NCCMP Annual Conference

No Surprises Act and Transparency Rules

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Agenda

Overview of No Surprises Act

What's been delayed?

How will payment for emergency services change?

What should plan sponsors do next?

Overview of No Surprises Act

No Surprises Act

Enacted December 27, 2020 as part of the Consolidated Appropriations Act, 2021, Public Law 116-260

Applies to most group health plans and insurers, including grandfathered plans

Generally, effective for plan years beginning on or after January 1, 2022

Retiree-only plans, excepted benefits, Health Reimbursement Arrangements (HRAs) exempt

What Drove this New Law?

- Patients were plagued by this long-recognized problem
- Patients and plan participants are exposed to huge financial burdens
- There was no legal standard to limit charges for non-contracted providers
- A few bad apples- notably where limited competition exists
- Media coverage created political opportunity

Ultimately the law protects consumers

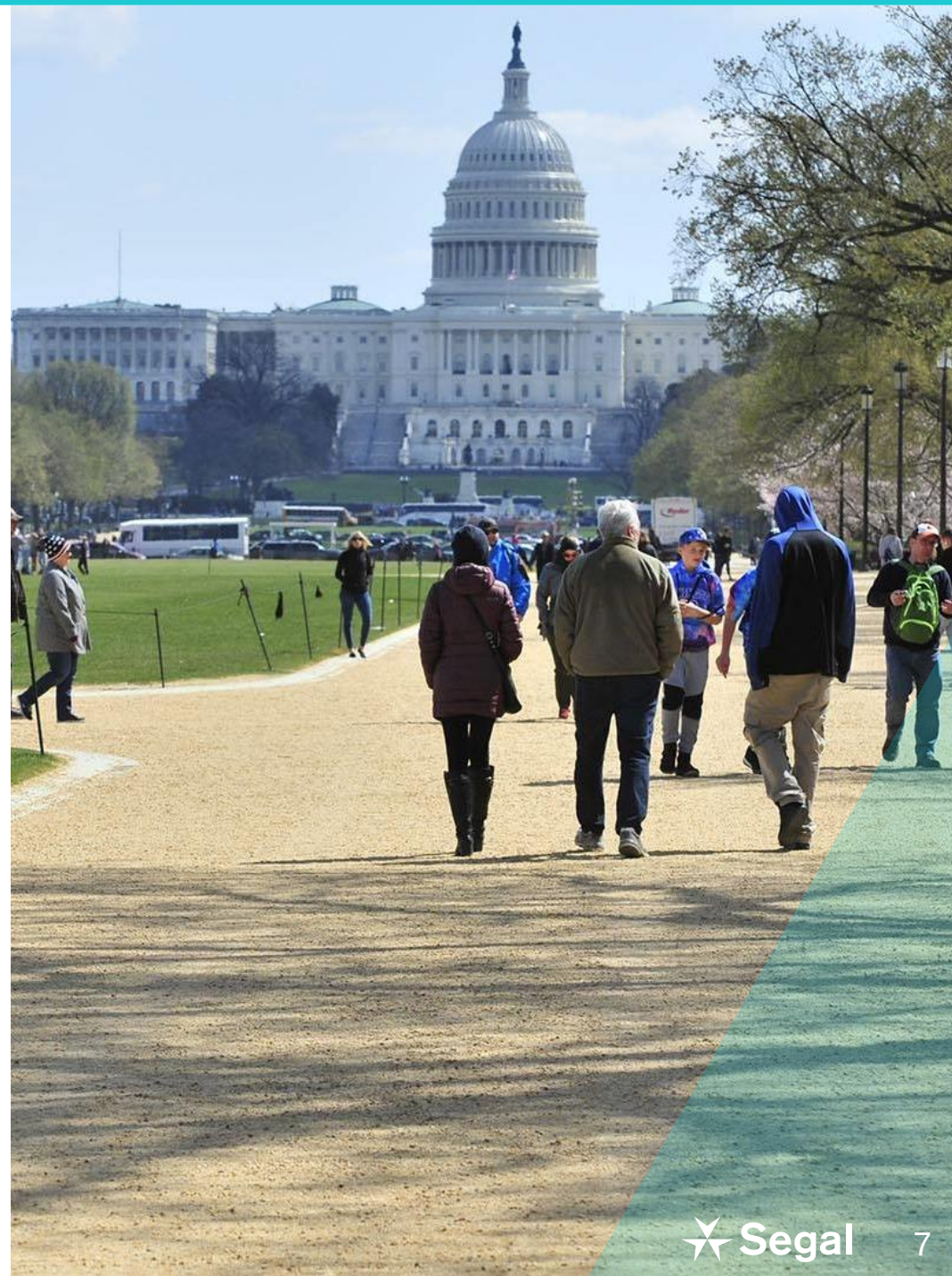
NCCMP Guiding Principles

- *Control medical cost inflation*
- *Avoid imposing unnecessary costs, including administrative costs, on plans*
- *The details matter: consider the unique structure of multiemployer plans as technical details are developed*

The NCCMP has provided extensive comments to both legislators and regulators both before and after enactment of the No Surprises Act.

Interim Final Rule

- Departments of Health and Human Services, Labor, and Treasury published an Interim Final Rule (IFR) on July 13, 2021 implementing Part I of the federal No Surprises Act (NSA)
- Rules likely to come later in 2021 on Federal Independent Dispute Resolution (IDR) process
- NCCMP has file multiple sets of comments on proposed and interim final regulations



New Rules for Emergency and Non-Emergency Services

- Participants will be protected from balance billing by out-of-network (OON) providers and are only responsible for in-network cost-sharing for:
  - Emergency services furnished at nonparticipating providers or emergency facilities
  - Non-Emergency services furnished by nonparticipating providers at in-network facilities
  - Nonparticipating air ambulance services

ACA's Emergency Room payment rules (applicable to non-grandfathered plans) are repealed

Emergency services

Defined broadly to include medical screening provided in the ER and services provided in any department of the facility to screen, treat, and stabilize the patient

New Payment Rules Apply to a Range of Care

- Hospital
- Independent freestanding emergency facility
  - Applies to urgent care if facility is state-licensed to provide emergency care
- Services provided within any hospital department until the patient is stabilized
- Services performed post-stabilization
  - If the patient cannot be transported using non-medical transportation

"Prudent Layperson" Definition of Emergency Medical Condition

Plans must use "prudent layperson" definition of "emergency medical condition"

- Medical condition, including mental health condition or substance use disorder, manifested 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 the absence of immediate medical attention to result in serious impairment or serious dysfunction of any bodily organ or part
  - Includes placing the health of a woman or her unborn child in serious jeopardy

Plans cannot deny an emergency service based solely on a diagnostic code

Coverage Rules that Directly Impact Participants

A group health plan must cover emergency services and certain non-emergency services:

- Without any prior authorization determination, even if services are out-of-network
- Without regard to whether the health care provider or facility is in-network
- Without imposing any administrative requirement or limitation on coverage that is more restrictive than in-network restrictions
- Without imposing greater cost-sharing requirements for out-of-network services

Coverage Rules that Directly Impact Participants

- Calculate participant cost-sharing requirement based on the recognized amount for such services
- Count participant cost-sharing for out-of-network emergency services toward any in-network deductible or in-network out-of-pocket maximums (including the annual limitation on cost sharing) in the same manner as if the care were provided in-network
- Without regard to any other term or condition of the coverage other than the exclusion or coordination of benefits

Timing and Payment

- Plans must send an initial payment or a notice of denial of payment to the provider or facility within 30 calendar days of the nonparticipating provider sending the bill
- The 30 day calendar period begins on the date the plan or issuer receives the information necessary to decide a claim for payment for the services
  - i.e., Plan does not have to pay until a clean claim has been received
- Must ultimately pay a total plan or coverage payment to the nonparticipating provider or nonparticipating facility that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services less any initial payment amount

Notice and Consent Exception for Emergency Services and Non-Emergency Services

- Coverage, timing, payment and balance billing requirements, will not apply to certain emergency and non-emergency services if the provider meets the notice and consent requirements

- Notice and Consent exception does not apply to hospital-based ancillary services providers, including emergency medicine providers, pathologists, anesthesiologists, radiologists, assistant surgeons and hospitalists

Notice and consent should be applied in limited circumstances, where the individual knowingly and purposefully seeks care from a nonparticipating provider, such as deciding to seek care from a physician the patient already knows.

Grandfathered Group Health Plans

Must use the “Prudent Layperson” standard for emergency medical conditions

Required to implement patient protections for choice of provider, pediatricians, and OB/GYN

Coverage Requirements for Air Ambulance Services

The law applies even if there is no contracted provider

- Cost-sharing must be the same as if the services were provided by a participating provider of air ambulance
- Cost-sharing must be calculated for a nonparticipating provider based on the lesser of the QPA or the billed amount

Air Ambulance Reporting

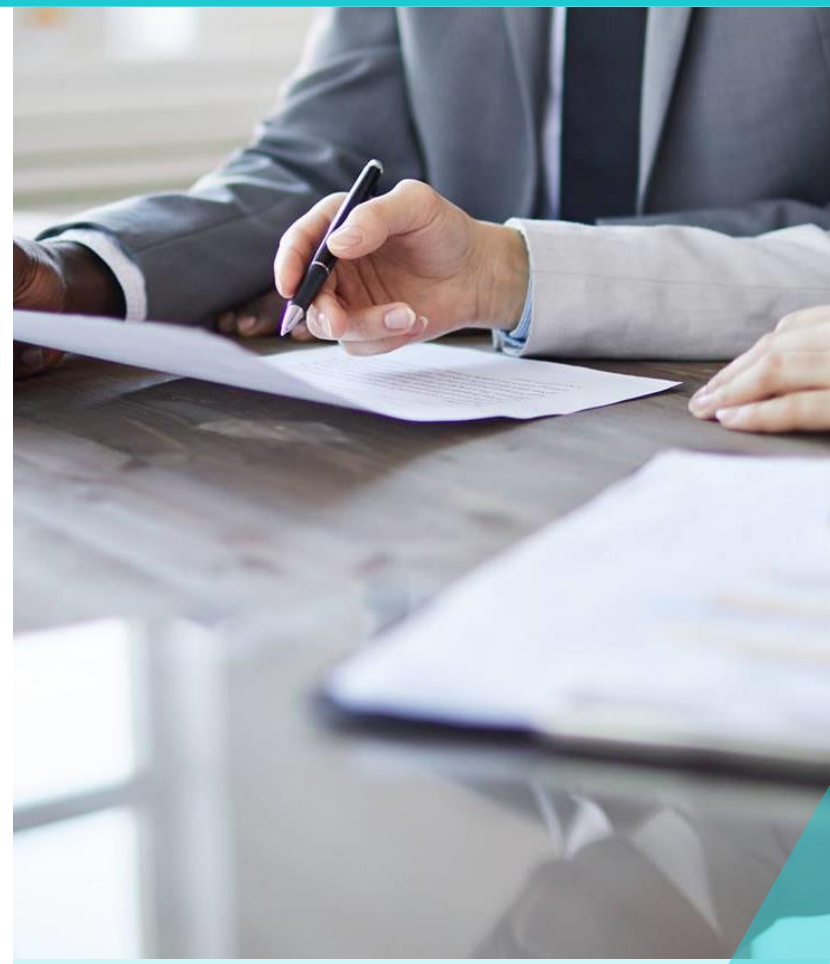
- Departments proposed rule on Air Ambulance reporting requirements (September 10, 2021)
  - Proposal would require plans to report information on air ambulances for 2022 and 2023 plan years, by March 31, 2023 and 2024
  - Required data includes:
    - Plan name, market (insured, self-insured, etc.), date of service, provider name, CPT code, transport information, claim adjudication, and payment information
    - Includes data for claims received or paid during reporting period
  - Plan may delegate reporting to insurer or TPA
- Comments due October 18, 2021

Independent Dispute Resolution

- If the group health plan and the OON provider cannot reach an agreement on the OON payment, the amount the health plan has to pay the OON provider is determined through an independent dispute resolution (IDR) process
- There is no threshold amount for claims to go to the IDR process
- The process is “baseball style,” meaning that the IDR reviewer picks one of the parties’ offers
- Losing party pays IDR costs

Independent Dispute Resolution

- The IDR reviewer must consider certain factors in making its decision, including the median in-network rate for the service, as well as other information the parties provide
- The IDR reviewer cannot consider UCR, billed charges, or Medicare/Medicaid rates in making its decision



Participant Notice of Rights

- Group health plans must give individuals a notice about their rights under the No Surprises Act
- The Departments have published a model notice that may be used for this purpose
- The notice must be posted on the plan's website and be included on each explanation of benefits for an item or service covered by the No Surprises Act

What's been delayed?

Delayed until Future Rulemaking

- Prescription drug negotiated rate machine-readable file
  - Is it necessary? Litigation ongoing
- Prescription drug reporting (proposed rule)
  - Expected to begin on December 27, 2022 (instead of 2021) and each June 1 thereafter
  - NCCMP filed comments on request for information
- Advanced Explanation of Benefits
  - First HHS must issue rulemaking on how providers/facilities submit estimated charges

Deferred Enforcement

- In-network and out-of-network rate machine-readable files – July 1, 2022
- Price-comparison tool
  - Because similar to the Transparency Rule internet-based, self-service tool, same date will be used:
  - Plan years beginning on or after January 1, 2023 (with respect to 500 services)
  - January 1, 2024 (for the remaining items and services)

Plan sponsors are expected to implement the requirements using a good faith, reasonable interpretation of the law

No regulations before the effective date

Rules concerning the following likely will be issued in 2022

- ID cards
- Continuity of care
- Accuracy of provider network directories
- Prohibition on gag clauses

Plan sponsors must comply in good faith and based on a reasonable interpretation of the law.

How will payment for emergency and non-emergency services change?

Out-of-Network Reimbursement Rates

Current State

Most Network Providers offer several options for setting out-of-network provider reimbursement:

Set based on a percentile of a national database (e.g. 80th Pct. of Fair Health	**Set based on a multiple of Medicare (e.g. 200% of Medicare)**	**Use billed or submitted amounts**

Out-of-network provider billed rates can be 5 to 7 times higher than network contract rates for some procedures.

Calculating the Cost-Sharing Amount for Emergency and Non-Emergency Services

The cost-sharing amount for emergency and certain non-emergency services must be equal to the recognized amount, which is one of the following in order of priority:

- An amount determined by an applicable All-Payer Model Agreement
- An amount determined by a specified state law that governs both the plan and the service
- The lesser of billed charges or the Qualifying Payment Amount (QPA), which is the median of the contracted rates of the plan or issuer for the item or service in the geographic region

Methodology for Calculating the QPA for Emergency and Non-Emergency Services

The QPA for 2022 is the median of the plan's contracted rate on January 31, 2019, for the same item or service that is provided by a provider in that specialty in that geographic region, adjusted for inflation

Special Rule: Self-insured plan sponsors have a choice whether to calculate the contracted rate based on their self-insured group health plans or the entirety of self-insured group health plans administered by the same entity (including a third-party administrator) that is responsible for calculating the QPA on behalf of the plan

Determining the Geographic Region

A geographic region is generally defined as one region for each metropolitan statistical area (MSA) in a state and one region consisting of all other portions of the state

- For air ambulance services, a geographic region means one region consisting of all MSAs in the state and one region consisting of all other areas

Special rules apply if a plan does not have sufficient information to calculate the median

Calculating the Median Contract Rate

- Plans must use at least three contracted rates to calculate the median
- Each single contract is considered when calculating the median rate
  - Ad hoc agreements designed to address a unique situation are not included in the calculation
- Plans that use bundled or capitated rate arrangements must still calculate a median rate based on their underlying fee schedule or the price they use for internal reconciliation

Finding the Median Contracted Rate

Assume three contracted rates for a self-insured plan for a service in a specific geographic region are:

$475	**$490**	**$510**

The median contracted rate for this service is $490.

Air Ambulance Costs

		Allowed Charges – Air Ambulance					
Year	# of Claims	Average	Minimum	25th percentile	50th percentile	75th Percentile	Max
2019	1,013	$36,507	$666	$15,937	$30,492	$53,065	$203,507
2020	850	$39,154	$677	$18,027	$32,216	$55,013	$233,483

Source –Segal Medical Plan Database

The median contracted rate for this service is $32,216

Cost Implications for Plan Sponsors and Plan Participants

Plan Participants will generally see lower cost-sharing for emergency care

- Typically out of network cost sharing is 30% to 40% of the allowed amounts submitted
- Under the new law, patients will see cost share limited to emergency copays and in-network cost sharing (0%-20% of much lower allowed charges)

Plan Sponsors are expected to see small savings

- CBO estimates approximately 1% savings
- Depends on level of benefit differences today, out-of-network utilization rates and long term results or influence of Independent Dispute Resolution

What Does This Mean for Your Costs for Emergency Care?

- Participants will be protected from Surprise Bills
  - Participant cost-sharing is based on a new formula
- Plans have to make an initial payment to providers and facilities, but that amount is not established in the rule
  - Will the plan's existing out-of-network payment rules still be effective?
  - What will be the cost implications of the new payment rules?

What do Plan Sponsors need to do next?

Key Implementation Concerns for Multiemployer Plans

- Grandfathered plans must comply with most of the rules, including prudent layperson standard for emergency care
- Plans with joint administrative agreements have challenges coordinating implementation
- Plans with separate agreements for services (e.g., carve out benefits) and separate out-of-network pricing services must coordinate with them while still paying participant cost-sharing based on Qualifying Payment Amount
- Many plans do not have websites
- Extensive plan document amendments necessary

What do Plan Sponsors Need to Do Next?

- Find out what payment changes your service providers plan
- Determine impact on plan finances
- Amend plan documents
- Get ready for regulations on Independent Dispute Resolution process later this year
- Create plan for good-faith compliance with remaining rules

Questions?

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