December 6, 2021

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

Attention: RIN 1210–AB0
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Room N–5653
Washington, DC 20210

RE: RIN 1210–AB00: Comments on the Federally-Developed Arbitration/IDR Process Detailed In The "Requirements Related to Surprise Billing; Part II"

To whom it may concern:

The Self-Insurance Institute of America, Inc. ("SIIA") respectfully submits these comments relating to the Federally-developed arbitration/independent dispute resolution ("IDR") process as detailed in the Interim Final Rule titled "Requirements Related to Surprise Billing; Part II" (hereinafter referred to as the "Part II IFR").

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.

SIIA strongly supports the framework of the Phase II IFR, and we believe that the Federally-developed arbitration/IDR process – and methodology contained therein – is consistent with Congressional intent. We further believe that the Phase II IFR sets out a fair process for arbitrating disputed payments between a medical provider and the plan sponsor of a self-insured health plan. And, we applaud the development of the Federally-developed arbitration/IDR process as it adequately protects patients who receive a surprise medical bill for emergency care – or in situations when they have no ability to choose a an in-network provider – by removing them from the financial hardship of exorbitant balance bills.

I. SIIA Supports the Qualifying Payment Amount Serving as the Primary Payment Factor, While the Additional Circumstances Are Secondary

As the Part II IFR provides, Congress clearly articulated in the *No Surprises Act* that the Qualifying Payment Amount, or "QPA," must be the baseline and primary payment factor that an IDR entity must consider when making a final payment determination. This finding is also supported by the Congressional Budget Office ("CBO"), which concluded that using the median in-network rate as the primary factor will decrease overall healthcare costs and incentivize providers to join networks, while also protecting patients from arbitrarily inflated surprise medical bills. These two considerations were at the core of what Congress intended when enacting the *No Surprises Act*: (1) lowering health care costs and (2) protecting patients and their families.

A. The Statute and Congressional Intent

As outlined in previously submitted comments, SIIA believes that the statute is clear: During the Federally-developed arbitration/IDR process, the IDR entity *must consider* the Qualifying Payment Amount when determining a final payment amount that a self-insured plan must pay to an out-of-network provider. Our belief is grounded in the development of new ERISA section 716(c)(5)(C)(i)(I), which provides in its own sub-clause that the IDR entity "*shall consider*…the Qualifying Payment Amount[]," along with the fact that Congress created a separate sub-clause following ERISA section 716(c)(5)(C)(i)(I) (i.e., new ERISA section 716(c)(5)(C)(i)(II)), providing that an IDR entity may – but is not required to – consider the specific factors listed as an "additional circumstance." Taken together, the statute clearly indicates that that Congress intended the additional circumstances to be secondary to the primary QPA (meaning that the additional circumstances merely influence whether the baseline QPA should be increased or decreased when a final payment determination is ultimately made).

Importantly, our belief was confirmed when the Chairs of the House Committee on Energy & Commerce and the Senate Health, Education, Labor and Pensions Committee sent a letter to the Federal Departments explaining that Congress intended the Qualifying Payment Amount to serve as the primary factor in arbitration/IDR and that any additional circumstances presented by a medical provider were merely secondary when making a final payment determination. In addition, a bi-partisan letter sent by the Chair and Ranking Member of the House Education & Labor Committee also told the Federal Departments that Congress meant for the additional circumstances to have less utility in determining an appropriate payment amount other than the QPA, and further, that Congress did not intend for the QPA and the additional circumstances to be given equal weight by IDR entities.

B. Anchoring Out-of-Network Payments to the Median In-Network Rate Protects Patients and Lowers Health Care Costs

In SIIA's opinion, because the Qualifying Payment Amount is the product of rates negotiated between two parties in an arm's length transaction, the QPA represents a reasonable value that patients who seek coverage under, for example, a self-insured health plan can rely on. More specifically, patients seek health coverage to protect themselves from unforeseen illnesses and/or accidents that require medical attention. And, once enrolled in a self-insured health plan, patients have an expectation that the value of any furnished medical items or services that are covered under the plan will be based on the arm's length negotiations between the plan sponsor and a medical provider.

By anchoring the amount a patient must pay to an out-of-network provider to the Qualifying Payment Amount (i.e., a reasonable market-based payment), patients are protected from the unscrupulous billing tactics that out-of-network providers employed prior to the enactment of the *No Surprises Act*. In addition, only requiring patients to pay this reasonable market-based value is consistent with patients' expectations of the type and level of coverage they are entitled to receive once they enroll in a self-insured health plan.

Most importantly, anchoring the amount a self-insured plan must pay to an out-of-network provider to the Qualifying Payment Amount (i.e., a reasonable market-based payment) will lower health care costs. Prior to the enactment of the *No Surprises Act*, patients were not the only ones over-charged by out-of-network providers. Employers and labor unions that sponsor self-insured plans were also required to pay inflated charges for the out-of-network medical items or services that were furnished.

However, with the enactment of the *No Surprises Act* – and with the new requirement that IDR entities must assume that the Qualifying Payment Amount represents the final payment amount in arbitration/IDR – plan sponsors will no longer be required to pay inflated amounts to an out-of-network provider. Rather, plan sponsors will only be required to pay a reasonable market-based value for the furnished medical items or services. With the reduction of these inflated charges, a plan sponsor's overall health care spend will be reduced, which will inure to the benefit of a patient enrolled in a self-insured plan through lower annual premiums (and also modest premium increases in future years).

II. The "Rebuttable Presumption Standard" Strikes the Right Balance

Medical providers should not be paid for services that are arbitrarily based on whatever amount a provider wants to charge. Instead, payments must be reasonable. Based on this belief, SIIA supports the "rebuttable presumption standard" fashioned by the Federal Departments, and we think this standard strikes the right balance between (1) an appropriate provider payment and (2) ending the egregious practice of over-charging patients and their plan sponsors.

We further believe that in arbitration/IDR, the burden of proof is on the provider to present evidence that would allow a qualified/certified IDR entity to determine if the reasonable market-based payment (which is the QPA) does not represent the appropriate value for the furnished medical items or services. It is only in these instances that a provider may be paid amounts that are higher than the QPA (i.e., in these instances, if "credible" evidence is presented, the IDR entity may choose the provider's "offer," which will likely be higher than the QPA). However, as the Part II IFR rightly points out, IDR entities must consider whether the additional circumstances that providers may present *are already* included in the in-network rates that are used to calculate the underlying Qualifying Payment Amount (so as to *not* "double-count" the criteria).

In short, SIIA supports policies that ensure that providers will be paid reasonable compensation for their services, and we believe that the requirements set forth in the Part II IFR – and in particular, the "rebuttable presumption standard" – will do just that. Such policies will not only foster equitable treatment among providers and payers, these policies will lower health care costs, which is exactly what Congress intended when debating and ultimately enacting the *No Surprises Act*.

III. The IDR Entity's Qualifications, Responsibilities, and Cost

SIIA believes that the Federal Departments correctly outlined the qualifications, responsibilities, and reporting requirements for "certified" IDR entities in the Part II IFR. In our opinion, the Part II IFR appropriately ensures the avoidance of conflicts of interest.

In addition, it is critical that IDR entities understand the unique nature of self-insured plans, including those utilizing value-based care and referenced-based pricing arrangements.

Furthermore, it is likely that a number of small- and medium-sized employers sponsoring a self-insured health plan will at some point enter the arbitration/IDR process. As a result, the administrative costs associated with the Federally-developed arbitration/IDR process is an important aspect of the Phase II IFR. These new administrative costs will be borne by these small- and medium-sized employers, requiring these plan sponsors to spend plan assets on disputes with medical providers instead of using the plan's assets to pay for health claims incurred by plan participants. SIIA continues to urge the Federal Departments to take steps to limit the overall cost of arbitration/IDR as the Departments continue to implement the *No Surprises Act*, including placing limitations on inflationary increases of IDR entity fees.

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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.