SPBA

spbatpa.org

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: No Surprises Act Regulations

May 18, 2021

Dear Ladies and Gentlemen:

Thank you for the opportunity to participate in the recent Tri-Department virtual listening session with stakeholders on the No Surprises Act (the Act). We welcomed the chance to share our perspective, and offer this additional feedback based on the questions discussed in the session.

Background
SPBA is the leading national trade association of Third Party Administration (TPA) firms hired by employers and employee benefit plans to provide contract-based management of their employee benefit plans. The Kaiser Family Foundation estimates 61%+ of all employees in non federal workplaces receive their health plan benefits on a self funded basis. (https://www.kff.org/report-section/ehbs-2019-section-10-plan-funding/).

Of this total, it is estimated that 55% of US workers and their dependents in non-federal health coverage are in plans administered by SPBA member TPAs. SPBA member TPA firms operate much like independent CPA or law firms, providing professional claims and benefit plan administration for a multitude of client employers and benefit plans.

A unique perspective of SPBA is that clients of TPA firms include every size and form of employment, including large and small employers, non-federal governmental plans, union, non-union, collectively bargained multiemployer plans (Taft-Hartley), as well as plans representing religious entities. The majority of these clients are ERISA self-funded plans and sponsors; some of our TPA members also provide services to other types of plans, including fully-insured plans and HMOs.

SPBA works closely with the relevant federal agencies to understand the constant flow of regulations and interpretations. This knowledge is used to give perspective and education to plan sponsors, including trustees. The agencies have appreciated our insights and have shared with us that this interaction helps the agencies in understanding issues and developing regulations.

Implementation Timeline
The short timeline for implementing many of the provisions of the Act will present challenges for TPAs and their clients.

Accordingly and respectfully, SPBA suggests enforcement discretion and phased-in compliance benchmarks will honor the Act's intent while affording plans working in good faith the necessary time to fully comply with the Act's requirements.

Additional implementation time is particularly important for plans building and acquiring the price comparison/cost sharing tool(s) and preparing to provide the advanced explanation of benefits documents. Prepared for the effective date associated in the Transparency in Coverage NFRM, the substitution to the shortened timeline of the Act is a substantial change, exacerbating already identified issues with building up these services.

Further clarification is requested on how the current effective date of "for plans starting on or after January 1, 2022" will be implemented. For instance, does this mean that ID cards do not have to be printed with the required elements in the Act until the date that plans are renewed – which is January 1 for many plans, but some other time of the year for others? Does the same standard apply for the price transparency/cost comparison tool and the advanced explanation of benefits?

Non-Enforcement Policy for Demonstrated Good Faith Effort
We request the agencies' involvement regarding the problem of obtaining pricing data from carriers, networks and PBMs.

Many SPBA members express great uncertainty whether plans will be able to obtain information required under the Act. This is because in many/most instances, the underlying pricing data at the heart of the Act is not owned or developed by the Plan(s) or the TPA(s) – but is originated, maintained and retained by insurance carriers (renting their networks), or privateer networks (having fashioned their own direct contracting with providers and then renting access).

The jarring fact is some networks are undecided whether they will provide the data at all -some outright stating so, while others are emmeshed in considering the proprietary nature of the underlying data and whether they can disclose it. Nevertheless, both positions thwart the ability of an underlying Plan/TPA renting the network to comply.

If a network bars disclosure of this essential information required by the Act, the underlying plans have no practical recourse.

To explain, a plan (unless representing a jumbo sized employer of 1000+ employees) will not have leverage to convince a recalcitrant network to suddenly release the information required under the Act. Alternatively, leaving to go to another network is of limited use for two reasons: 1) There is no guarantee the subsequent network will have any different of a position on the matter, and 2) Market Forces – networks are chosen largely on the basis of discounts achieved from billed charges. Leaving a network because they refuse to make pricing data required under the Act now exposes the plan to a diminished fiscal performance – very likely negating the best or only option available in the geographic areas where plan participants are located.

Humbly stated, plans on their own do not have leverage to take their business elsewhere, hoping to convince carriers, networks or PBMs to change their policies to retain the plan as a customer. While often a vital partner to self funding, many networks have a "take it as is or leave it" attitude.

Plans and TPAs in such a position should not be penalized for a failing not of their own making.

To address this reality, SPBA encourages the agencies to require entities that develop reimbursement prices (i.e., carriers, networks and PBMs) release this information to plans. This is the most practical approach. However, we offer several alternative methods plans could use to "derive" the rates in the section "Qualifying Payment Amount" section of this comment letter (next page).

Technical Standards

Implementation of the advanced explanation of benefits touches upon many entities and a wake of associated vendors. Coordination in approach for the industry (widely defined) is essential. Transaction standards, operating rules and/or technical specifications are all possible approaches.

SPBA suggests a timeframe be developed in which industry and government stakeholders jointly develop such standardization. Laudable prior examples include HL7's DaVinci Project or CAQH CORE's development of sub-regulatory standardization of data transmission via a collaborative industry/government model.

Regarding timing (as deadlines must be set if progress is to be achieved), January 1, 2022 is offered as the date set by the agencies for industry and government stakeholders to define and agree on such standards – wherein the compliance calendar would then follow. Industry buy-in, with the oversight of the agencies (ensuring the methods selected themselves are auditable by the agencies) would be achieved by this approach.

Qualifying Payment Amount

The Act defines "qualifying payment amount" as the median of contracted rates recognized by the plan or issuer with respect to all such plans (of a sponsor) offered within the same insurance market; defined further as the total maximum payment under such plans on January 31, 2019 (inflated forward by the CPI-U) for the same or similar items or service that is provided by a provider in the same or similar specialty and provided in the geographic region.

Every single application of the No Surprises Act relies upon the accurate tabulation and disclosure of that amount. To the patient/provider (being the main goal), and to the arbitrator (when disputes remain unresolved).

As outlined earlier, the hardest data for plans and TPAs to acquire is in-network rates, and by extension, the required median rate(s). Carriers, networks and PBMs frequently withhold their pricing information as proprietary. Although a mandated requirement of disclosure under the Act, there has been no perceivable shift among these industry actors to share this information with plans and TPAs. SPBA repeats its request that regulations require carriers, networks and PBMs share this data with plans in a timely and unimpeded manner, thus enabling plans and TPAs to comply with the Act.

In the absence of such a requirement, we suggest plans be allowed to "derive" their in-network rates and median in-network rates from the plans' own historical data. This "derived" approach was allowed (with caveats) in the Transparency in Coverage NFRM, offering the agencies a pre-vetted platform for consideration (and hopeful adoption).

We suggest this alternate approach will produce a more granular and accurate disclosure with the plan(s)/TPA(s) being closest to actual reimbursement outcomes (as compared to regional or national carriers, networks and PBMs). To illustrate, in the case of a TPA administering a plan with a small network with limited providers and pricing data, a more accurate measure will result from the TPA taking the median in-network rate across the various plans serviced by the TPA within its defined and reasonable geographic area.

SPBA expresses concern that the exclusion of all public payers from calculation of median in-network rates may artificially inflate the "median in-network rate(s)." This is due to the prevalent practice of renting several tiers of networks to address out of network services and so-called "wrap networks." While technically "in-network", their performance is usually much poorer than primary rented networks (meaning the end payments are much higher). This prevalent market practice (of using out of area and wrap networks), for which we do not have a direct answer how to qualify or exclude, necessarily skews the median rate higher.

This problem of the inflated in-network median rate is compounded by excluding the public sector "in network" median rates (i.e., Medicare, Medicaid, Tricare, etc.) from the calculation of the median in-network rate.

Simply stated, exclusion of public payers (Medicare, Medicaid, TriCare, etc.) does not mirror most providers' reality. That is, with extremely limited exception, few providers only treat commercial-only patients/payments. The more accurate market reality is providers accept both public and commercial rates – wherein *the inclusion of* public sector median rates will more accurately reflect the market reality ... and median (which the Act requires).

Striving for accuracy and inclusion, a particular subgroup is worthy of comment. Namely, a growing number of plans do not maintain contracts with a carrier or network on any basis. Rather, these plans utilize pricing based upon multiples and blending of Medicare (collectively, such plans are referred to "reference based pricing"). To account for the compliance requirements of such plans under the Act, SPBA strongly suggests the Medicare reference points selected by the underlying plan(s) (i.e., 150%, 200%, etc.) should be a permitted representation of the qualifying payment amount. This approach would also serve as a compliance place-holder for newly established group health benefit plans (as in starting out, such plans will not have any established rates to calculate and disclose).

SPBA also respectfully recommends the permission of plans and TPAs to utilize other commercial pricing mechanisms or databases - beyond state all payer databases to arrive at the qualifying payment amount and its median. While certainly not limited to the following, FairHealth is an excellent example. The nation's largest database of privately billed health insurance claims, FairHealth is entrusted with Medicare Parts A, B and D from 2013 to the present. It is accepted by numerous states as the benchmark of record. Without overstatement, it is an industry standard. In many cases, it is actually referenced as the pricing benchmark of a plan. Such a reference, widely regarded as commercially reasonable and developed on an arms-length, third-independent-party basis, is worthy of consideration by the agencies as an acceptable and neutral standard of the qualifying payment amount and its median.

We acknowledge the Act already allows use of limited types of database(s) to calculate

median in-network rates. The shortfall (respectfully stated), is for an "approved database" to allow for more than just semi-public or state all payer claims database(s).

The reality in this age is almost no plan has employees (and retirees and/or COBRA recipients) tidily located within one state. They are dispersed. The larger the sponsoring company, even more so. Accordingly, while all-payer state databases are the result of impressive effort, they seldom capture claims activity outside of their borders. As a check upon this assertion, we suggest reference to the New York Health Care Reform Act/Public Goods Pool, which imposes a surcharge upon any services rendered by any and all New York based facilities – the activity of plans domiciled in the remaining 49 states needing to report to NYHCRA being instructive.
https://www.health.ny.gov/regulations/hcra/

The request is for greater latitude to permit use of expanded but agency-limited database source(s). The agencies would retain all oversight in clarifying by regulation or guidance what criteria a commercial or public database would have to satisfy, and under what circumstances a plan, TPA or carrier could utilize same. By deferring to entities that already collect the data, actuarily confirm and stratify the data (which mimics many of the calculations the Act requires), instant protections exist. Deference to such underlying data sources is encouraged.

These recommendations (ability to derive internal actual median rates, reference to applicable Medicare multiples, and reference to agency-approved third party databases), immediately improve the ability (and practicability) of plans and TPAs to comply with the Act – shortening compliance timelines.

Federal IDR Process
Fairness, consistency, predictability and efficient processing of decision are the goals of the Act when arbitration is necessary.

Equipping arbitrators to these ends is paramount. Balancing competing interests is also necessary to prevent each arbitration from bogging down. While a formulaic approach would be optimal, some considerations are worthwhile noting. For instance, the classification of the diseases for which providers are rendering services (the International Classification of Diseases, version 10 (ICD-10)), is compiled by the World Health Organization, and contains 70,000+ codes. Similarly, the nomenclature of the procedures rendered by providers and for which they bill (the heart of the Act), is codified by the American Medical Association within the series "Current Procedural Terminology" (CPT), whose current 2021 version literally spans 1,000 pages. These points underline the obvious: current medical conditions and the procedures for which providers bill is approaching a near-incomprehensible complexity.

The preceding is offered in a supportive manner to suggest that an "either/or" approach to arbitration may miss valid nuances and considerations of the parties; while efficiency

of decision may be achieved, fundamental fairness may be missed.

To prevent unfairness, we seek clear administrative guidelines, defining permissible criteria and how each may be used to adjust the base qualifying payment amount. Accordingly, it may create an array of factors an arbitrator may consider (rather than from a stoic either/or position). We suggest the stated terms of what a plan will pay be one of those acceptable standards. It is a term of contract, recognized for decades.

In any event, once the agencies have clarified and defined to their satisfaction the acceptable array of factors for the arbitrator to consider, arbitrators would be enabled to select the offer that is closest to the adjusted qualifying payment amount, documenting their reasoning and evidence upon which their decision rests.

In this manner, the Departments will level the playing field during the initial 30-day period, since all parties will have a clear idea about what to expect regarding arbitration. Such efforts will appreciably aid the arbitrator, improve efficiency in resolving disputes, and simplify each party's choice selecting an arbitrator.

Conclusion

SPBA applauds the goals of the No Surprises Act, and fully supports taking the patient out of surprise billing disputes.

However, as currently designed, we point out while consumers are initially held harmless through the Act, there is an unintended consequence. Sparing the individual consumer/patient, the additional cost of an arbitration award is upon "the Plan." What will happen in a practical sense is the very same cost will be apportioned upon all the members of that Plan in the subsequent year as an overall and legitimate cost of "the Plan." Fully insured carriers will do the same.

The point, intended to be respectfully stated, is that the ability of payers (widely defined and including the SPBA's member plans and TPAs) is considered endless, whereas the prime driver of this issue – being the cost of care billed by a provider, being set by the provider without oversight - is by comparison, unaddressed, unregulated and unchecked.

Our comments are in no manner to be interpreted as adversarial or obstructionist. To the contrary, we endorse the Act and seek meaningful engagement with all stakeholders – wishing to be a practical resource to the agencies in this potent moment of reshaping healthcare in this country.

To this end, we believe greater transparency in health care pricing has true potential. It levels the playing field. It lowers cost of care by promoting objectively fair payments and empowering patients.

The SPBA is proud of our long and documented history of championing greater

transparency. Without hesitation, we will continue such efforts.

We welcome the opportunity to discuss these ideas further with you. We look forward to hearing from you. Emphasizing our commitment, past and future, the immediate past, current and next year's Chairs of the SPBA jointly sign in our desire to work with your offices on this matter of vital importance.

Respectfully and Jointly Submitted,

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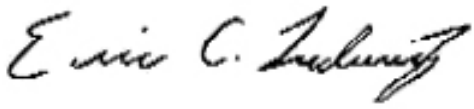

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