No Surprises Act, health plan transparency requirements of the Consolidated Appropriations Act, 2021 (CAA), and the Health Coverage Transparency Final Rule

Multiemployer Plan Considerations

General Considerations

The NCCMP supports the objectives of the No Surprises Act to protect plan participants from surprise medical bills. In implementing the new law, the following general guidelines should be considered:

- Control medical cost inflation. The details of the new law, including the determination of the initial amount to be paid by the plan as well as the IDR process that determines the final payment, should be implemented so as to prevent against medical cost inflation and control health care costs. In the long run, this will provide the greatest protection to plan participants.

- Avoid imposing unnecessary costs, including administrative costs, on plans. The No Surprises Act contains many new notice and disclosure requirements for group health plans, some of which overlap with the Transparency Rule. Burdensome costs can undermine the goal of providing high quality health care. Multiemployer health plans are essentially pools of workers' earnings held in trust under federal law for the exclusive purpose of providing benefits to plan participants and beneficiaries. The trust funds are funded entirely by collectively bargained employer contributions for which covered workers explicitly trade off wages through the bargaining process. In a very direct sense, workers pay for their health coverage. If a trust fund's costs increase, despite the trustees' best efforts at cost containment, the burden falls directly on the workers, as trustees may be faced with the need to reduce benefits or adjust eligibility rules to address new costs. The benefits of any new benefit mandates or administrative requirements (e.g., additional notices) must be carefully weighed against the costs to ensure that workers continue to receive real value for their health care dollars.

- The details matter: consider the unique structure of multiemployer plans as technical details are developed. Multiemployer group health plans are generally subject to the same requirements as other large group health plans (e.g., the ACA market reforms). However, the structure of multiemployer plans differs significantly from that of single-employer plans. Among the key differences are the Taft-Hartley Act requirement for a joint labor-management board of trustees and the more limited role of contributing employers. Because of this different structure, rules designed with single employer plans often, but do not always, work in the multiemployer plan structure. It is essential that any technical operational details be workable for and reflect the multiemployer plan structure.

Specific Issues

1. Effective date

We suggest that the agencies adopt a delay or enforcement discretion rule for plans that are attempting in good faith to implement the law and regulations. The enforcement discretion should apply to any requirement that does not directly affect participant cost-sharing and balance billing protections (e.g., posting machine readable files, Advanced Explanation of Benefits, price comparison tool, etc.).

There are generally different deadlines for compliance with the No Surprises Act and the Transparency Rule. In some cases, similar requirements have different effective dates. For example, the No Surprises Act Advance EOB and Price Comparison tool rules require disclosure of information to participants for plan years beginning on or after 1/1/2022, but similar disclosure rules in the Transparency Rule apply for plan years beginning on or after 1/1/2023.

Our discussions with third party administrators, pharmacy benefit managers, and insurers indicates to us that these entities are struggling to understand the requirements and are not going to be ready to comply on a timely basis. Even plans that currently use some consumer price transparency tool will need to redesign it to reflect the new rules. Moreover, plans that are self-administered may have a variety of administrators (claims pricing, claims administration, out-of-network pricing) who need to come into compliance.

The agencies should provide for enforcement discretion upon demonstration of good faith compliance. We suggest that the HIPAA EDI good faith enforcement process may be instructive. In that case, covered entities were faced with a short effective date window in a process involving multiple parties and the need for testing and exchange of information. HHS provided that covered entities that had a compliance plan for implementation would not be penalized for inability to complete the process in a timely manner. Similar enforcement guidance would be welcome here.

2. Effective date should be after the issues of rules when technical specifications from the agencies is required

A variety of the rules require technical specifications to be issued by the Departments, including items such as model notices, reporting requirements, and machine-readable file data fields. We suggest that plans should have a minimum of one year after the technical specifications are finalized to comply.

3. Effective date for gag clause provision

The CAA amends ERISA Section 724, IRC Section 9824, and PHSA Section 2799A-9 to prohibit group health plans from entering into an agreement with a health care provider, network of health care providers, third party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict the plan from providing provider-specific cost or quality information to referring providers. There is no specific effective date in the statute for this provision. However, the law requires plans to access historic claims information that may or may not be available without application of the gag clause. For example, the plan must be able to access in-network rates as of January 31, 2019 in order to determine the qualifying payment amount.

Regulations should clarify the effective date, with an appropriate exception for existing contracts and provide that plans that are not able to access rates because the gag clause rule is not yet in

effect may set the qualifying payment amount based on a reasonable determination of the plan's in-network rates.

4. Conflict between ERISA Claims and Appeals Rules and No Surprises Act

The Department of Labor, working together with ERISA plan sponsors, has fine-tuned its claims and appeals procedures over many years. The short deadlines in the No Surprises Act are inconsistent with the DOL claims and appeals time frames. The inconsistent time frames have the potential to create conflict for plan sponsors because the time frame for making a claim decision is different from that for paying the claim to a health care provider or facility.

Even if the time frames can be reconciled by the Departments, the law creates two tracks for claims processing, a process for out-of-network emergency services (and other claims subject to the surprise billing provisions), and a separate process for ERISA claims processing, which can include issues such as eligibility determination, medical necessity review, and other issues. The Departments will need to address how to reconcile the two separate claims processing guidelines with potentially different factors and conclusions.

5. Independent Dispute Resolution (IDR) Process

It is important to clarify when the IDR process applies, particularly in light of the ERISA claims and appeals process, and what the standards are for the IDR entity to make the claim determination.

First, the Departments should clarify whether an ERISA plan is required to submit to IDR if the claim has not yet been processed under the ERISA claims and appeals requirements. Similarly, the law does not address how the participant's claims and appeals rights are affected. For example, suppose the participant believes the claim (and their cost-sharing) should have been determined in a particularly manner. It seems appropriate to process the claim though the ERISA process first, including protecting the participant's rights, and then send the claim to IDR to determine the provider payment. This process would be consistent with claims processing today, where the participant's right to a claim payment is adjudicated prior to the provider having the right to payment.

Consequently, in light of the conflict between ERISA and the No Surprises Act, we suggest it would be reasonable to resolve the conflict between the statutes by tolling the IDR process until the claim is resolved under the ERISA claims and appeals process.

Second, we suggest that the Departments should limit the issues that may be resolved in the IDR process to the amount that the provider is paid. Any claims determinations involving eligibility, medical necessity, exclusions and limitations, or plan benefits should not be subject to review in the IDR process or determination by the IDR entity.

Third, the IDR factors in the statute assume a number of issues will be considered that are exclusively within the knowledge of the provider or facility, such as the status of the facility as a teaching hospital. The plan should be permitted to review the claim of the provider or facility prior to filing its response, in order to be able to understand the provider's claim and act appropriately. Otherwise, the IDR entity will be reviewing simultaneous filings which may not accurately reflect the details of the claim.

Fourth, the IDR process should be affordable and efficient, and should also involve reporting of settlement rate patterns, frequency in use patterns by both providers and payers, and should result in a method to establish a rate of fair payment for services in a region that can be used to minimize using the IDR process instead of agreeing to fair contracts with plans that protect patients. Regionally, if either side has a higher than average use of the IDR process, a community average should be used as the payment amount for a service, when such a rate can be established. This would result in dampening the pattern of refusing fair payment and sending a large percentage of claims to IDR rather than contracting at a fair rate. If IDR results in payments that are higher than the norm, provider groups will be more likely to end or avoid contracting, further eroding the patient protection built into plan design, and raising the price of care beyond current practices. This is already a troubling trend regarding private equity groups that purchase practices and then terminate contracts, and instead bill at heavily inflated pricing.

6. Payment to provider during the initial payment period

Plans often use an administrative service provider or third-party administrator to determine out-of-network payable amounts and negotiate fees with health care providers and facilities. Plans that use that type of process should be able to continue to use it within the No Surprises Act framework. That is, plans that pay a different amount from the qualifying payment amount during the initial 30-day period after a claim is received should be able to negotiate the claim with the provider, protect the participant from balance billing, and avoid the IDR framework, regardless of whether they make a payment based on the statutory structure. Consequently, plan procedures that currently work well and protect the participant from balance billing should be able to remain in place.

Plans that currently charge the participant cost-sharing based on the in-network rate for the same or similar services should not have to determine a median in-network rate if they are paying based on the greatest in-network rate for the service within the plan's contracts.

7. Claims processing concerns

The Departments should provide guidance to plan sponsors on how to determine when a claim is subject to the No Surprises Act. There could be many situations of concern, but we describe two. First, plans will not be able to identify whether a provider claim was for an emergency service because provider claims are generally submitted separately from facility claims. The provider claim may or may not be identified as an emergency service. For example, a radiology bill may not be identified as provided in connection with an emergency. Second, plan sponsors may not know that a claim is an out-of-network claim from an in-network facility, because the in-network claim may not have been received yet. In addition, the plan will not know whether the provider obtained the informed consent from the participant or not.

8. Freestanding emergency departments

Clear guidance is needed with respect to the scope of what constitutes an "Independent Freestanding Emergency Department" beyond the terms that it is geographically separate and distinct and licensed separately from a hospital and provides emergency services so that plans (and providers) can clearly understand their obligations and participants can understand their rights. Guidance should clarify that an Independent Freestanding Emergency Department would not include urgent care centers or employer-provided clinics.

9. Requirements should take into consideration the impact on plan finances

Multiemployer plans are often self-insured and self-administered. In this manner, plans can maximize the amount of plan assets used for participant and dependent health care expenses. To the extent that compliance with the disclosure requirements of the rule has a detrimental impact on plan finances (e.g., over one percent of plan claims expenses), plans should be able to delay implementation.

10. External appeals applicability

The ACA external appeals requirements do not apply to grandfathered plans. Thus, the provisions extending external appeals to adverse determinations by group health plans concerning payment for emergency services, non-emergency services by nonparticipating providers at in-network facilities or air ambulance services in Section 110 of the No Surprises Act do not apply to grandfathered plans. While the statute appears clear on this point, it would be helpful for the Departments to clarify that these provisions do not apply to grandfathered plans.

11. Retiree-only plans

Based on the statute, the provisions of the No Surprises Act and the gag clause provision should not apply to retiree-only plans, for the same reasons that the ACA requirements added to the PHSA, the Code and ERISA do not apply to such plans. While the statute appears clear on this point, it would be helpful for the Departments to provide clarification that the new provisions do not apply to such plans.

12. General applicability

The Departments should clarify which portions of the No Surprises Act apply to grandfathered plans. The Departments will need to resolve applicability issues where the health care provider is subject to the law but the plan is not. The Departments should make it clear that a plan that is otherwise not subject to the new law, e.g., a stand-alone excepted benefit dental plan or a retiree-only plan, does not become subject to the law because the provider is subject to the new law. We believe that the statute is clear in this regard, but regulatory confirmation would be helpful to avoid any confusion.