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American Benefits Council
Health Provisions in the CAA

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Today's Agenda

- Legislative Background
- "No Surprises Act"
  - Surprise billing provisions
  - Additional provisions
- "Transparency Provisions"
  - Prohibition on gag clauses
  - Disclosure of broker and consultant compensation
  - MHPAEA NQTL comparative analyses
  - Mandatory annual reporting on pharmacy benefits and drug costs

CAA Legislative Background

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Legislative Background

- Provisions are part of year-end funding bill – Consolidated Appropriations Act, 2021 (CAA)
- Surprise billing is just one part of an omnibus package of patient protections
- All of the provisions build on the Affordable Care Act structure, **but** in addition to regulating group health plans and health insurance issuers, many provisions directly regulate providers and service providers
- Package has surprising breadth, and came together quickly – largest package since the ACA

Legislative Background

- "No Surprises Act"
  - Roughly two years off and on-again negotiations
  - Payment resolution remained the primary point of contention
  - The current compromise came together very quickly and had not been previously discussed by Committee leadership
  - Relatively little time for stakeholder input and technical drafting advice

CAA – "No Surprises Act"
Surprise Billing

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Surprise Billing Legal Framework

- "Preventing Surprise Medical Bills"
  - Applies to group health plans and health insurance issuers in the individual and group markets
  - Also applies to certain health care providers
  - Amends PHSA, ERISA and the Internal Revenue Code

We will focus on emergency services and non-participating providers at participating facilities; similar, but not identical, provisions apply to air ambulance providers and their services

Surprise Billing Legal Framework

IN-SCOPE

OON AIR Ambulance Services

+

OON ER Facility Charges

OON ER Professional Services

+

Non-ER Services by **Non**participating Providers at **Participating** Facilities

Emergency Services

OUT-OF-SCOPE:
Everything else – e.g., elective and other non-ER procedures at OON facilities

SCOPE: Emergency Services

- Replaces current ACA-created emergency services requirements (1/1/22)
- Requires:
  1. Plans and issuers that cover emergency services to cover services:
     - Without prior authorization or restrictions greater than in-network; and
     - With in-network cost sharing;
     - Cost sharing applied to in-network deductible and out-of-pocket maximum
  - Prompt submission of either payment or notice of denial (30 days)
- Introduces new payment audit requirement of plans/issuers
- **Can there be balance billing? NO.** Generally can charge no more than the defined cost sharing amount

SCOPE: Emergency Services

- Determination of whether it is an "emergency service"
  - Remains a prudent lay person standard
  - Emergency Services key off of EMTALA examination and stabilization, **but** expanded to include:
    - **Broader settings** – Includes (1) independent free standing emergency rooms and (2) all parts of the hospital, not just the ER
    - **Broader scope** – Includes post-stabilization observation and inpatient/outpatient stay associated with the emergency visit:
      - If patient's plan covers the services; and
      - Provider does not opt-out through notice and consent

SCOPE: Non-ER Services by Non-Network Provider at Network Facility

- Group health plans and health insurance issuers in the individual and group market **must** (for items and services they cover):
  - Impose in-network cost sharing (based on a "recognized amount");
  - Pay (or deny) within 30 days;
  - Pay provider directly; **and**
  - Count cost sharing toward in-network deductible and in-network out-of-pocket maximums (as applicable)
- **Can there be balance billing? Depends (see next slide)**

SCOPE: Non-ER Services by Non-Network Provider at Network Facility

- **Balance billing:**
  - Generally, provider **cannot** bill the individual more than the cost-sharing amount
  - **However, a non-participating provider offering non-emergency services *may* proceed with providing services and resulting balance bill if (1) provide qualifying written notice (including an estimate of charges and a list of network providers) and (2) receive qualifying consent from the patient**
    - EXCEPT, providers of **ancillary services** (e.g., emergency medicine, anesthesiology, others) **cannot** use notice & consent – therefore, no balance billing permitted by the ancillary providers

SCOPE: Non-ER Services by Non-Network Provider at Network Facility

- **Notice & Consent Rule**
  - Requirements:
    - 72 hours in advance or on date appointment is made
    - Written, paper or electronic, selected by participant
    - Required information, including good faith estimate of services
    - Consent must be signed
  - Note:
    - Cannot be utilized with respect to unforeseen, urgent medical needs that arise at the time the covered item or service is provided
    - Cannot be invoked by ancillary providers
    - If get notice and consent, the provider cannot use the IDR process

Required Payments to Non-Participating Providers

The following three requirements **must** be satisfied within the first 30 days:

1. The plan or issuer must either deny the claim or determine the claim is covered
2. If covered, the plan or issuer must pay the **"initial payment"**
3. The initial payment must be paid directly to the provider

Initial Payment = Allowed amount (per the plan) minus the participant's **"cost-sharing"**

Cost-Sharing = copayments as well as deductible and coinsurance (based on **"recognized amount"**)

Recognized Amount

- **Defined to mean (as applicable):**
  - All-Payer Model Agreement amount (MD, VT, PA for rural facilities)
  - State set amount (if applicable)
  - **"Qualifying payment amount"**

Note: For self-funded plan claims outside of MD, VT and (some) PA, recognized amount is generally going to be the qualifying payment amount

Qualifying Payment Amount

- **Generally –** the median contracted rates (market/geography/January 31, 2019)(increased by CPI-U)
- **For 2022** – the **median contracted rates** recognized by the plan or issuer (**determined by market** or "all such plans offered by the sponsor") as the total maximum payment (including cost-sharing) from January 31, 2019 for the **same/similar item** in the **geographic region** increased by CPI-U over 2019, 2020, 2021
- **For 2023** – the qualifying payment amount determined under this clause for such an item or service furnished in the previous year (i.e., 2022), increased by CPI-U
- Note: Special rules apply for new plans and coverage and newly covered items and services

Now what...

So... The provider wants more....

Independent Dispute Resolution Process

- Within 30 days of non-par provider receiving an initial payment or denial, **provider or plan or issuer may initiate negotiations** to determine an agreed upon amount for item or service
  - Provider AND plan or issuer have 30-day period to negotiate, beginning on date of initiation of negotiations
- **If negotiations fail, the provider or plan or issuer have 4 days to initiate the binding IDR process** by submitting notification to the other party and the Secretary

Independent Dispute Resolution Process

- **A certified IDR entity determines the amount of payment for qualified IDR item or service**
  - Provider and plan or issuer can continue to negotiate and agree on a payment amount before IDR entity makes a determination (if there is an agreement, IDR process must provide for allocation of payment to IDR entity)

Total Payment =

Out-of-network rate
- state set amount (if applicable)
- **negotiated/agreed amount or IDR amount (if cannot agree)**
- All-Payer Model Agreement

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Cost sharing amount, *which is based on:*
- state set amount (if applicable)
- **"qualifying payment amount"**
- All-Payer Model Agreement amount

Independent Dispute Resolution Process

- **Multiple items and services may be "batched" and considered as part of a single determination under IDR process**
  - Items and services may only be batched if:
    - Furnished by same provider or facility
    - Payment by same plan or issuer
    - Related to treatment of similar condition
    - Furnished during same 30-day period (following date on which first item or service was included with respect to determination) or alternative period for use in limited circumstances, as determined in regulation
  - Secretary must specify criteria as part of IDR Process regulation
  - Single determination for items and services as part of bundled payment

Independent Dispute Resolution Process

- Tri-Agency must establish a process to certify (and recertify) IDR entities
- Secretary must provide for a method for plan or issuer and non-par provider to jointly select a certified entity, and if parties do not make a selection, the Secretary will make a selection
- **Within 30 days after selection, the certified IDR entity must select one of the offers for the payment**
  - Certain additional information may be offered and considered
  - Must consider the qualifying payment amounts, any requested information, additional circumstances, and submitted information
  - May **not** consider UCR, amount that otherwise would have been billed, public payor amounts

Independent Dispute Resolution Process

- 90-day "cooling off" period following a determination for the party that submitted request
  - For same other party and item or service
  - After 90-day period, party has 30 days to submit such requests
- If a determination is made by certified IDR entity, the party whose offer is not chosen is responsible for all fees for IDR process
  - If parties reach a settlement before determination, parties split the fees
- Payments are made directly to non-par provider within 30 days of determination

Effective Date & Regulatory Implementation

- Provisions effective for **plan years beginning 1/1/22**
- Regulations required under several provisions:
  - **Audit process**: not later than 10/1/21
  - **Qualifying Payment Amount methodology**: not later than 7/1/21
  - **IDR Process, including certification of IDR entities**: not later than 12/27/21 (one year after effective date)
  - **Complaint process for providers**: not later than 1/1/22

Surprise Billing

- **Employer considerations:**
  - Limited time to implement
  - Likely departments will issue IFR with comment versus NPRM
  - Need to modify plan documents and SPDs
  - Enrollee experience
  - Potential for IDR process to result in new informal OON benchmark rate

CAA – "No Surprises Act"
Other Provisions

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Additional Provisions of "No Surprises Act"

- Encompassed in CAA
  - Provider nondiscrimination
  - Price transparency requirements
  - Mandated government reports on cost, access, and integration of healthcare
  - Application of external review to surprise billing denials
  - Price comparison tool
  - Provider good faith estimates and dispute resolution process
  - Verified and updated provider directories
  - Continuity of care requirements
  - Advisory committee on ground ambulance services and insurance coverage

Advance EOBs

Plans and issuers must provide an **advance EOB** to participants and beneficiaries (through mail or electronic means) on **good faith estimate received from the provider, including:**

(1) whether a provider is in-network or OON, contracted rate information for the in-network provider and how individual can get information about in-network providers;

(2) good faith estimate from provider;

(3) good faith estimate of coverage;

(4) good faith estimate of cost-sharing;

(5) good faith estimate of accumulated amounts; and

(6) any medical management for the item or service

Timing: within 1 business day after date the plan or issuer receives good faith estimate from the provider **OR** within 3 business days if service scheduled at least 10 business days in advance (OR a request is made by participant or beneficiary) after the date the plan or issuer receives good faith estimate from the provider (or request from participant or beneficiary)

- **Effective date:** 1/1/2022

Advance EOBs

- **Employer considerations:**
  - Limited time to implement
  - Unclear if there will be regulations
  - Requires disclosure of good faith estimate of costs based on information from provider
  - Complex provision to operationalize

All-Payer Claims Database (APCD)

- Provides for grants to states to establish an APCDs or improve their APCD
- Entities can apply for access to APCDs (research entities, employers, issuers, TPAs, or health care providers) to use data to improve quality of care or cost
- Employers may request customized reports (for a cost) subject to privacy, security, and proprietary financial information
- Non-customized reports available free of charge
- HHS may prioritize grant requests if state implements reporting format for self-funded plans
- **Effective date:** Grants begin FY2022
  - By **12/27/21**, DOL required to establish a standardized reporting format for **voluntary reporting** by group health plans to State APCD of claims, eligibility and provider data
  - DOL is required to establish an advisory committee to be convened by **3/27/21** to assist with format and guidance on standardized reporting for voluntary reporting by group health plans - report due no later 6/27/21

All-Payer Claims Database (APCD)

- **Employer considerations:**
  - Statute seems clear that self-funded plan reporting is voluntary
  - Concern re: states setting requirements for self-funded plans to report to State APCD
  - Unclear how useful pricing information will be after implementation of Transparency final regulations, although quality data may still be helpful

CAA – "Transparency Provisions"

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Prohibition on Gag Clauses

- **Plans and issuers prohibited from** entering into provider contracts that restrict, directly or indirectly, the disclosure of provider-specific cost and quality information
- The **contract cannot restrict plans and issuers from electronically accessing de-identified claims and encounter information for enrollees**, including:
  - financial information (such as the allowed amount),
  - provider information,
  - service codes,
  - and any other data element included in claim or encounter transactions
- Contracts cannot restrict plans and issuers from sharing such information with a HIPAA business associate
  - **Effective date:** Unclear, likely upon enactment

Prohibition on Gag Clauses

- **Employer considerations:**
  - Effective date of requirement remains unclear
  - Need for implementing regulations
  - Unclear when/if applies to in-force agreements
  - Potential need for transition relief to allow for opening and renegotiation of ASO agreements
  - Overlap/interaction with other transparency provisions (such as ACA section 2715A)
  - Annual attestation will be required

Disclosure of Compensation

- Service providers must disclose to plan fiduciaries *upfront* (e.g., at time of contracting) a description of:
  1. The services to be performed; **and**
  2. Any direct or indirect compensation that they reasonably expect to receive for the **brokerage or consulting services**

- **Effective date:** 12/27/21

Disclosure of Compensation

- Employer considerations:
  - Fiduciary responsibilities associated with receipt of new comp information
    - E.g., Additional schedule C reportable information
  - Appears to apply only to brokers and consultants that provide services to ERISA group health plans

Parity NQTL Analysis

- Plans and issuers must be able to provide, if requested by the respective Secretary (DOL or HHS) or a state insurance regulator (if applicable), a detailed written analysis regarding compliance with the Mental Health Parity and Addiction Equity Act's (MHPAEA's) **nonquantitative** treatment limitations ("NQTLs")
- Analysis should include: (1) factors and (2) evidentiary standards used as well as the results
- 45-day correction period if analysis is found noncompliant; mandated notice of noncompliance to enrollees within 7 days if analysis is not corrected with the 45-day period
- **Effective Date:** Requests may be made as soon as 45 days after the CAA's enactment (i.e., February 10, 2021)

Parity NQTL Analysis

- **Employer considerations:**
  - Limited time for implementation
  - May need to communicate with TPA/ASO/carrier
  - Analysis may demonstrate NQTL compliance weakness that could suggest/mandate plan re-design

Reporting on Pharmacy Benefits and Drug Costs

- Plans and issuers must annually report to the Secretaries detailed information regarding plan spending, the cost of plan pharmacy benefits, enrollee premiums, and any manufacturer rebates received by the plan or issuer

- **Effective Date:** Reporting not later than 12/27/21

Reporting on Pharmacy Benefits and Drug Costs

- **Employer considerations:**
  - Significant new detailed reporting requirement on plan prescription drug spend, total health care spend, premiums paid by employer and enrollees, impact on premium by rebates, and reduction in premiums and out-of-pocket costs associated with rebates
  - Public reporting of aggregated prescription drug reimbursements under group health plans, drug pricing trends, and role of drug costs in premium costs

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