April 19, 2024

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Re: Request for Extension of Enforcement Discretion Related to Qualifying Payment Amounts

Dear Mr. Khawar, Ms. Leiser Levy, Ms. Morrison, Ms. Rivers and Mr. Wu:

I write on behalf of the American Benefits Council ("the Council") to request that the U.S. Departments of Health and Human Services (HHS), Labor and Treasury (the "tri-agencies") extend the enforcement discretion previously provided in Frequently Asked Questions about Consolidated Appropriations Act, 2021 Implementation Part 62 (FAQs)

regarding recalculation of the qualifying payment amount (QPA) in response to the district court's decision in *Texas Medical Association et al. v. HHS et al.* ("*TMA III*"). As explained below, despite good faith efforts being made to respond to *TMA III* by our members, including plan sponsors and their service providers, more time is needed, due to the complexity and extent of changes required.

The Council is a Washington, D.C.-based employee benefits public policy organization. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial wellbeing of their workers, retirees and families. Council members include over 220 of the world's largest corporations and collectively either directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans.

BACKGROUND

Under the No Surprises Act (NSA) the QPA[1] plays a central role. The QPA is the basis for participant cost-sharing, can be used to determine initial payments to providers, is often raised in open negotiation and is a factor that must be considered in independent dispute resolution (IDR), each of which involve our members. Moreover, our members, as plan sponsors and their services providers, are the entities required to calculate the QPA.

As such, the QPA and its calculation methodology have been a focus for the Council and its members. We have worked to support reasonable, predictable, market-based rules for determining the QPA, which were reflected in the interim final regulations (IFR) published by the tri-agencies in July 2021, including by submitting regulatory comments and, in the judicial arena, filing *amicus* briefs to support the IFR.

In *TMA III*, provider plaintiffs successfully challenged many of the core pieces of the IFR's methodology for calculation of the QPA and the district court vacated the majority of the provisions challenged by plaintiffs, requiring a massive overhaul of the QPA calculation for most plans and issuers. Following that decision, in October 2023, the tri-agencies issued the FAQs acknowledging the substantial work required to implement the changes required by the decision in *TMA III* and the fact that actions (like calculating cost-sharing) will need to be taken before the new QPAs are calculated. In response, the tri-agencies provided they will exercise their enforcement discretion under the relevant NSA provisions for any plan or issuer, or party to IDR, that uses a QPA calculated in accordance with the methodology under the IFR and guidance in effect immediately before the decision in *TMA III*, for items and services furnished before May 1, 2024. The tri-agencies also noted that, if necessary, they would reevaluate

[1] The QPA is generally the median of the contracted rates recognized by a health plan on January 31, 2019, for a particular item or service (adjusted for inflation).

whether it is necessary to provide additional time for the enforcement relief as plans and issuers take reasonable steps to come into compliance but that it is not expected that any such additional time would extend beyond November 1, 2024.

COMMENTS ON FAQS

We greatly appreciate the relief provided in the FAQs, which has provided our members time to begin to make the changes required by the vacatur in *TMA III*. Our members understand that the *TMA III* decision is in effect and have been making good faith efforts to come into compliance for the last several months.

However, we are writing now to make the tri-agencies aware that our members, including plan sponsors and their service providers, including third party administrators (TPAs) (who do the bulk of the work regarding the QPA calculation), have expressed to us that additional time is needed in order make the QPA-related changes required by *TMA III*. This is due to the complexity and breadth of the required changes, including the following:

- **Plan-by-plan calculation:** Under *TMA III*, instead of allowing the QPA to be calculated across all of the self-insured plans that work with one TPA in a geographic area, each separate group health plan will need its own QPA calculated just for that plan (regardless of whether there are any differences in the underlying fee schedule between group health plans administered by the same TPA). We understand that this is the most significant change imposed by the vacatur. In the U.S., there are almost 38,000 self-insured group health plans (as of 2020)[2], which generally cover employees across the country and thousands of items and services. As such, some are estimating this could potentially mean billions of *new* QPAs must be calculated.[3] This will require changes to IT systems (which were built on the aggregation concept in the IFR), coordination for plans that use multiple TPAs and in some cases going back to prior service providers to solicit 2019 data. This is to say, the vacatur not only requires a recalculation of the current QPAs, it also exponentially expands the number of QPAs that must be calculated. In addition, guidance on how plans should calculate a plan-level QPA has not yet been provided (*e.g.*, how should a plan-level QPA be calculated when there are multiple TPAs for one plan and the items, services and contracting practices utilized for each of the TPAs is different? If a current TPA was not in place in 2019, is the TPA expected to

[2] See https://www.dol.gov/sites/dolgov/files/EBSA/researchers/statistics/retirement-bulletins/annual-report-on-self-insured-group-health-plans-2023.pdf.

[3] See AHIP Request for Enforcement Discretion Under the No Surprises Act (April 8, 2024) at https://www.americanbenefitscouncil.org/pub/A616430F-F599-AA72-C890-36C0D53F4B03.

use a database for the plan's 2019 rates or the current TPA's rates from 2019 as a proxy?). This guidance is needed for consistent, efficient implementation.

- **Bonus and incentive payments**: The IFR provided that the QPA calculation should exclude risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments but this rule was vacated in *TMA III*. This raises many issues, including the fact that these types of payment amounts are generally not associated with a particular item or service and instead relate to overall performance or are based on broader quality metrics. As such, incorporating these amounts into the QPA will require development of an entirely new process to determine which amounts should be attributed to which items and services and will require manual review of each contract that involves an alternative bonus or incentive payment in order to create a whole new dataset. Guidance on how plans should allocate these amounts has not yet been provided and will be needed for consistent, efficient implementation.

- **Services provided:** Under the IFR, the QPA was to be based on contracted rates, which meant amounts that a group health plan contractually agreed to pay a participating provider, without regard to whether the provider actually provided that service for a participant in the plan that year. Under *TMA III*, the QPA is only to take into account contracted rates for services that have actually been provided. This will require a wholesale reworking of the QPA calculation because it changes the information on which the QPA calculation is based. Moreover, the data needed (*i.e.*, claims data) is not part of the data currently incorporated into the current QPA calculation systems, which focus on contractual rates and not claims utilization. Additional guidance is needed regarding how to determine if a service has been provided (*e.g.*, what time period should be analyzed? Is it sufficient if the provider intends to or customarily provides the service?).

- **Single case agreements:** Under the IFR, single case agreements, which are ad hoc agreements that cover unique circumstances for particular participants, were not to be included in the calculation of the QPA but this rule was vacated in *TMA III*. This adds a great deal of complexity to the QPA calculation process because this is a totally new data set, which will need to be compiled manually, with the review of agreements from 2019. Further, single case agreements often cover a range of items and services, addressing an episode of care or even a more global payment arrangement covering multiple individual claims, and so a method will need to be developed to disaggregate lump sum payments across the various items and services covered. This is all highly manual and cumbersome and requires guidance on the time frame for which single case agreements must be included in the QPA, as they normally only apply for a specific date of service and the QPA calculation is generally tied to January 31, 2019 (*e.g.*, Is it sufficient to only rely on single case agreements used on January 31, 2019?).

- **Specialty-by-specialty:** Under the IFR, plans were required to calculate the QPA specialty-by-specialty, but only if contracted rates varied by specialty. Under the vacatur, QPAs must be calculated specialty by specialty even if there is no rate difference based on specialty. This has substantially increased the number of QPAs that must be calculated and requires more parsing of what services apply to a given specialty.

As evidenced above, *TMA III* does much more than require recalculation of current QPAs, it requires a fundamental alteration of the methodology of the calculation of the QPA including greatly expanding the number of QPAs that need to be calculated. These changes will require changes to IT systems, updated and new data sets (in many cases manually compiled) and more staffing and communications, among other changes. These changes are also all interrelated, so the updates will need to be multi-step and sequenced, adding to the complexity and resources needed. The associated cost, both financial and timewise, is very significant.

In addition, the uncertainty due to the ongoing nature of the *TMA III* litigation adds complexity. Many, but not all, aspects of the *TMA III* ruling have been appealed to the U.S. Court of Appeals for the Fifth Circuit. The Council and our members are concerned about the inefficiency and confusion caused by recalculating the QPA under the district court opinion to only then need to revise the QPA calculation yet again following the appeals court's decision. To do so seems unnecessarily inefficient, confusing, disruptive and wasteful. Importantly, this would impact not only plans but also their participants because changes to the QPAs necessarily result in changes to the determination of member cost-sharing. In addition, the significant administrative expenses of these serial re-calculations would ultimately be borne, in part, by participants.

Moreover, we understand that the tri-agencies do not intend to provide additional guidance on the aspects of the IFR impacted by *TMA III* while the litigation is pending, but we note that this further adds to the difficulty that plans and their TPAs face. As noted above, there are several areas where more guidance will be needed for there to be consistent, clear rules for how the QPA is to be calculated under the fundamental changes reflected in the district court opinion.

For all these reasons, we ask that the tri-agencies extend the exercise of their enforcement discretion, to allow plans, issuers and parties to IDR to use a QPA calculated in accordance with the methodology under the IFR and guidance in effect before *TMA III*, for items and services furnished beyond May 1, 2024. We recognize that the tri-agencies indicated that additional time given was not expected to extend beyond November 1, 2024, but we urge the tri-agencies to consider extending the exercise of enforcement discretion until there is resolution of the legal proceedings related to *TMA III* and to allow a reasonable amount of time following final resolution in the courts for the tri-agencies to provide the needed guidance and for plans and issuers to implement the final changes. Aligning implementation with a final decision (rather than requiring

multiple rounds of recalculations) would reduce inconsistencies and duplication of efforts, be less disruptive and reduce wasteful costs ultimately borne by participants.

At the same time, we appreciate that the date of resolution of *TMA III* is not yet known and if the tri-agencies determine they must choose a date certain, we ask that the enforcement discretion be extended to items and services furnished through December 31, 2024, with the possibility of future extensions if necessary.

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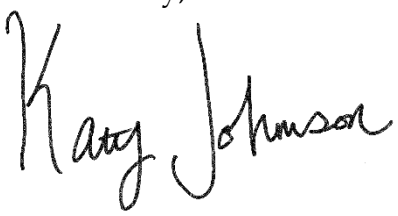
We thank the tri-agencies for their continued work to support and implement the NSA and appreciate your consideration of this request. If you have any questions or would like to discuss further, please contact me at kjohnson@abcstaff.org.

Sincerely,



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