Advanced Benefit Consulting


# No Surprises Act Part 1 Podcast Show Notes

Dorothy Cociu and Marilyn Monahan Show Notes from No Surprises Act Interim Final Rules and Other Related Laws & Rules (such as the Transparency in Coverage Rules – TiC rules)

# Deadlines: ACA Transparency in Coverage Final Rule (TiC Final Rule)

| Mandate | Original Compliance Date | New Compliance Date |
|---|---|---|
| | | |
| Machine-readable file with in-network provider rates for covered items and services | For plan years beginning on/after January 1, 2022 | Delayed until July 1, 2022 (but as of that date will also apply to plan years beginning on/after 1/1/22) |
| Machine-readable file with out-of-network allowed amounts and billed charges | For plan years beginning on/after January 1, 2022 | Delayed until July 1, 2022 (but as of that date will also apply to plan years beginning on/after 1/1/22) |
| Machine-readable file with negotiated rates and historical net prices for covered prescription drugs | For plan years beginning on/after January 1, 2022 | Delayed indefinitely |
| Price comparison tool with initial list of 500 shoppable items/services | For plan years beginning on/after January 1, 2023 | Not delayed |
| Price comparison tool with all other items/services | For plan years beginning on/after January 1, 2024 | Not delayed |

# Deadlines: CAA "No Surprises Act" and "Transparency"

| Mandate | Original Compliance Date | New Compliance Date |
|---|---|---|
| Price comparison tool | For plan years beginning on/after January 1, 2022 | For plan years beginning on/after January 1, 2023 |
| Reporting on Pharmacy Benefits & Drug Costs | December 27, 2021 & June 1, 2022 | Delayed indefinitely pending guidance; plans should start preparing to report for 2020 and 2021 by December 27, 2022 |
| ID Cards | For plan years beginning on/after January 1, 2022 | Not delayed |
| Provider Directories | For plan years beginning on/after January 1, 2022 | Not delayed |
| Good Faith Estimates by Providers | For plan years beginning on/after January 1, 2022 | Not delayed for uninsured individuals |
| Advanced Explanation of Benefits (EOB) by Plans/Issuers | For plan years beginning on/after January 1, 2022 | Delayed indefinitely pending guidance |
| Surprise Billing | For plan years beginning on/after January 1, 2022 | Not delayed |
| Continuity of Care | For plan years beginning on/after January 1, 2022 | Not delayed |
| Mental Health Parity | February 10, 2021 | Not delayed |
| Gag Clauses | December 27, 2020 | Not delayed |
| Gag Clauses - Attestation | December 27, 2020 | Delayed indefinitely pending guidance |
| Broker Disclosure | December 27, 2021 | Not delayed |

# A Note about Grandfathered Plans . . . .

- **Grandfathered (GR)** health plans are not subject to certain provisions in the ACA (e.g., preventive care, TiC rule, patient protections (choice of provider & emergency services))—this has not changed. However, GR plans are subject to the CAA (FAQ 11). Where this could make a difference:
- **Surprise Billing IFR**:
  - IFR re-states the patient protection rules from the ACA, which will now apply to GR plans (GR Plans: Don't forget to add patient protection notice to plan documents)
  - IFR re-states and rewrites rules on emergency services, which will now apply to GR plans
- **TiC Rules**:
  - Prescription drug reporting requirement in TiC Rule does not apply to GR plans, but similar requirement in CAA does; Departments are delaying enforcement of TiC Rule and working on updated rulemaking to address overlapping requirements
  - Self-service tool requirement in TiC Rule does not apply to GR plans, but similar price comparison tool in CAA does; Departments are delaying enforcement of CAA (but not TiC Rule) and working on updated rulemaking to address overlapping requirements

# Summary of the Interim Final Rule (IFR), Part 1

- Bans surprise billing for emergency services.  Emergency services, regardless of where they are provided, must be treated on an in-network basis without prior authorization
- Bans high out-of-network cost sharing for emergency and non-emergency services.  Patient cost sharing (such as coinsurance or deductible) cannot be higher than if such services were provided by an in-network doctor, and any coinsurance or deductible must be based on in-network rates
    - Limits cost-sharing as if the total billed amount for services are equal to the "recognized amount."  Commonly:  UCR amount.
    - Amount must be calculated based on one of the following amounts:
        - Amount determined by an applicable All Payer Model Agreement (section 1115A of Social Security Act)
        - An amount determined under a specific state law
        - If neither apply, the lesser amount of either the billed charge or the "qualifying payment amount"  (more later)
- Bans out-of-network charges for ancillary care (like an anesthesiologist or assistant surgeon) at an in-network facility in all circumstances
- Bans other out-of-network charges without advance notice.  Providers and facilities must provide patients with a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before the provider can bill at the higher out-of-network rate

# Emergency Medical Condition

- 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:
  - 1) place their health in serious jeopardy
  - 2) seriously impair bodily functions, or
  - 3) cause serious disfunction to a bodily organ or part
- 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.*
- May require Plan Amendments.
- TPA's claims procedure manual and processes must also be updated
  - 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).

# Surprise Billing IFR & CAA  Rules 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.
  - Changes created by the CAA will probably require changes to plan documents, ID cards, provider directories, and more
  - 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
  - Do changes need to be made to the written contract with the TPA, including adjustments in cost, scope of services, indemnification, and other key clauses?
  - Who will be responsible for each item required?  Create a checklist and assign who is responsible for each requirement and communicate with all.

# Qualifying Payment Amount - QPA

- QPA - The median of the in-network (or contracted) rate in a geographic area (becomes complex for RBP plans – will discuss later).
- Also 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.
- 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 (IDR).
- 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.

# Determining QPA

- 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.
- TPAs often will not have the databases needed to determine the QPA, and will likely have to rely on their Business Associates, such as PPO networks or RBP vendors.
- 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.

# Independent Dispute Resolution (IDR) Process

- 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 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 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.

# No Surprises Act RBP Strategies/Options

- **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 a knee replacement, 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.
- TPAs and Self-Funded Employers (and likely their brokers) will need to have serious discussions with RBP vendors to see how they are approaching the No Surprises Act and what their plan is for “work-arounds.”

# No Surprises Act – Reference Materials

- 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

# Questions?

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