Today's webinar will begin shortly. We are waiting for attendees to log on.

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No Surprises Act

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Agenda – No Surprises Act

- The requirement for group health plans to treat emergency services as in-network, without requiring pre-authorization, regardless of where they are provided.
- Patient cost-sharing requirements, such as co-insurance or a deductible, that cannot be higher for emergency and non-emergency services than if such services were provided by an in-network doctor, and the requirements related to the treatment of coinsurance or deductible as in-network.
- Issues associated with the treatment of ancillary care (like an anesthesiologist or assistant surgeon) as in-network.
- Notices that must be provided by health care providers and facilities explaining that patient consent is required to receive care on an out-of-network basis before that provider can bill at the higher out-of-network rate.

BACKGROUND

Key Provisions

Key provisions in the No Surprises Act:

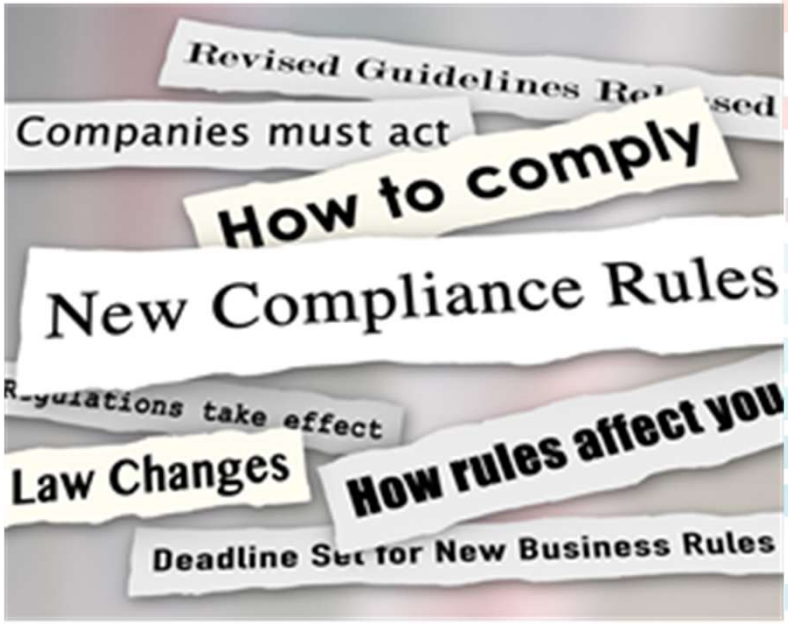
- Protect participants from receiving surprise medical bills resulting from gaps in coverage for emergency services and certain services provided by out-of-network clinicians at in-network facilities, including by air ambulances.
- Holds participants liable only for their in-network cost-sharing amount, while giving providers and insurers/plans an opportunity to negotiate reimbursement.
- Allows access to an independent dispute resolution (IDR) process in the event disputes arise around reimbursement. The legislation does not set a benchmark reimbursement amount – must be negotiated or resolved in IDR.
- Requires both providers and group health plans to assist patients in accessing health care cost information, including advance EOBs.

Sources of Law

- No Surprises Act adopted as part of the Consolidated Appropriations Act signed by former President Trump on December 27, 2020
- Interim Final Rule issued jointly by IRS, DOL and HHS on July 1, 2021
  - Addresses some, but not all, aspects of the law
    - Scope of balance billing prohibition
    - Methodologies for patient cost sharing and provider payment
    - Requirements and limits on law's notice and consent exception to be treated by OON provider
    - Standards for required provider and facility disclosures
    - Complaints processes
  - Written comments to the IFR must be received by 5 p.m. on September 7, 2021

Regulatory Guidance Forthcoming

- HHS must issue regulations by 10/1/2021 regarding audits to ensure compliance
- Under the Act, HHS, DOL, and the IRS are to issue regulations to govern IDR process within one year of enactment of the law
- Agencies also indicate another proposed rule on air ambulances will be forthcoming – other issues may not be addressed in rulemaking before 1/1/22



Effective Date for Covered GHPs

- Effective for plan years on or after 1/1/2022 (providers, air ambulance and facilities subject to NSA on 1/1/2022)
- The NSA will apply to all GHPs **(including grandfathered plans)** other than:
  - Excepted benefits (e.g., limited-scope dental and vision plans);
  - Short-term, limited-duration insurance (STLDI);
  - Health Reimbursement Arrangements (HRA) or other account-based group health plans; and
  - Retiree-only plans.

Building on ACA – Patient Protections

- The IFR extends certain ACA patient protection provisions to grandfathered plans:
  - participants in a plan that requires designating a primary care physician ("PCP") must be allowed to designate any participating provider as PCP.
  - a participant may name a pediatrician as the PCP for a child beneficiary, and
  - prohibits a plan from requiring pre-authorization or PCP referral for treatment or care from any participating provider of gynecological or obstetric care.

The IFR provides sample language for plans to include in summary plan descriptions ("SPDs") or other explanations of plan terms and conditions.

Building on ACA – Emergency Services

- The IFR and NSA expand on emergency treatment protections in ACA. -- As background, under ACA:
  - Non-grandfathered GHPs and insurers that cover emergency services are required to do so without requiring prior authorization and regardless of whether a provider is OON
  - Non-grandfathered GHPs or health insurer may not impose any administrative requirement or limitation on benefits for OON emergency services that is more restrictive than the requirements or limitations that apply to in-network emergency services
  - Non-grandfathered GHPs or health insurers are required to meet defined and "reasonable" minimum payment standards for OON emergency care if they otherwise provide OON emergency services – however, balance billing was not prohibited by ACA *(some states have regulated for insured plans)*

The IFR Sunsets these ACA provisions at the end of 2021 *(or end of 2021 PY for non-calendar year GHPs) and expands protections for emergency services, non-emergency services by OON providers and air ambulance services*

NO SURPRISES

EMERGENCY SERVICES

OON PROVIDER AT IN-NETWORK FACILITY

AIR AMBULANCE

Emergency Services

- For emergency services at OON hospital ER or OON freestanding ER, the NSA:
  - Prohibits prior authorization
  - Prohibits more restrictive administrative requirements or limits on coverage for OON if cover emergency services (EHB for individual and small group policies)
  - Requires cost sharing at in-network rates (the “recognized amount”)
  - Allows provisions excluding emergency services, imposing waiting periods and COB
  - Requires initial payment or denial within 30 days of receipt of bill from the OON provider
  - Requires the cost sharing to count towards in-network deductibles and OOP maximums
  - Prohibits providers from balance billing participants

Emergency Services Expanded

- The NSA and IFR expands the traditional concept of "emergency services" to include **post-stabilization services** unless the following four-part test is satisfied:
  - the attending provider determines the patient is able to travel using nonmedical/non-emergency transportation to an available participating provider or facility located within a reasonable travel distance;
  - the provider/facility must satisfy notice and consent criteria to move the patient (a model notice was published simultaneously with the IFR);
  - the patient or authorized representative must be in a condition to provide informed, voluntary consent; and
  - the provider/facility must satisfy any additional state law requirements.

Emergency Services Expanded

- Emergency services include coverage at free standing and independent emergency departments, broadly defined to include
  - A healthcare facility that provides emergency services, which
  - Is geographically separate and distinct from a hospital, and
  - That is separately licensed by a state.
- IFR prohibits summary denials based on final diagnosis codes – must consider whether prudent layperson would view the situation to be an emergency in seeking services
- Preamble also indicates services include coverage for emergencies relating to conditions otherwise excluded under the GHP (aimed at GHPs and insurers denying emergency coverage for pregnant dependents based on exclusion of dependent maternity care)

OON Provider

- If GHP covers non-emergency services by OON provider at an in-network facility, the plan or issuer:
  - must not impose cost-sharing greater than would apply if services had been provided by a participating provider;
  - must calculate the cost-sharing requirements as if the total amount that would have been charged for the items and services by such participating provider were equal to the recognized amount for the items and services;
  - must make an initial payment within 30 days;
  - must pay a total plan or coverage payment directly to the OON provider that is equal to the amount by which the OON rate for the items and services involved exceeds the cost-sharing amount for the items and services, less any initial payment amount; and
  - must count cost-sharing toward in-network deductibles and out-of-pocket maximums.

However, participant may opt-out of the protections for certain providers if notice and consent requirements satisfied.

OON Provider

- The protection from balance billing does not apply when a provider provides notice and receives consent from the participant to receiving services OON at OON rates – model notice on CMS website
  - Consent to OON treatment can only be sought for certain non-emergency services or certain post-stabilization services at in-network hospitals, hospital outpatient departments and ambulatory surgical centers *(does not apply to urgent care centers, emergency pre-stabilization or air ambulance services)*
  - Visits to an in-network facility does not require physical presence and includes furnishing equipment or supplies, telemedicine, imaging and lab services
- OON Provider may balance bill if provide cost estimate and obtain individual's consent at least 72 hours prior to treatment – *certain providers excluded. including anesthesiologists, radiologists, pathologists, neonatologists, assistant surgeons and labs*
- *Providers/facilities must timely notify plans and issuers where the notice and consent criteria have been satisfied, as well as provide a copy of the consent, and requires plans/issuers to assume that notice and consent have not been satisfied where they have not received that notice. Where notice is received, plans and issuers are permitted to rely on the notice, unless they know, or reasonably should know, that the notice and consent were not proper.*

OON Provider

- Providers are not allowed to request the patient's consent to balance bill in four common scenarios:
  - The provider provides an ancillary service typically not selected by the patient, such as radiology, anesthesia, or hospitalist services.
  - There are no in-network providers available to provide the service at the facility.
  - The service is urgent or arises from unforeseen circumstances.
  - Relates to air ambulance services
- Providers may request consent to OON treatment
  - Services are "post-stabilization" services meeting the 4 criteria discussed earlier in which patient could be moved to another in-network facility, with proper notice and consent to remain OON
  - Services are non-emergency and non-ancillary, with proper notice and consent to treatment

OON Provider – Notice and Consent

- Providers must use notice prescribed by HHS which includes certain information required by law
- Notice must be tailored to individual and include, for e.g., treatment codes, services and items reasonably expected to be provided and anticipated costs
- Must advise payment won't be counted to in-network cost sharing
- Must be provided at least 72 hours in advance
- Must require acknowledgement that patient may be balance billed
- Must meet language accessibility requirements
- Does not apply to unforeseen emergencies arising during course of treatment by consent

No Surprise Air Ambulance Bills

- OON Air Ambulance Providers prohibited from billing participants for more than the "recognized amount"
- Details of implementation subject to future regulation
- Will be subject to payment negotiation and IDR process also subject to future regulation

Cost Sharing and Payment Methodologies

"Recognized Amount"

Determination of Out-of-Network Rates "Recognized Amount"

Plans must calculate the participant's cost-sharing requirement as if the total amount that would have been charged was equal to the IFR defined "Recognized Amount," set as:

- the amount approved by the state in the case of items and services furnished in a state with an All-Payer Model Agreement; or
- the amount determined in accordance with state law (to the extent the state has an applicable law), or
- If neither of the above apply, the lesser of
  - the market-based median in-network rate, called the "Qualifying Payment Amount," or
  - *The lowest amount offered by the provider or facility*

Plans also must count cost-sharing payments for such OON emergency or non-emergency services toward any applicable in-network deductible or OOP maximum

Determination of Out-of-Network Rates "Recognized Amount" – Defined Terms

All Payer Model Agreement: an advanced alternative payment model agreement between a state and CMS that permits the state to establish rates for all services provided by a particular provider or facility regardless of payer. (Maryland and Vermont)

Specified State Law: A specified state law is one that sets an OON provider's rate and is applicable to the relevant insurer — including any ERISA plans that have opted to be subject to the state law — as well as the relevant provider and to the services at issue. "Specified state law" is not straightforward as to ERISA plans that are self-insured – IFR recommends proceeding with caution and outlines examples in the regulations.

Determination of Out-of-Network Rates "Recognized Amount" – Defined Terms

Qualifying Payment Amount (QPA): The IFR explains in great detail that the QPA will generally be an insurer's median in-network (i.e. "contracted") rate for (a) the same or similar services; (b) furnished in the same insurance market;* (c) by a provider of the same or similar specialty; (d) in the same or similar geographic area. Calculation of the median rate will be pegged to insurer rates as of January 31, 2019, and then adjusted for inflation going forward.

**For self-funded plans, insurance market refers to all self-insured group health plans of the plan sponsor, or at the option of the plan sponsor, all self-insured group health plans administered by its TPA, if applicable. Plan sponsors that utilize TPAs should evaluate whether it is more advantageous to use a QPA calculated based on its own plans or based on all self-funded plans administered by its TPA.*

Determination of "Recognized Amount" – Disclosure to Provider

- When the QPA is the "recognized amount" for a claim to an OOP nonparticipating provider, emergency facility, or provider of air ambulance services, the plan or issuer must provide to the provider or facility
  - the QPA for each item or service involved;
  - a statement certifying that the plan has determined that the QPA applies and was calculated in compliance with the rules;
  - a statement providing specifics on the IDR process and its deadlines; and
  - contact information for the appropriate office or person to contact to negotiate.

Determination of "Recognized Amount" – Disclosure to Provider

- *Upon request* by the provider or facility, the plan or issuer must also provide,
  - information about whether fee schedules were used when contracted rates were not set on a fee-for-service basis;
  - in the case of a new service code, identify any related service codes used; and
  - in the case that an eligible database was used, information to identify the database.

Cost Sharing and Payment Methodologies

Provider Payments

Negotiation and Independent Resolution Process – Provider Payment

GHP or insurer must make a total payment to the OON provider equal to the following (less the participant's cost-sharing responsibility):

- an amount determined by an applicable All-Payer Model Agreement;
- if none, an amount determined by a specified state law;
- if neither of the above apply, an amount agreed upon by the insurer and the provider or facility; or
- if no agreement and the parties do not settle prior to completion of the independent dispute resolution process established in the law, the amount determined by the independent dispute resolution entity.

Negotiation and Independent Resolution Process – Provider Payment

Payment Negotiation and IDR Procedures – ACA "greater of three" payment for emergency OON is now superseded. New method as follows:

- Health plan has 30 days from initial bill to make "initial payment" or deny payment
- When OON provider receives notice of payment or denial – 30-day period to negotiate agreed upon amount
- If no agreement within 30 days, IDR Process may be initiated
  - Notice to HHS and other party within 4 days
  - No minimum threshold of payment amount to initiate IDR

Notice and Disclosure

Notice and Disclosure Requirements Health Plans

- Disclosure of balance billing protections
- Updated Insurance Cards with cost sharing and contact info for questions
- Advance Explanation of Benefits for scheduled services, including provider's network status and good faith estimate of charges
- Notification of network status changes for continuing care patients
- Online price comparison tool for participating providers
- Updated provider directories (at least every 90 days) and respond to requests for information

Model notices on DOL website

Notice and Disclosure Requirements Advanced EOB Content

- Whether the provider or facility is in- or out-of-network;
- If in-network, the contracted rate for the item or service;
- If out-of-network, a description of where to find information on in-network providers and facilities;
- The billed amount estimate from the provider or facility;
- An estimate of the amount the plan will pay;
- An estimate of the person's cost-sharing responsibility for the item or service, as of the date of the notice;
- An estimate of the amount the person has incurred toward their cost-sharing limits, including deductibles and out-of-pocket maximums, as of the date of the notice;
- Whether the item or service is subject to medical management, including concurrent review, prior authorization, or step-therapy or fail-first protocols;
- A disclaimer that the advance cost estimate is only an estimate; and
- Any other information or disclaimers that are appropriate and consistent with the above.

Notice and Disclosure Requirements Advanced EOB Timing

Timing of Advanced EOB:

- Patient schedules service three to nine days prior to the date of service: the plan must provide the advanced EOB within one business day after receiving the provider's or facility's notice.
- Patient schedules service at least 10 days prior to the date of service, or requests an advance EOB: plan must provide the advanced EOB within three business days after receiving the provider's or facility's notice.

Notice and Disclosure Requirements Health Care Facilities and Providers

- Disclosures of Patient Protections Against Balance Billing
  - Publicly available on website
- Notice of Good Faith Estimates of Scheduled Services
  - HHS must establish by 1/1/2022 a dispute procedure between patients and providers in addition to IDR for plans/payers and providers
- Notice of Facility and Provider Network Status
  - If an incorrect network status is provided to patient and patient pays an amount in excess of the in-network cost-sharing amount, the provider must refund the excess amount, plus interest

Enforcement

Participant Complaints and DOL Investigations

- The IFR states that participants (or their "authorized representatives") should contact the DOL in writing or by phone if the participant feels there has been a potential violation of the Act.
- The IFR also outlines information the DOL could request as it addresses any complaints under the Act, including plan information from the sponsor.
- Thus, plan sponsors will have another reason to be sure that all plan documentation is up-to-date and readily available.

Participant Complaints and DOL Investigations

- Finally, the IFR provides that DOL, after reviewing relevant information and making a determination on a complaint, could:
  - Refer the complainant to another appropriate Federal or State resolution process.
  - Refer the plan or issuer for an investigation for enforcement action.
- Group health plan sponsors should expect more DOL investigative activity as a result.

Penalties for Noncompliance

- No specific enforcement mechanisms or penalties that apply to GHPs or health insurance issuers for violation of NSA, although HHS received additional enforcement and penalty authority over providers and facilities.
- However, the NSA amended the PHSA, ERISA and the IRC, so those statutory enforcement mechanisms generally apply.
- The IFR states that the Departments will generally achieve the CAA-required oversight through existing processes, though HHS intends to amend its enforcement regulations through future notice and comment rulemaking.

IFR Effective Date

- The IFR will take effect September 13, 2021 and will apply to group and individual health plans beginning with plan years that start on or after January 1, 2022.
- The Departments have invited interested parties to submit public comments through September 7, 2021.
- Any Final Rule issued after the comment period should track the IFR closely, but we expect that the Departments ultimately could modify certain elements of the IFR.
- Stay tuned for further developments and updates!

Final Questions

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Thank You

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