CAA's No Surprises Act IFRs Spark Administrative Questions and Industry Concerns While Awaiting Further Guidance

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We've all been there, or know someone close to us that has, or for health agents, you've seen this from the clients we all serve. You need healthcare, you see a doctor or go to an emergency room. You may even be hospitalized. If it's an emergency, you go to the nearest emergency room, which may or may not be part of your health plan's network. Even if the ER is part of the network, you are seen by an ER doctor, who it turns out, is not part of the network. Or you have surgery, and although the surgery center may be a network facility, the surgeon or assistant surgeon, or more commonly, the anesthesiologist or radiologist, is not. You go about your life, you pay your co-pays or coinsurance, and think everything will be fine, because after all, *you have insurance!* One day, you come home from work, check your mail, and there is an envelope with a medical provider's address on it. You open it, thinking it's only a confirmation of the insurance payment, or a copy of the plan's EOB or something. And then, as you're staring at the black and white in front of you, the text becomes blurred, you start to feel tunnel-vision coming on, because you're staring at a bill from the provider that says you owe $800+ dollars, even though your most recent EOB that you received says that the bill was paid by your health plan. After the initial shock, you think it's a mistake, so you wait until the next day and call your health plan, and you discover that the health plan has paid everything it was supposed to pay, so the provider has "balanced billed" you the difference between the billed charge and the amount paid by your health plan.

Imagine now (or recall from personal experience if it's happened to you) a similar situation after you were hospitalized for a major surgery. There was only one hospital near you, or perhaps they had to move you to a hospital that specializes in the type of care you need. You thought you did all of the right things. You had the surgery or procedure pre-authorized, and again, you thought everything would be fine after you pay your co-pays or coinsurance, because once again, *you have insurance*! And then it arrives in the mail… that "surprise" bill that says that you owe $47,500 for your recent hospitalization or surgery expenses. *This time, it's not just tunnel-vision; it is panic.* Your body is drenched in sweat and you are visibly starting to shake, because you don't have $47,500 right now to pay for this! As someone who in my past ran a third party administrator and have seen many, many balance bills, I will tell you that I've seen balance bills of over $125,000 for hospitals and over $75,000 for air ambulance charges, and I've heard of them up to $100,000!

Some people actually ended 2020 and began 2021 in a positive financial position, because they were able to keep their jobs during the pandemic, and because you were stuck at home, you didn't spend much, so your bank account balance is higher than normal. But for many, it's been a tough financial 18+ months. COVID has impacted our lives in so many ways, including, in many cases, our income. We may feel lucky that we didn't lose our jobs, but basic expenses, like the cost of buying a home, the cost of fuel for your vehicle, and the cost of groceries we need have all increased, and our pay has decreased or stayed the same. Or perhaps you were laid off, and you're now just starting to get back on your feet, but it seems like everything you do or need to buy is now more expensive. Your savings account has decreased, or perhaps been depleted.

Whatever your financial position may look like right now, none of us wants a surprise medical bill. The good news on that front is that recent federal actions, it is hoped, will stop these sorts of provider practices from happening in the future.

For some time, many in the health insurance industry have asked for two important pieces of legislation…. transparency in health care costs and the control of providers that "balance bill" their patients after insurance

payments and normal plan co-payments and coinsurance have been paid, an amount in excess of the expected or "usual and customary" or "reasonable" amount. This "Surprise Billing" practice is so common that it has become almost the norm. It's definitely one of the most important issues in the healthcare industry in the minds of consumers, and therefore, the legislators. Recent legislation on both of these items will soon be in effect. New legislation, as we all know, often comes confusion and misunderstanding. I will attempt today to break these rules down for you in understandable terms.

On July 1, 2021, federal departments (HHS, DOL and Treasury, as well as the Office of Personnel Management (OPM)) released an interim final rule IFR) with a comment period on the No Surprises Act (NSA – if you choose to use an acronym, and not the National Security Administration, which could get confusing), which is part of the Consolidated Appropriations Act (CAA) of 2021; one of the largest pieces of legislation in the health care and insurance industry since the ACA, and it goes into effect on January 1, 2022. This rule is entitled "Requirements Related to Surprise Billing: Part 1." This was followed by Frequently Asked Questions (FAQs) in late August, which dove into many provisions of the No Surprises Act and Transparency in Coverage rules.

Background

Most health plans, whether they are group plans, individual plans, a Marketplace plan or Medicare plans, offer a network of providers and facilities (your PPO or EPO network – or "in-network" providers) that agree to accept payment at an established, contracted rate. Non-network providers generally charge higher amounts as there is no contract rate pre-established for that service or stay. In many cases, the out-of-network provider may balance-bill the patient for the difference between the billed charge and the amount that the health plan or insurance has paid, unless it's prohibited by state law. Balance bills can happen in both emergency and non-emergency care.

In the case of an emergency, as briefly described above, the patient usually goes to the nearest emergency room. In many cases, although the ER is a network-contracted facility, many of the providers that work inside of that facility may not be part of those networks. Often emergency rooms are staffed by independent contractors or doctors not belonging to many networks; they are often non-negotiated third parties, providing services such as anesthesiology, pathology, radiology, rehabilitative care, physical therapy, or neonatology. In many cases, the patient has no control over the physician or other provider inside those facilities. When I was managing a TPA some years ago, we called these "forced providers." It's unfortunate, but common, and even more so because most consumers do not routinely ask their providers inside of an emergency room or hospital if they are contracted… Perhaps a good practice may be to ask simply, "who pays you?" Let's face it… Most people are too concerned with getting care in an emergency situation, and family members are too concerned about their loved ones to ask those basic questions. The result is often a balance bill.

We also see this often in the event that you need an air ambulance… you generally do not have the ability to select an air ambulance from a network provider directory. Air ambulance companies have notoriously over-charged in many circumstances.

It's important to note that in most cases, surprise bills usually do not count toward your deductibles or out-of-pocket maximums, which many people do not understand.

According to CMS (Fact Sheet – Requirements Related to Surprise Billing: Part 1 Interim Final Rule with Comment Period, July 1, 2021):

- A recent study found that payments made to providers by people who got a surprise bill for emergency care were more than 10 times higher than those made by other individuals for the same care.
- 9% of individuals who got surprise bills paid more than $400 to providers, which may result in financial distress for consumers, given recent findings that show 40% of Americans struggle to find $400 to pay for an unexpected bill.

- Studies have shown that in the period from 2010-2016, more than 39% of emergency department visits to in-network hospitals resulted in an out-of-network bill, increasing to 42.8% in 2016. During the same time, the average amount of a surprise medical bill also increased from $220 to $628.
- Although some states have enacted laws to reduce or eliminate balance billing, these efforts have created a patchwork of consumer protections. Even in a state that has enacted protections, they typically only apply to individuals enrolled in insured health insurance coverage, as federal law generally preempts state laws that regulate self-insured group health plans sponsored by private employers. In addition, states have limited power to address surprise bills that involve an out-of-state provider.

It is important to understand that the provisions of the No Surprises Act relate back to former ACA requirements, such as the requirement of plans to reimburse emergency services at a rate at least the amount that would have been paid in-network, regardless of whether or not there was a network in place. The ACA did not, however, prevent the out-of-network emergency room from any sort of balance billing.

The interim final rules generally apply to group health plans and health insurance issuers offering group or individual coverage, including grandfathered health plans, effective January 1, 2022. The No Surprises Act does not apply to retiree-only plans, excepted benefits, short-term limited-duration plans, Health Reimbursement Accounts (HRAs), flexible spending accounts (FSAs) or health savings accounts (HSAs).

What Is the Intention of The No Surprises Act?

The No Surprises Act was passed in December, 2020, as part of the Consolidated Appropriations Act of 2021, and goes into effect, as mentioned above, on January 1, 2022. The intention of the law is to protect consumers from the types of balance-billing or surprise billing practices described above. The No Surprises Act focuses on billing practices in certain non-network situations by limiting the amount of the bill to the amount that would have been payable under an in-network arrangement. This piece of legislation was bipartisan, which is not exactly common in Washington in recent years. That tells you that everyone seems to agree on the intent… To protect consumers from these horrendous and detestable provider practices. However, I do want to mention up front that although this legislation, as it stands now, protects consumers from these practices in non-network situations, it may not fully protect self-funded health plans when they use financing methods such as reference-based pricing, which I will address later in this article.

Summary of The No Surprises Act's Interim Final Rules (IFR)

Protections addressed in the No Surprises Act apply primarily to emergency services, non-emergency services delivered by out-of-network providers at an in-network facility, and out-of-network air ambulance services.

If a plan or health insurance coverage provides for any benefits for emergency services, this rule requires emergency services to be covered without any prior authorization, regardless of whether the provider is an in-network or out-of-network emergency facility. In addition, plans must cover emergency services regardless of other terms or conditions of the plan or health coverage, other than exclusions due to coordination of benefits or any waiting period.

The interim final rule limits cost sharing for out-of-network services to be limited to the amount paid in-network, and requires such cost sharing to count toward any in-network deductibles and out-of-pocket maximums. Most importantly, it prohibits balance billing.

The IFR state that these limitations apply to out-of-network emergency services, air ambulance services furnished by out-of-network providers, and certain non-emergency services furnished by out-of-network providers at certain in-network facilities, including hospitals and ambulatory surgical centers.

Specific provisions of the No Surprises Act limit out-of-network services to billing amounts without cost-sharing requirements that are greater than those applied in-network, and limits cost-sharing as if the total amount billed

for services are equal to the "recognized amount." Commonly, in an out-of-network scenario, this has been limited to the Usual, Customary & Reasonable (UCR) amount. Under the No Surprises Act IFR, the amount must be calculated based on one of the following amounts:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.
- If there is no such applicable All-Payer Model Agreement, an amount determined under a specific state law.
- If neither of the above apply, the lesser amount of either the billed charge or the "qualifying payment amount," (or QPA), which is generally the plan or issuer's median contracted rate. (We now have a new industry acronym – QPA – for qualifying payment amount, ju in case you are confused).

According to the IFR, the All-Payer Model Agreement is an agreement between the Centers for Medicare & Medicaid Services (CMS) and a state to test and operate systems of the all-payer payment reform for the medical care of residents of the state under the authority of Section 1115 A of the Social Security Act, and it may voluntary or mandatory for a given payer.

Emergency services also include any post-stabilization services, unless all of the following conditions are met:

- The treating provider determines the patient is able to travel using non-medical transportation to an available provider or facility;
- The provider or facility provides notice and obtains consent;
- The patient is in a condition to receive the information and provide informed consent;
- The provider or facility satisfies any additional requirements or prohibitions under state law.

Employer/Plan Sponsor Concerns

Employers are just now starting to realize that all of the provisions of the No Surprises Act will impact them. I asked our attorney, Marilyn Monahan of Monahan Law Offices, what she thinks are the most important/impactful sections that affect employers and their insured participants? Marilyn responded as follows:

a. "The restrictions on surprise billing for out-of-network emergency and non-emergency services will be good news to many participants who have experienced—or who are worried about experiencing—surprise medical bills. During open enrollment, employers should consider the most effective way to explain these new rules, so that participants understand when and how they apply.
b. The new restrictions on ancillary services provided in conjunction with a non-emergency visit to an in-network facility (such as anesthesiology, pathology, radiology, and diagnostics) will also be good news, since the definition of 'ancillary services' encompasses a broad range of services that have often been the basis for surprise bills in the past.
c. Employers with self-funded plans should review their plan documents to ensure that the terms are consistent with the IFR. These employers should also communicate with their TPA to ensure that the TPA will be prepared to administer benefits according to the new rules as of the applicable effective date and make any amendments to their services agreement that may be necessary. In fact, a detailed conversation with the TPA about the implementation process for the many provisions in the CAA that impact health and welfare plans is essential."

Administrative Concerns & Confusion Over the No Surprises Act

The No Surprises Act throws confusion into the claims payment industry by requiring that coverage be provided without limiting what constitutes an emergency medical condition, solely on the basis of diagnosis codes, such as the ICD-10 codes, which are common in claims adjudication use. *The federal departments appear to have*

expressed their disapproval of claims practices which do not look at all of the facts and circumstances, relying solely on the diagnosis codes to determine if a claim is eligible for payment. Many plans and claims administrative practices will automatically deny an emergency claim, for example, based on a pre-determined list of final diagnosis codes without regards to the actual symptoms being presented to them at the time of care. It is often only following claim denial that a plan or claims administrator will review all of the facts, and generally upon a formal (but sometimes informal) appeal.

If you review the term "emergency medical condition," it refers to a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to either 1) place their health in serious jeopardy, 2) seriously impair bodily functions, or 3) cause serious disfunction to a bodily organ or part. In general, it requires a plan to consider anything a prudent layperson should consider, given all documentation and all symptoms, without relying solely on an ICD-10 code. This includes mental health and substance abuse disorders. Plans must ultimately determine whether the standard was met by reviewing presenting symptoms, without imposing any type of time limit between onset and presentation for emergency care.

I asked Marilyn what she thinks plan sponsors and administrators need to focus on to apply this prudent layperson standard in an emergency situation? Marilyn responded: "If the plan documents apply a different standard to claims for emergency services, amendments will have to be made. The TPA's claims procedure manual and processes must also be updated. The TPA should also consider this guidance from the preamble: 'the determination of whether the prudent layperson standard has been met must be based on all pertinent documentation and be focused on the presenting symptoms (and not solely on the final diagnosis).' Based on this reminder, the revised claims procedures should also include, as necessary, updated record keeping requirements that will enable the plan to prove that it is has satisfied the new legal standard in each case. The emphasis placed on the prudent layperson standard in the preamble to the regulations implies that this issue may be a priority for the Departments. (86 Fed. Reg. 36872, 36879-36880.)"

In relationship to the administrative and legal process for plans, including plan documents and plan communications, Marilyn continued: "The Surprise Billing IFR—along with the other provisions of the CAA applicable to health and welfare plans—place many new obligations on plans and issuers. Employers with fully insured plans should communicate with their carriers to ensure the carriers intent to comply on time. Employers with self-funded plans have more work to do. The changes created by the CAA will probably require changes to plan documents, ID cards, provider directories, and more. They may also require changes to the terms of TPA contracts and claims processing manuals. Employers should be prepared to discuss with their TPA who will be responsible for implementing each relevant section of the CAA, and the timeframe for implementation. Employers should also consider whether any changes need to be made to the written contract with the TPA, including adjustments in cost, scope of services, indemnification, and other key clauses."

Some plans and administrators may be concerned that if you can't control costs by using strict ICD-10 codes, what can plans and administrators do to control the cost of health care, particularly in a self-funded health plan? Plans may have to find alternate ways of reducing or maintaining costs, such as higher ER copays or coinsurance, raising deductibles, or having additional deductibles for ER services. Other ways of keeping ER costs down in a health plan is to educate your employees on more cost-effective steps prior to walking into an emergency room. This would include things like using Urgent Care Centers instead of high-cost emergency rooms, or for many services that are not life-threatening, implementing new or encouraging plan participants to use Telehealth options.

Qualifying Payment Amount – QPA – Applications to Self-Funded Health Plans

The definition of a qualifying payment amount and applications to the marketplace are a bit confusing… Particularly in the self-funded market. The QPA is defined as the median of the in-network (or contracted) rate in a geographic area, and applies in other portions of the law, including the base-line factor that an arbiter may

consider when they determine the final amount to be paid under the new federally-established independent dispute resolution process (IDR – yes, another new acronym).

Another important self-funded consideration is that ERISA must always pre-empt state surprise billing laws when applied to self-funded plans. The IFR allows the option for self-funded plans to voluntarily opt-in to a state law.

Under the No Surprises Act, when a self-funded plan and an out-of-network provider cannot agree on a rate, they must go through an independent dispute resolution process. The IFR stated that a median contract rate should be determined by taking into account every group health plan offered by the self-insured plan sponsor. The IFR allows for administrative simplicity for self-funded plans to permit the TPA who processes their claims to determine the QPA for the plan sponsor by calculating the median contract rate based on all of the plans that it processes and administers claims for. The IFR states that the contracted rates between providers and the network provider for the health plan would be treated as the self-insured plan's contracted rates for purposes of calculating the QPA.

Third Party Administrators will find the No Surprises Act quite complicated, and frankly, quite expensive to administer. TPAs will need to set up their claims payment systems to administer the QPA. Most self-funded health plan sponsors will rely on their TPAs to assist them with all of the No Surprises Act requirements, and it will likely be the norm for TPAs to assist self-insured plans with the Model Notice that is required. Ultimately, the No Surprises Act will be costly to administer for TPAs. They will need to determine the QPA, which will not be easy and will not be cheap in most cases. In addition, changes will need to be made in understanding the implications of the ER services determination – and taking the extra steps up front to examine more documentation and understand symptoms, rather than initially denying a claim up front, and all of that will cost more; in claims adjudication training, in system adjustments, and more. Not to mention the QPA's independent dispute resolution process. *What this means to self-funded employers is that they should expect their claims fees to increase due to the No Surprises Act.*

The geographic regions used to determine the contracted rates will follow the metropolitan statistical areas (MSA) used by both Medicare and the U.S. Census. The IFR includes the "rule of three" expansion, meaning that if a plan cannot identify three rates to determine a median rate within an MSA, then the plan is permitted to increase the size of the MSA to include the state as a single region.

The IFR issued clear guidelines for steps to be taken in order to determine the appropriate rate, using primarily databases. This piece ties in directly with the Transparency rules, which were in part also addressed in the IFRs. One important provision that was included in the IFR addressed self-insurance industry concerns related to the possibility of conflicts of interest while using databases. The IFR states that the organization maintaining the database cannot be affiliated with, controlled by, or owned by any health insurance issuer, provider, or healthcare facility.

Although the IFR did not address all self-funded concerns, the rules did for the most part, follow comments made from industry associations such as the Self-Insurance Institute of America (I am a member of this association), and overall, the self-funded industry seems pleased with the initial set of rules, and are anxiously awaiting additional guidance.

From an administrative perspective, many of the requirements were not addressed in Part 1, but we're hoping those will follow soon in expected fall rules and guidance. We are expecting more guidance on the arbitration/IDR process to be released in early September.

Independent Dispute Resolution (IDR) Process

Although I mentioned the IDR above, I wanted to come back to it and explain a bit more about how this will work. Under the Interim Final Rules (IFR), if a payer, such as a carrier or health plan, cannot resolve a payment

settlement with a provider, then the payer and provider must resolve the payment dispute using methods of negotiation and arbitration. The No Surprises Act requires payers to send an initial payment or denial of payment of a claim no longer than 30 days after a claim is submitted. After the 30-day period, either party may begin negotiations on a claim. If the parties involved cannot agree on payment terms during the 30-day period, then they will move to an Independent Dispute Resolution (IDR) process. This process may be initiated within 4 days after the end of the open negotiation period of the 30 day period (for a 34-day window). Each entity will offer a final payment amount and then the arbiter will use a variety of factors to determine the final amount, including geographic areas, service codes, etc. The intent is to make it fair to both parties.

Under the IDR process, they are not allowed to use lower payment rates such as Medicare or Medicaid.

The good news is that the IDR does not impact the consumer or plan participant. The dispute is between the provider and the health plan. The provider has no recourse against the consumer, and therefore, it is not an adverse benefit determination.

The agencies will issue the IDR process by December 27, 2021, so we can expect a happy holiday season….

Facility/Provider Notices

There are required notices for Facilities and Providers. The first is the Patient Consent for Out-of-Network Care, which requires providers and facilities to provide a notice to a patient regarding potential out-of-network care. The patient must consent to such out-of-network care and any additional costs that may be incurred. However, there are exceptions. *A patient is not required to sign the form and should not sign it if they didn't have a choice of health care providers when they received care (i.e. a forced provider).*

There is also a Public Notice requirement for facilities and providers to post a one-page notice on a public website. The Model Disclosure Notice Regarding Patient Protection Against Surprise Billing is required under Section 2799B-3 of the Public Service Act. A provider must make publicly available such notice by posting it on a public website of the provider or facility, and provide a one-page notice that includes information in a clear and understandable language on 1) the restrictions on providers and facilities regarding balance billing in certain circumstances, 2) any applicable state law protections against balance billing, and 3) information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.

The Model Notices can be found at: https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780.

Health Insurance and Health Plan Notice

Health insurers and Health Plans must provide a notice to individuals about their rights under the No Surprises Act. There is a Model Notice available on the DOL website (although it has been on and off the site a few times since I started researching for this article, so they could be updating it). The notice must be posted on the plan's website and be included on each EOB for an item or service covered by the No Surprises Act. Although TPA's may assist in preparing this notice for self-funded plans, the plan sponsor has the ultimate responsibility for compliance. Plan participants can expect that their EOBs will become quite thick when they receive them in the mail… Hence, more administrative/postage costs also.

I asked Marilyn if a plan is self-insured and uses a TPA, is there coordination that is needed between the plan sponsors and the TPA about the notices that are included in the EOB? Does (or should) the Plan Sponsor notices be the same, consistent notices? I expressed to her my fear that the plan notice may differ from the TPAs notice, causing some confusion and possible liability. Marilyn clarified: "The IFR contains new notice and posting requirements. For example, health care providers must provide certain notices to the plan or issuer, and additional notices to patients. Another notice and posting requirement applies to plans and issuers; plans/issuers

must post and provide certain notices to participants, including a notice that should accompany explanations of benefits (EOB). Regulations have not yet been issued on the mandate applicable to plans/issuers. In the meantime, the Departments expect plans/issuers to comply using a 'good faith, reasonable interpretation' of the CAA. Also in the meantime, a model notice has been issued which may be used by plans/issuers. Ultimately, in the case of a self-funded plan, the responsibility for issuing compliant notices rests with the plan, and not the TPA. The employer should therefore work with its TPA to ensure that compliant notices are prepared and distributed, and that all legal requirements are satisfied."

No Surprises Act Impact on Self-Funded Health Plans Using Reference-Based Pricing

The No Surprises Act's limitation on balance billing for services provided in an "in-network" facility by an out-of-network provider is likely to be quite problematic for self-funded plans that use Reference-Based Pricing as their financing method, in place of a PPO network. Because there is no network, and all claims are generally paid at a reference-based rate (most commonly a percentage above known Medicare Rates, such as 150% or 200% of Medicare), such self-funded health plans and their RBP vendors will need to discuss how they intend to deal with the No Surprises legislation, sooner rather than later.

Financing plans with reference-based pricing have grown in popularity over the last decade. However, as RBP has become more prevalent in the industry, hospital systems have become more knowledgeable about it, and at times, have refused payment entirely from RBP plans, and instead, have opted for immediate balance billing to all plan participants. In response to these provider actions, certain RBP vendors are struggling to produce solutions that will limit disruption to employer and employees while attempting to retain as much of the savings that RBP Plans have been known for. RBP plans generally pay claims at a stated percentage above Medicare (such as 140%, 150%, 200%, etc.), while PPO contracts, although a great savings over non-contracted provider rates, generally result in (if compared to Medicare, which of course their rates are not based on) costs ranging from 300% to 800% of Medicare rates. Sadly, I've seen many initial bills from hospitals coming in at over 1,000% of Medicare rates when no network is in place.

"Work-arounds" for RBP vendors have included (so far) one-off facility agreements, creating a networked facility, or single case agreements, which is negotiated often-times prior to the participant entering the facility for service. An example is a known procedure or surgery, such as an ACL reconstruction, hip replacement or other procedure. In these cases, some RBP vendors have opted to offer pre-payment to the facility, to encourage them to accept the patient at the RBP rate. There is concern, however, that such pre-negotiated rates could be perceived as a contracted rate, and may set precedents. One of the administrative concerns of this type of solution is the burden that would likely result from pre-negotiations, as well as a possible delay in service while negotiations are in the works.

Another work-around may be direct provider contracts, but those may likely be limited to certain services only, and if providers result in providing additional services, they could opt to balance-bill for those additional services, which may or may not be prohibited under the No Surprises Act, depending on the type of service.

It is assumed by most in the self-insured industry that work with RBP plans that the level of payment for RBP plans may end up increasing to a higher percentage, to still provide savings over PPO plans, but not at the wide difference we are seeing currently. Many of us are expecting payment levels to raise from the 140%-200% rate to perhaps raise to something more like perhaps 200% to 250% for normal facility payments, to cut back on the provider pushback and possible refusal to accept patients under RBP plans.

Because we are still awaiting guidance, I asked two RBP vendors I work with about how they intend to deal with the No Surprises Act. When asked how HS Technologies, an RBP vendor based in Orange County, California, will adjust, President Ryan Day responded as follows: "The No Surprises Act impacts reference-based pricing programs with no facility network. The Interim Final Rule published in July specifically mentions these types of plans in the context of indemnity plans, acknowledging that the scope is limited to emergency facility and professional claims.

If there is no facility network associated with a plan, there can't be a scenario where a member is surprised by receiving services at an in-network facility from an out-of-network provider. This limited scope doesn't apply when there are one-off agreements with a facility. Our reading of the rule made clear that these agreements would now make it a surprise bill if a member receives out-of-network care at a facility that has such an agreement."

Ryan continued with additional solutions. "HST will be able to identify these surprise bill scenarios and, when the plan includes access to a MultiPlan network, ensure the plan administrator has the network QPA needed to determine the member's cost share." HST is now part of Multiplan, with contracted national networks such as PHCS and MultiPlan.

I asked the same question of Larry Thompson, Chief Revenue & Strategy Officer for AMPS, another RBP vendor. Larry stated: "There are many pieces to this. Our Chief Legal Counsel is working on a White Paper to address all of this, and I will provide it once it is complete. In the interim, here are few things to consider. The Act does not specifically target RBP or repricing. While it does address OON, we are prepared to assist our clients who use us for this service. More to follow from our CLO."

I also asked Ryan how they propose to bridge the gap if/when facilities refuse to accept payment entirely from RBP plans? Ryan replied: "HST has routinely experienced a 98% acceptance rate from providers, recognizing not only the fair reimbursement we generate, but also the benefits we can bring to high-accepting facilities. Our HST Connect application helps to steer plan members to those providers, delivering the steerage benefits they typically only expect from network participation. We also engage the provider at key points before service is rendered, to ensure they understand the plan benefits. Should the facility disagree with the reimbursement, our PAC program and settlement portal make it efficient for the provider to engage in the negotiation now required by the No Surprises Act. Any subsequent arbitration resulting from an inability to reach agreement will leverage the analytic and arbitration support services of MultiPlan to help our employers present the best case."

Larry Thompson, when asked the same question, responded as follows: "Rarely does this happen – less than 1% of our members ever face this problem. When they do, our advocates work with the facility to explain how our program works, and in the majority of the cases, access is allowed. Failing that, we offer single case agreements so that the facility will allow service. Barring that, we can revert to safe harbor contracts we have in AMPS America, or redirect the service to another facility."

I also asked Larry how the RBP vendor will coordinate these efforts with the TPA? "Our TPA's are the first line of contact for most members and providers," responded Larry. "Through our integration the TPA will know when to transfer members to our Advocacy or Care Navigation teams to resolve any issues with providers."

Lastly, I asked Ryan what types of plan changes/provisions they are recommending plans that are using reference-based pricing add to their plan documents specifically related to the No Surprises Act? "We are considering adjusting the negotiation corridor to allow for settlement above the typical level for surprise bills specifically ER claims. We are also looking at changing the default reimbursement for ER claims that are impacted by the No Surprises Act."

Many questions remain related to RBP plans by the Departments in future guidance. We don't know whether the Departments will treat pre-negotiated rates as contracted rates or "network" rates. Several industry groups are known to have asked the Departments for further guidance in this area, so we expect answers in the coming months.

Federal vs. State Balance Billing Laws

It is important to note that the No Surprises Act is not intended to displace any state balance billing laws. The issue of state vs. federal law is quite complex and I suggest you seek the advice of legal counsel on this. I will attempt to summarize just the basics of the interaction, but again, this is only a brief summary. The Interim Final

Rules defer to existing state requirements with respect to state laws and states that have an established process in place to resolve payment disputes and allow for arbitration. Self-funded plans have the option to opt into a state law where payment standards of the state are expanded, with full protection against balance billing.

Existing federal law says that the out-of-network provider must have a patient sign a consent to receive non-emergency services, but the sate law might prohibit an individual from providing consent to be balance-billed. If a state develops model language that is consistent with the No Surprises Act, HHS will consider a provider or facility that makes appropriate use of the state-developed model language to be compliant with the federal requirement. Again, this is quite complex. I asked Marilyn Monahan if she could comment on the state of California's balance billing laws and how they will interrelate with the No Surprises Act… "Existing state limits on balance billing – and California has some – will remain in effect for fully insured plans, to the extent that they provide participants with greater rights than they are entitled to under the CAA."

Enforcement

Enforcement of the No Surprises Act is similar to that of the Affordable Care Act. If a fully insured plan sponsor contracts with a third party, then the third party will be responsible for compliance. In a self-funded health plan, the employer plan sponsor will be responsible for compliance, even if they contract with a third party, such as a TPA, to assist them with providing all of the necessary requirements. The Department of Labor will regulate self-funded plans, and fully insured plans will be regulated by the states.

As of now, it is stated that up to 25 health plan audits per year will be performed to ensure compliance with the Act, starting in 2022. If, however, the Departments should receive a consumer complaint, they can audit that consumer's health plan.

Complaints

The No Surprises Act requires the Departments to establish a process for receiving complaints regarding potential violations of the law by providers and insurers. They announced their intention to create one system to intake all complaints related to the various components of the law and direct them to the various departments. The IFR clarifies that there will be no time-limit on complaint filing, but the relevant departments must respond in writing no later than 60 business days after a complaint is received. The regulations contained within the IFR are set to be effective on September 13, 2021, which is 60 days after its publication in the Federal Register.

Next Steps & Conclusion

If you're feeling stressed over these rules, or if just reading them is making you have that tunnel vision I mentioned in the beginning, or you begin to panic or sweat, remember to breathe, and remember, the goal of this legislation is to help people and *prevent* surprise billing practices. Anything new is often confusing and frustrating. Just take one step at a time and keep an eye out for the anticipated end game. Won't it be nice to one day soon, not have to listen to the anxiety in your family member or your clients' voices and angst in their eyes when they tell you they've received an unexpected, surprise medical bill? The No Surprises Act won't help in every case, but it should help the majority of cases in which surprise medical bills show up in our mailboxes. Personally, I'm hoping they expand the No Surprises Act (or offer something similar) to cover other provider bills not covered under this legislation.

We are anticipating additional guidance on many parts of the CAA and Transparency rules in the next few months. We expect rules on the IDR process (sections 103 and 105) around the first of September, as well as patient-provider dispute resolution (section 112), patient protections through transparency (section 112), and price comparison tools before the year is out. In addition, we are expecting guidance on the Broker Compensation Disclosure rules under the CAA around October of this year (although many parties, such as NAHU, have asked for a delay of implementation date until after the rules are released and brokers have time to review and implement

the requirements). I expect that my next article will be focused on many of these new rules, so we can look forward (or not!) to that!

Helpful Links

If you need/want additional information, you can visit the following links to assist you…

Interim Final Rule and Comment Period: CMS: https://www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf

Federal Register: https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i

CMS Fact Sheets: https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-i-interim-final-rule-comment-period

https://www.cms.gov/newsroom/fact-sheets/what-you-need-know-about-biden-harris-administrations-actions-prevent-surprise-billing

References: All of the links above, plus NAHU Webinar, "Surprise! An Overview of the First Balance Billing Interim Final Rule", By Josh Gertz and Deanna Sizemore, July, 2021; "Interim Final Ruling for the No Surprises Act Meets Industry Approval," The Self-Insurer, August, 2021.

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