in-network rates and/or "allowed amounts" may be outdated based on the date on which the participant requests information about his or her cost-sharing liability and the date on which the medical item or service is actually utilized (e.g., on March 1st, a participant may request cost-sharing information on a medical procedure that will not be performed until September 1st). The participant's "accumulated amounts" may also change during the time of the request and when the medical procedure is actually performed.

I. Disclosure to Participants About Claims Incurred But Not Yet Processed

As discussed, the proposed regulations already require plans and insurance carriers to inform the participant that the cost-sharing information is simply an estimate. We believe this disclosure should also specifically spell out that the cost-sharing estimate does not take into account health claims that have been submitted by the participant, but have not yet been processed. This type of disclosure actually inures to the benefit of the participant because in many cases, any out-of-pocket exposure associated with the unprocessed claim will count toward the participant's "accumulated amount," which may ultimately lower the participant's cost-sharing liability associated the participant's request. However, there may be instances where the plan has placed a limitation on the medical item or service, and the participant may have reached their limit under the plan on account of the unprocessed claim, but that information will not yet be available to be conveyed upon the participant's request.

J. Plans and Carries Should Be Required to Include a Disclosure About "Surprise Medical Bills"

The Departments requested comments on whether plans and carriers should include a disclosure advising participants of their potential exposure to a "surprise medical bill." We believe that such a disclosure is necessary, and we urge the Departments to finalize this proposal. In our opinion, this type of disclosure should inform the participant that they should confirm with the out-of-network provider the amount the plan and the participant will be paying for the medical item or service based on the information provided to the participant through the on-line cost-sharing liability self-service tool. This type of disclosure should also encourage the participant to ask an in-network facility – in advance – whether an out-of-network provider will or may potentially be furnishing any services during a particular in-network medical procedure.

K. "Surprise Medical Bills" Could Be Reduced Through Increased Disclosure of Medical Prices and Cost-Sharing Information

"Surprise medical bills" have become a serious issue for patients and their families. Too often, patients who receive medical services from an out-of-network provider are subsequently blind-sided by bills in amounts far exceeding reasonable in-network rates. Patients deserve to be protected from excessive and unexpected costs. If Congress is unable to eliminate – or at least mitigate – the scourge of surprised bills, we believe the Departments should take steps to equip patients with information to estimate a portion of what they may owe to an out-of-network provider.

It is important to emphasize that plan sponsors of self-insured health plans typically do not – and will not – know what the overall price an out-of-network provider may charge for a particular item or service. However, plan sponsors are in a position to know the negotiated in-network rate for the same medical item or service, in addition to the "allowed amount" that the plan will pay to an out-of-network provider for a particular medical item or service. We, therefore, believe that disclosing the negotiated in-network rate for the same medical item or service, in addition to the "allowed amount" that the plan will pay to the out-of-network provider (plus any cost-sharing for the "allowed amount"), could motivate the patient to request – in advance – the price the out-of-network provider will be charging for a particular medical item or service.

In addition, in cases where a participant is undergoing a medical procedure at an in-network facility, the participant typically does not expect to be treated by an out-of-network provider. Too often, however, out-of-network providers furnish medical services at the in-network facility, which produces a bill for medical services that are not covered under the plan. If a participant at least knows the plan's negotiated in-network rate of the medical procedure, in addition to knowing any cost-sharing liability for this in-network service, the participant may confirm with the in-network provider – in advance – the amount the plan and the participant will be paying for the medical procedure. Then, if a surprise medical bill is produced because an out-of-network provider happened to furnish medical services at the in-network facility, the participant can claim that the plan and the participant are not responsible for the out-of-network charge, rather the in-network facility is responsible, because the participant was not informed – in advance – that an out-of-network provider would furnish the medical services.

L. The On-Line Cost-Sharing Liability Self-Service Tool

We believe that TPAs and other third-party developers are equipped to help build an on-line cost-sharing liability self-service tool for plan sponsors. For example, TPAs are typically responsible for tracking participants' "accumulated amounts," and thus, TPAs can easily incorporate this information into any cost-sharing liability tool they may build (or any cost-sharing liability tool that the TPA may partner with another third-party developer to build). However, as discussed above, insurance carriers (and medical providers) that possess information on the self-insured plan's negotiated in-network rates and "allowed amounts" *must* share this information with the TPA and/or third-party developer (or it will be impossible for the TPA and/or the third-party developer to build the on-line self-service tool and/or disclose this information on public websites).

It is important to emphasize that the cost associated with building an on-line cost-sharing liability tool will likely be significant. In some cases, TPAs may not have the necessary resources to actually build the tool. Or, TPAs may possess the necessary resources, but the TPAs may arbitrarily pass these costs onto the plan, which would simply increase the cost of the plan's administration.

However, the cost associated with building the on-line cost-sharing liability tool may be reduced if the cost-sharing information could be delivered to participants through a mobile application, instead of traditional website. The Departments went so far as to request comments on whether the final regulations should permit the disclosure of cost-sharing information through mobile applications, or to require that the disclosures be made through multiple means, such as *both* a website and a mobile application. We believe that the delivery of the cost-sharing information should be able to be made through mobile applications independent of an official website because we believe that the resources required for building and maintaining a mobile application are less relative to building and maintaining a website.

M. The Negotiated In-Network Rate and "Allowed Amounts" Files Posted on Public Websites

We support the disclosure of negotiated in-network rates and "allowed amount" payments to out-of-network providers on public websites, although we do have concerns relating to the cost associated with creating – and maintaining – these public websites, especially in the short-term. The Departments requested comments on whether the negotiated in-network rates and "allowed amount" payments should be combined and displayed on one, single website. We do not support such an approach because we believe that a combined negotiated in-network rates and "allowed amount" file will be so massive that the cost associated with storing and maintaining this information – in addition to maintaining the website – may outweigh the benefit of making this data public.

We also believe that the plan's negotiated in-network rates are fundamentally different from the plan's "allowed amount" payments to out-of-network providers. For example, the negotiated in-network rates are typically set prior to the start of the plan year, and these amounts often times do not change over the course of the plan year. As a result, updating the negotiated in-network rate file monthly will typically not show any differences in the disclosed rates from month-to-month. Therefore, we believe that the negotiated in-network rate file only needs to be updated on a quarterly basis.

The "allowed amount" payments, however, will vary over the six-month period that plans are required to display this information. As a result, we believe that the historical "allowed amount" file should be updated monthly. While an argument can be made that this file should be updated more frequently than monthly (due to the dynamic nature of the varying out-of-network health claims that a plan pays during the course of a particular month), we believe that requiring plans and their designated agents to update the "allowed amount" file more frequently than monthly would be overly burdensome.

N. Public API and APIs That Can Be Used By Patients and Providers

The Departments suggested that instead of a self-insured plan and an insurance carrier developing a public website to disclose the plan's and carrier's negotiated in-network rates and "allowed amounts," that the plan and carrier could send the negotiated in-network rates and "allowed amount" files to HHS where HHS could post this information on a publicly accessible website. We support this approach, but only if HHS requires that those entities that possess a self-insured plan's data (e.g., an insurance carrier and/or a medical provider) provide this information directly to HHS, or consistent with our comments above, that HHS requires that these entities share this information with the plan sponsor and its designated agents.

We also request that HHS develop and maintain a publicly accessible standards-based API that can transmit a plan's negotiated in-network rates and/or "allowed amounts" not only to the public (e.g., participants, researchers, and policymakers), but to the plan sponsor and its designated agents. This will assist plan sponsors and their designated agents in building the on-line cost-sharing liability tool. After all, the core elements of the cost-sharing liability tool are the plan's negotiated in-network rates and "allowed amounts," which are critical for calculating a participant's cost-sharing liability.

If the cost-sharing liability tool can access the HHS-developed and maintained API directly, this would likely reduce the administrative burdens associated with building the self-service tool, and we believe it would reduce the cost of data-storage. This type of public API would also significantly reduce the administrative burdens and costs associated with data-storage and the requirement that each self-insured plan – regardless of size – build its own internet website to display the plan's negotiated in-network rates and "allowed amounts" files.

If HHS chooses not to develop and maintain a publicly accessible API, we are supportive of allowing individual plan sponsors to create an API that third-party developers can then access to, for example, create a mobile application that would provide participants with their cost-sharing liability information upon their request, as well as a mobile application for the negotiated in-network and "allowed amount" files that can be accessed by participants, researchers, and policymakers. Again, we believe that the development of an API will streamline the administrative burdens and costs associated with building a plan-specific cost-sharing liability tool and an internet website for the negotiated in-network and "allowed amount" files.

O. Delay the Effective Date of the Regulations

As discussed throughout this comment letter, SIIA is supportive of increasing the transparency of medical prices and cost-sharing information. However, as also discussed throughout this comment letter, we believe that plan sponsors and their designated agents will experience difficulties when it comes to accessing the plan's negotiated in-network rates and "allowed amount" payments to out-of-network providers. Based on these difficulties, we believe the Departments should delay the effective date of the regulations by at least one year. Or at a minimum, the Departments should develop staggered effective dates, giving self-insured health plans more time to comply with the proposed requirements relative to date on which insurance carriers must comply with the final regulations.

In addition, the Departments have signaled that plan sponsors should be able to comply with the proposed regulations by outsourcing the data aggregation and collection to third-parties, and also hiring third-parties to develop an on-line cost-sharing liability self-service tool and public websites. However, if every self-insured plan sponsor is expected to hire these third-party developers and/or data aggregators and collectors, there may not be enough third-party service providers to satisfy the demand for complying with the regulations. A similar problem was experienced by TPAs in the wake of the previous Administration's regulations relating to the payment of contraceptive coverage.[3]

We believe some sort of relief should be afforded to self-insured health plan sponsors that may not be able to find a suitable TPA or third-party developer to build the on-line cost-sharing liability tool and/or the public websites to disclose the plans' negotiated in-network rates and "allowed amounts." The Departments could consider a "safe harbor" for complying with the proposed requirements in this case, or the Departments could delay the effective date of the regulations for another year (or develop a staggered effective date as noted above).

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[3] Under those regulations, a TPA of a self-insured health plan – and not the plan itself – was required to pay for the contraceptive coverage, and then seek reimbursement from an insurance carrier that was selling "individual" market plans on the ACA Exchanges (reimbursement was in the form of the "user fees" the insurance carrier had to otherwise pay to the Exchange). However, a large number of TPAs could not find an insurance carrier that was willing to provide reimbursement primarily because those insurance carriers selling "individual" market plans through an ACA Exchange were already partnering with TPAs. In other words, there was a shortage of insurance carriers that were in a position to reimburse the TPAs, resulting in a large number of TPAs going without any reimbursements for their payments for the contraceptive coverage made on behalf of their self-insured health plan clients.

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Thank you in advance for considering these comments. Please do not hesitate to contact me if 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.