No Surprises Act

August 19, 2021

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BACKGROUND

- Included in the Consolidated Appropriations Act, 2021, signed in to law December 2020
- Comprehensive legislation to protect consumers from surprise medical bills and improve price transparency
- Goes into effect January 1, 2022
- Interim final rule issued July 1, 2021 addressing some parts of NSA. More regulatory guidance to come in 2021 and beyond.

HOW THE NSA APPLIES

- Group health plans and health insurers
  - Includes self-funded plans, non-federal governmental plans, church plans, grandfathered plans
  - Does not apply to excepted benefits; short-term, limited duration insurance; or account-based plans
- Providers, Facilities, and Air Ambulances
  - Includes physicians and health care provider, health care facilities, and air ambulances

OVERVIEW OF TOPICS

- Financial Protections: limit the financial liability of consumers
  - Emergency services and surprise billing
- Information Protections: provide consumers with information before receiving care
  - Continuity of care, notices, provider directories and price comparison tools

Financial Protections

EMERGENCY SERVICES

- NSA builds on ACA and prohibits restrictive coverage practices for emergency services.
- If a group health plan provides benefits for "emergency services," the plan must cover the emergency services subject to the following conditions:
  - (1) Without prior authorization
  - (2) Without regard to whether to provider or facility is in-network

EMERGENCY SERVICES
(CONTINUED)

- (3) Without limiting what constitutes an emergency medical condition solely on the basis of diagnosis codes
- (4) No other coverage condition can apply other than an exclusion, coordination of benefits, waiting period, or cost-sharing
- (5) if the emergency services are provided by an out-of-network provider or facility:

EMERGENCY SERVICES
(CONTINUED)

- (a) Without imposing requirements and limitations that are more restrictive and cost-sharing that is greater than what applies to in-network providers and facilities
- (b) Cost sharing applied to in-network deductible and out-of-pocket maximum
- (c) Cost-sharing calculated using the "recognized amount"
  - Generally the median in-network rates, adjusted for inflation
- (d) plan or insurer must make initial payment or denial to provider within 30 days
- (e) payment must be the amount in excess of cost-sharing up to the out-of-network rate (discussed later)

NONEMERGENCY SERVICES

- These provisions apply in nonemergency situations where an individual receives care from an in-network facility, but the provider is an out-of-network provider.
- For covered items and services, the plan or insurer must
  - (1) apply in-network cost sharing calculated on a recognized amount
  - (2) pay or deny the bill within 30 calendar days
  - (3)the cost-sharing must count toward the participant's in-network deductible and out-of-pocket maximum

SURPRISE BILLING/BALANCE BILLING

- Occurs when an insured patient unknowingly receives care from an out-of-network provider or at an out-of-network facility
- Exists in emergency and non-emergency situations
- Examples
  - patient taken to closest emergency room, which happens to be out-of-network
  - Patient goes to an in-network hospital and is treated by an out-of-network physician

SURPRISE BILLING/BALANCE BILLING (CONTINUED)

- Out-of-network providers and facilities typically charge higher rates than in-network providers, leading to higher cost-sharing for consumers
- If plan refuses to pay the out-of-network provider's billed charge, the provider generally tries to recover the balance by billing the patient
- NSA aims to protect patients from the most pervasive types of surprise/balance bills

SURPRISE BILLING/BALANCE BILLING
(CONTINUED)

- Emergency Services (including air ambulance) – NSA prohibits balance billing for emergency services received at an out-of-network facility or by an out-of-network provider at either an in-network or out-of-network facility

SURPRISE BILLING/BALANCE BILLING (CONTINUED)

- Nonemergency Services - NSA generally prohibits balance billing for nonemergency services provided by an out-of-network provider at an in-network facility
- Limited exception if patient knowingly and voluntarily consents to waive NSA protections
  - Only applies to nonemergency situations
  - Prohibited where the provider furnishes ancillary services (e.g. emergency medicine, anesthesiology, pathology, radiology, etc.)

SURPRISE BILLING/BALANCE BILLING (CONTINUED)

- Notice and Consent Requirements
  - providers must use forms provided by HHS and tailor with patient specifics
  - Must be given separately and cannot by buried with other documents
  - Generally must be give at least 72 hours in advance of a scheduled appointment
    - If the appointment occurs less than 72 hours after scheduling, must be given at least 3 hours in advance of appointment

DETERMINING PLAN PAYMENT

- All-Payer Model Agreement
  - Maryland, Vermont and Pennsylvania
- State set amount
  - 17 states have enacted comprehensive surprise billing laws and another 15 have enacted more limited protections.
- Negotiated amount or independent dispute resolution amount

INDEPENDENT DISPUTE RESOLUTION

- Plan has 30 days to make an initial payment or deny the claim
- For 30 days after initial payment or denial, the parties can try to agree on a payment price
- If no agreement is made, either party may, within 4 days, initiate IDR by submitting notice to the other party and applicable agency
- Parties can continue to negotiate and agree on a payment up until the IDR entity make a decision

INDEPENDENT DISPUTE RESOLUTION
(CONTINUED)

- Parties must select a certified IDR entity within 3 business days after initiation of the IDR process. The entity must not have any conflict of interest with either party
  - If the parties cannot agree, the applicable agency will select the entity
- Multiple items and services may be arbitrated in a single process if certain requirements are met

INDEPENDENT DISPUTE RESOLUTION
(CONTINUED)

- Within 10 days after the entity is selected, the parties must submit to the IDR entity:
  - An offer of payment
  - Any information requested by the IDR entity
  - Any other information the parties believe relevant
- Within 30 days after the IDR entity is selected, it must select one of the submitted offers – it cannot come up with its own payment amount

INDEPENDENT DISPUTE RESOLUTION
(CONTINUED)

- To determine which offer of payment to select, the IDR entity must consider the following:
  - "Qualifying payment amounts" (generally, the median in-network rate) for the applicable year for that item in that geographic region
  - Any additional information submitted by the parties
  - Level of training, experience, and quality and outcomes measurements of the provider that furnished the item or service
  - Market share held by the nonparticipating provider or the plan in the geographic region

INDEPENDENT DISPUTE RESOLUTION
(CONTINUED)

- Acuity of the individual receiving the item or service or the complexity of furnishing the item or service
- Teaching status, case mix, and scope of services of the nonparticipating facility
- Demonstrations of good faith efforts (or lack thereof) made by the nonparticipating provider or the plan to enter into network agreements and, if applicable, contracted rates during the previous four plan years

INDEPENDENT DISPUTE RESOLUTION

(CONTINUED)

- IDR entity may NOT consider:
  - Usual and customary charges
  - Amount that would have been billed if these requirements would not have applied
  - Payment rate by a public payor (e.g., Medicare, Medicaid, CHIP, TRICARE, VA programs)

INDEPENDENT DISPUTE RESOLUTION

(CONTINUED)

- Prevailing party entitled to payment within 30 days of the decision
- Non-prevailing party pays the IDR entity's fees
- Each party must pay an administrative fee to the applicable agency
- New regulations indicate that the IDR process is not subject to ERISA's claim procedures since participant payment is not involved

Information Protections

CONTINUITY OF CARE

- If a participant is a "continuing care patient," the plan must notify the individual and potentially provide transitional care for up to 90 days, if:
  - The network contract is terminated;
  - Benefits under the plan for the provider are terminated because of a change in network contract terms; or
  - The contract between the plan and an insurer is terminated and in-network status for the provider is lost
  - **NOTE:** Terminated means the expiration or nonrenewal of the network contract – if the contract is terminated for fraud or failure to meet quality standards, no triggering even occurs

CONTINUITY OF CARE
(CONTINUED)

- A continuing care patient is a person who:
  - Is undergoing treatment for a "serious and complex condition" from the provider or facility
  - Is undergoing a course of institutional or inpatient care from the provider or facility
  - Is scheduled to undergo nonelective surgery
  - Is pregnant and undergoing treatment for the pregnancy
  - Is or was determined to be terminally ill and is receiving treatment

CONTINUITY OF CARE
(CONTINUED)

- "Serious and complex condition" defined as:
  - Acute illness – a condition serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;
  - Chronic illness – a condition that is:
    - life threatening, degenerative, potentially disabling, or congenital; and
    - requires specialized medical care over a prolonged period of time

CONTINUITY OF CARE
(CONTINUED)

- If a triggering event occurs, the plan must:
  - Notify each individual who is a continuing care patient of the person's right to elect continued transitional care
  - Provide the individual with an opportunity to notify the plan of the individual's need for transitional care
  - Permit the individual to elect to continue benefits as if the provider was still in-network

AIR AMBULANCE REPORTING

- Plans must submit two reports to the applicable agency
- First report is due no later than 90 days after the last day of the first calendar year beginning on or after the date on which the agencies promulgate a final rule on the form and manner of the report
- Second report must be provided no later than 90 days after the last day of the immediately succeeding year

AIR AMBULANCE REPORTING
(CONTINUED)

- Reports must include the following information:
  - whether the services were furnished on an emergent or nonemergent basis;
  - whether the provider of such services is part of a hospital-owned or sponsored program, municipality sponsored program, hospital independent partnership (hybrid) program, independent program, or tribally operated program in Alaska;

AIR AMBULANCE REPORTING
(CONTINUED)

- whether the transport in which the services were furnished originated in a rural or urban area;
- the type of aircraft (such as rotor transport or fixed wing transport) used to furnish the services;
- whether the provider of the services has a contract with the plan to furnish such services under the plan; and
- other information as specified by the agencies in future guidance

ADVANCED EXPLANATION OF BENEFITS

- Plans and insurers must provide an advanced EOB that includes certain information
- Deadline:
  - within 1 business day after receipt of the request from the provider or individual; or
  - if item or service is scheduled, or individual request is made, at least 10 business days before item/service the item or service is to be furnished, provide within 3 business days after the request
- Electronic or mail as requested by participant or beneficiary

ADVANCED EXPLANATION OF BENEFITS (CONTINUED)

- Must include:
  - Whether provider or facility is in-network, and:
    - if in-network, the contracted rate under the plan for the item or service; or
    - if out-of-network, a description of how such individual may obtain information on providers and facilities that are in-network
  - Good faith estimate included in the notification received from the provider or facility (if applicable) based on billing and diagnostic codes
  - Good faith estimate of amount covered by plan

ADVANCED EXPLANATION OF BENEFITS (CONTINUED)

- Must include:
  - Good faith estimate of the amount of cost-sharing
  - Good faith estimate of amount person has incurred toward meeting the limit of the financial responsibility under the plan as of the date of the advanced EOB
  - Disclaimer that coverage is subject to a medical management technique, if applicable
  - Disclaimer that information provided in the notification is only an estimate
  - Any other information or disclaimer plan deems appropriate and consistent with the required information and disclaimers

ID CARD TRANSPARENCY DISCLOSURES

- Group health plans must include, in clear writing, on any physical or electronic plan ID card issued to participants or beneficiaries:
  - any deductible applicable to the plan;
  - any OOP maximum limitation applicable to the plan; and
  - a telephone number and website for consumer assistance information, such as in-network hospitals and urgent care facilities

PRICE COMPARISON TOOL

- Group health plans must maintain a price comparison tool that allows enrolled individuals to compare cost-sharing for items an services.
- Must be available via telephone and through the plan website
- Information must be specific as to plan year, geographic region, and participating providers

PROVIDER DIRECTORY

- Group health plans must establish public website database containing:
  - List of every healthcare provider and facility with which the plan has a direct or indirect contractual relationship
  - "Provider directory information" for each
  - Must verify and update provider directories at least every 90 days
  - Must establish a system to respond, within one business day, to individuals who inquire about network status of a provider or facility

BALANCE BILLING DISCLOSURES

- Group health plans, providers and facilities must post a publicly available notice of the NSA's patient protections and balance billing requirements on their website
- Group health plans must also include this disclosure on every EOB for items or services that fall under the NSA
- Providers and facilities must also provide notice to patients
- DOL to issue a model notice

EFFECTIVE DATE AND EXPECTED REGULATORY ACTIVITY

- NSA goes into effect January 1, 2022
- Additional regulatory guidance to be issued:
  - October 1, 2021, audit process
  - December 27, 2021, IDR process
  - January 1, 2022, complaint process
  - Regulated entities are expected to adopt a good faith, reasonable interpretation of the NSA until implementing rules are issued.

Questions?