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April 8, 2024

Mr. Jeff Wu
Deputy Director for Policy
Center for Consumer Information and Insurance Oversight
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201
Via Electronic Mail

RE: Enforcement Discretion Under the No Surprises Act

Dear Mr. Wu:

AHIP members continue to share details about the impact on the process for adjusting the methodology for calculating Qualifying Payment Amounts (QPAs), as required under the No Surprises Act (NSA), in light of a 2023 court order. AHIP appreciates the enforcement discretion exercised by the Departments and has found additional time is necessary to implement the changes resulting from the August 24, 2023 order by the U.S. District Court for the Eastern District of Texas in *Texas Medical Association v. U.S. Department of Health and Human Services* (*TMA III*).

By way of this letter, AHIP is requesting an extension of enforcement discretion for compliance with that process. Specifically, that the Departments and OPM extend the exercise of enforcement discretion under the NSA beyond May 1, 2024, with the possibility of future extensions pending the release of further guidance, final resolution of still pending legal challenges or as may otherwise be appropriate. Below we offer detailed explanations of many of the challenges health plans currently face as they seek to align their processes with the result of the *TMA III* decision.

Background
In its *TMA III* decision, the district court vacated several regulations governing the calculation of QPAs for purposes of patient cost sharing, disclosures with an initial payment or notice of denial of payment, and disclosures and submissions required under the Federal IDR process. Given the extent of changes mandated by the district court, on October 6, 2023, the Departments and OPM issued "FAQs About Consolidated Appropriations Act, 2021 Implementation Part 62" (FAQ Part 62), which stated that plans and issuers were "expected to calculate QPAs using a good faith, reasonable interpretation of the applicable statutes and regulations that remain in effect after the *TMA III* decision." Additionally, for items and services for items and services furnished before May 1, 2024, enforcement discretion would be exercised with respect to any plan or issuer that

uses a QPA calculated in accordance with the methodology under the July 2021 interim final rules and guidance in effect immediately before the decision in *TMA III.*

AHIP appreciates the enforcement discretion exercised by the Departments and has found that due to the extensive nature of determining new QPAs for millions of items and services, additional time will be necessary to ensure proper compliance with rules affected by the district court vacatur. We therefore request the Departments and OPM extend the exercise of enforcement discretion under the NSA beyond May 1, 2024, with the possibility of future extensions pending the release of further guidance or future legal developments.

The vacatur substantially burdened group health plans and health insurance issuers because it fundamentally altered the process and methodology for calculating QPAs, a complicated and burdensome task that the NSA requires health plans and issuers to complete.

The process and methodology for determining QPAs was laid out in Interim Final Rules (IFR) published July 13, 2021, which became effective on September 13, 2021. The QPA is relevant to consumer protections under the NSA applied to group health plans and health insurance policies for plan years beginning on or after January 1, 2022. Among those protections was the requirement that plans and issuers apply the equivalent of in-network cost-sharing to items or services covered by the NSA furnished on or after January 1, 2022 based on the recognized amount or QPA. Implementing this provision necessitated calculation of millions of QPAs for each billing code so that cost-sharing amounts for NSA-eligible items or services could be properly calculated.

In comments on the IFR, submitted by AHIP in September 2021, we articulated "significant concerns about whether health plans have sufficient lead time and regulatory clarity to implement and operationalize" the QPA and recommended a good-faith safe harbor for the first calendar year of implementation. What transpired during implementation was that the 2021 calculation process took eight months and at substantial cost to health plans and issuers. While these costs varied among the AHIP member companies tasked with determining QPAs in 2021, we know they were a significant expense. For example, we heard from AHIP members that the original cost to implement QPA provisions under the IFR ranged from just over $1 million for one health insurance provider that operates in several states to at least $25 million for a health insurance provider operating in more than a dozen states. Considering both the central role the QPA plays under the NSA and that are approximately 1,758 entities obligated to calculate QPAs, 86 Fed. Reg. 36,872, 36,927 (July 13, 2021), a reasonable estimate of the total cost for just the initial QPA calculation likely approached or exceeded $1 billion.

Ongoing Impacts of the *TMA III* Decision

Since the release of FAQ Part 62, plans and issuers began anew the process of calculating QPAs with costs and administrative processes that are greater with the vacatur in place. Implementing

these changes is far different than reprocessing prior calculations under slightly different rules. It has required major system modifications, addressing substantial unknowns, gathering and manipulating new data, changes to cost-sharing amounts and calculating exponentially more QPAs than required under the Departments' regulations. All of which are processes that are still ongoing for many plans and will not be completed by May 1, 2024, when the initial 6-month enforcement discretion will expire.

The district court decision had an immediate impact on consumer cost-sharing, as for many the amount they pay is tied to the QPA. Research conducted by AHIP and BCBSA last year repeatedly found that the NSA was preventing approximately 1 million out-of-network claims per month from reaching consumers in the form of a surprise bill.[1] Each of these claims requires recalculation under a more complex process to ensure accuracy when determining consumer cost-sharing.

The court's decision also impacts the overall function and credibility of the QPA. The district court vacated regulatory provisions and guidance statements that can be grouped together as five distinct changes to the QPA methodology. Each vacated regulation helped serve the purpose of establishing a credible, stable, market-based QPA. Examples of specific challenges now posed by determining QPAs without each vacated provision are discussed further below.

1. Vacatur of regulation allowing self-insured group health plans to use rates from all plans administered by a TPA

Calculating new QPAs for every self-insured client contracted with a TPA has caused the greatest burden. Large TPAs that operate nationally or in multiple states have started to calculate what could potentially be billions of new QPAs.

To give a sense of the difference in the magnitude of the endeavor, in 2020 (the most recent year for which data is available) there were approximately 37,900 self-funded group health plans in the United States,[2] many of which contract with multiple TPAs, and those self-funded plans have plan participants spread across the country. A TPA that had been calculating one, albeit large, set of QPAs for clients in each geographic region, must now recalculate hundreds and in some cases thousands of sets of self-funded plan-specific QPAs solely due to this vacatur.

A non-exhaustive list of measures TPAs are now processing include:

- Modifying their QPA calculation IT systems, which were built on an aggregate model;
- Communicating with each self-funded client, and potentially receive written consent from each;
- Identifying all self-funded clients that contract with multiple TPAs and determine how to combine contracted rates from those TPAs, for calculating QPAs; and

- Identifying all relevant health care providers and facilities for each ASO client a TPA entity served in 2019 and recalculate every QPA for each client, which for many clients will involve soliciting data from the prior (or legacy) TPA with whom a client was contracted in 2019.

This has been a time-consuming process, and one that cannot be completed by May 1, 2024. For scale, one national health insurance carrier estimated that the volume of QPAs that will be needed if each self-insured group requires a unique QPA will equate to 32 million new fee schedules.

The process has also imposed new and significant direct costs. This includes plans paying for new or modified IT infrastructure, systems and processes, staffing, and necessitated legally required communications to plan participants and health care providers. For example, for just one national health insurance carrier, the communication costs alone—including only sending updated notices to plan participants and providers and excluding the re-calculation itself—are estimated at $4.65 million.

2. Vacatur of exclusion of value-based adjustments.

Alternative payment models, including value-based payments, incentive-based payments, risk-based payments, and retrospective payments do not readily translate to the item and service billing codes for which QPAs are calculated. In many instances, forcing a value-based model to fit in a QPA framework is simply not workable. And even for the payment models where health insurance providers may be able to allocate alternative payment model amounts to item and service billing codes, the process will require manual review of the terms of each alternative payment contract. Such allocation is difficult because alternative payment models are tied to a particular provider's, group of providers', or facility's overall performance over a period of time, and are based on quality metrics or the avoidance of unnecessary costs or harmful outcomes. There is no one-size-fits-all or self-evident method to account for such adjustments in per-service rates. Neither the initial QPA calculations under the Departments regulations, nor the datasets on which those calculations were based, address value-based adjustments.

Removing this regulatory provision impacts the QPA determination process in a way that goes well beyond adding additional QPAs to calculate; it is a wholesale rewrite of the methodology.

Accordingly, we request additional time for plans to implement these changes, which will likely require further guidance on how each health insurance plan provide may:

- Develop an entirely new methodology for accounting for value-based adjustments across all provider and service types;
- Manually review every contract involving alternative payments and creating a new dataset of all of the relevant data across myriad types of contracts; and

- Modify QPA calculation IT systems accordingly.

3. Vacatur of inclusion of rates negotiated for services that do not qualify as "provided."

The vacatur of regulations permitting the inclusion of all contracted rates in the QPA, without regard to whether a provider "provided" that service, requires a wholesale re-working of the data on which each QPA calculation is based, including the need to gather data not readily available in existing systems. Moreover, health insurance providers are attempting this process without any guidance regarding what it means for an item or service to qualify as "provided."

The district court's decision does not specify whether, to satisfy the court's reading of the Act, a service must have been provided in the past (and if so, looking how far back) or whether it is enough that the provider intends to provide the service when negotiating the rate (and if so, how that intent would be established). Much of this information is unknown, as a clinician presumably has provided services prior to contracting with a given health plan but may not have provided those same services during the time period a health plan has data. The upshot is that rather than rely on a single dataset of contracted rates, each health insurance provider must analyze each contract and rate to determine whether the rate qualifies as a "provided" service under criteria that each health insurance provider must determine. This would require more time for plans to implement and additional guidance on how to:

- Analyze each billing code for each contracted provider to delineate all items and services that provider has provided and for which they have ever been paid, potentially dating back to the earliest available date; and
- Recalculate QPAs without many contracted rates that were originally included in the dataset.

4. Vacatur of exclusion of single case agreements.

The vacatur of the regulation excluding single case agreements from the QPA requires a manual review process to create an entirely new dataset. Single case agreements are ad hoc arrangements that cover a specific beneficiary in unique circumstances, and often are aggregate payments for a single episode of care, that includes multiple items and services with costs not delineated for each. Records of such one-off agreements are not stored with negotiated rates in health insurance provider systems. Given the QPA is based on contracted rates in 2019, vacatur requires a detailed review of archived agreements.

Accordingly, plans will need an extension of the enforcement discretion to include such agreements in the QPA because of the time-consuming and resource intensive process of, among potentially other things:

- Reviewing archived records, often at the individual subscriber level, to identify ad hoc payment agreements;

- Disaggregating any lump sum payment into distinct payment amounts for each item and service involved;
- Attributing each distinct payment amount to the relevant service and geographic market; and
- Modifying QPA calculation systems to integrate this data with contracted rates.

5. Vacatur of regulation clarifying that per-specialty QPAs are not necessary when contracted rates do not vary by that specialty and specialty makes no material difference.

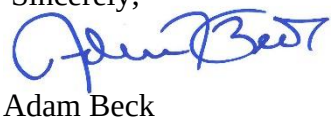
The district court's ruling that a per-specialty QPA must be calculated for every service, even when it makes no material difference to the QPA, has greatly multiplied the number of QPAs that must be calculated. Health insurance providers face substantial uncertainty, however, because there is no guidance on how broadly or narrowly to define specialties.

Depending on a health insurance provider's contracting process, per-specialty QPA recalculation may require a substantial re-working of the dataset of contracted rates to include specialty information for specialties that the health insurance provider does not use or recognize in its contracting process.

* * *

In conclusion, the complexities involved with complying with the court's vacatur has caused major disruptions and required plans to implement new or modified IT infrastructure, systems and processes, staffing, and necessitated legally required communications to plan participants and health care providers. Moreover, ongoing legal challenges present significant uncertainty regarding which, if any, of the changes required by the district court's decision will ultimately remain in place or require even further modifications based on later appellate rulings, including perhaps even returning to the requirements that were in place before the *TMA III* decision. We appreciate the Department's enforcement discretion provided for in CAA FAQ Part 62 applicable through May 1, 2024. Plans and issuers are in the process of implementing these changes. However, notwithstanding those efforts, these significant modifications will not be completed by May 1, 2024. AHIP requests enforcement discretion continue for items and services furnished through November 1, 2024 with the possibility of future extensions pending the release of further guidance or changes.

Sincerely,



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