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No Surprises Act:

What Every Plan Sponsor Needs to Know

Risk to Reference-Based Pricing Health Plans

Contents

Main Points

- The Independent Dispute Resolution (IDR) process added by the No Surprises Act (NSA) triggers a new risk for health plans that use Reference-Based Pricing (RBP) as well as for plans that include a network of providers and plans that directly contract with providers and facilities.

- Providers may challenge RBP determinations even where the NSA doesn't apply – such as for plans where there is no network of providers, where services are provided in a non-network facility, or by a non-network provider in a non-network facility.

- Where the NSA does apply, out-of-network providers who challenge the RBP determinations shift the risk for charges in excess of RBP from the participant to the plan sponsor.

Introduction

Beginning January 1, 2022, federal provisions of No Surprises Act (NSA) took full-effect to protect health plan participants from "surprise" medical bills from out-of-network providers delivering services at in-network facilities. Interim Final Rules require the arbitrator in the independent dispute resolution (IDR) process to presume that the "qualifying payment amount (QPA)" – or median contracted rate – set by health insurance companies for patient cost-sharing purposes is "the appropriate out-of-network rate."

Reference-Based Pricing (RBP) can be a self-funded health plan's most valuable provision. Designed to moderate excessive hospital costs, RBP establishes a benchmark fee schedule and payment ceiling instead of negotiated fees by contracting with a provider network. There is, however, a new potential risk to RBP that health plan sponsors and participants need to be aware.

Where the NSA applies, the arbitrator may not accept RBP as the QPA. Provider and facility contracts may be bound by all the provisions of the NSA's independent resolution process in certain geographic regions if there is sufficient data to calculate a median contracted rate.

No Surprises Act

"Surprise" medical bills occur when patients are treated by out-of-network (OON) providers under circumstances where they are unable to avoid the OON service and can also occur when a patient is unaware an OON provider will administer their care.

The No Surprises Act (NSA), part of the Consolidated Appropriations Act of 2021, now protects patients from receiving surprise medical bills when seeking emergency services or certain services from out-of-network providers at in-network facilities, mandating that patients are only responsible for in-network cost-sharing amounts for these services.

What Claims are Covered by NSA?

A health plan that provides emergency coverage must provide that coverage without prior authorization, without regard to whether a facility is in-network or out-of-network, and regardless of other terms of the plan, except for exclusions or coordination of benefits.

Effective January 1, 2022, providers are prohibited from balance billing for:

- Out-of-network emergency care at an out-of-network facility
- Care at an in-network emergency facility from an out-of-network provider
- Non-emergency care at an in-network facility from an out-of-network provider without the patient's informed consent
- Air ambulance claims

Patients will be responsible for payment of the in-network cost-sharing amount, which will count toward the patient's health plan deductible and out-of-pocket cost-sharing limits.

No Surprises Act Will Apply Based On Who Provides Service

	In-Network Hospital, Office or Other Facility non-emergency care without patient consent	Out-of-Network Hospital, Office or Other Facility non-emergency care	Emergency Care at a Hospital, Office or Other Facility	Air Ambulance
In-Network Provider	**N/A**	**N/A**	**N/A**	**N/A**
Out-of-Network Provider*	**Yes**	**N/A**	**Yes**	**Yes**

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* Includes providers in plans where there is no network or a network that only includes primary care physicians - where the NSA only applies to non-network primary care physicians.

One in five emergency healthcare claims and one in six in-network hospitalizations are said to include out of network charges. OON providers for emergency services are not allowed to balance bill patients beyond the applicable in-network cost sharing amount. This same requirement applies to out-of-network providers who render non-emergency services at an in-network hospital or other in-network facility. The law specifies that providers "shall not bill and shall not hold patients liable" for an amount that is more than the in-network cost sharing amount for such services. The NSA has an Independent Dispute Resolution (IDR) process is in place for any provider-payer disputes.

The NSA contains provisions to protect patients against the cost of surprise medical bills. The law requires private health plans to cover surprise medical bills for emergency services, including air ambulance services, as well as out of network provider bills for services rendered at in-network hospitals and facilities. The law also requires surprise bills must be covered without prior authorization and in-network cost sharing must apply. In-network cost sharing for surprise bills will be based on a "recognized amount," which in most cases will be the median in-network payment amount under the plan for the same or similar services.

With respect to private health plans, enforcement of the NSA generally follows the same rules that apply under the Affordable Care Act (ACA). States with surprise billing laws that regulate fully insured plans remain intact. The NSA fills the gap by enforcing protections for self-insured (ERISA plans) and fully insured plans with no state surprise bill law. The NSA applies to participants, beneficiaries and enrollees in group health plans and group and individual health insurance coverage offered by health insurance issuers and FEHB plans.

How Will it Work?

The NSA sets a process with an aggressive timeline that must be followed by providers and health plans:

1. Within 30 days after receipt of a bill from the provider, the health plan must send an initial payment or notice of denial of payment.

2. If the provider disagrees with the payment amount or the denial, the provider and health plan enter an "open negotiation" period to allow the parties to settle the payment dispute. The 30-business-day open negotiation period begins on the day on which the open negotiation notice is first sent by a party.

3. If the dispute is not settled within the 30-day "open negotiation" period, the parties have FOUR business days in which to initiate the IDR process (arbitration by another name). Within the FOUR business days after the close of the "open negotiation" period, the initiating party must notify the other party and the Secretary of Health and Human Services that it is requesting IDR.

4. The parties have THREE business days after initiation of the IDR process to jointly select an IDR entity (an arbitrator). If they cannot agree or do not make a joint selection, an IDR entity will be appointed no later than SIX business days after initiation of the IDR process. The plan and the provider have the first THREE business days to jointly select the IDR entity. If they cannot agree, then the Health and Human Services Secretary has the remaining THREE business days to appoint an IDR entity on their behalf.

5. TEN business days after selection/appointment of the IDR entity (arbitrator), the parties must submit their payment offer, information requested by the IDR Entity and any additional relevant information they want to use to support their offer.

6. 30 business days after selection/appointment of the IDR entity (arbitrator), the IDR entity (arbitrator) must select one of the two offers and notify the parties of his/her determination. The IDR entity must select one of the two offers and does not have any discretion to fashion his/her own award. The Act does not provide for a hearing at which evidence could be offered or arguments made.

7. The loser pays all IDR fees. If the parties settle during the IDR process, they split the IDR fees 50/50 (or however they agree to split the fees).

8. The decision of the IDR entity is binding absent fraud or misrepresentation.

What Information can an IDR Entity Consider in Determining which Offer to Select?

The IDR entity can consider the qualifying payment amounts for the applicable year for items or services comparable to the disputed item or service furnished in the same geographic region. Additionally, the IDR entity can consider the level of training, experience, quality and outcomes measurements of the provider, the acuity of the individual receiving the item or service, and the complexity of the item or service. The IDR entity can also consider the good faith efforts (or lack thereof) between the provider and/or the plan to enter into network agreements and the contracted rates between the provider and the plan during the previous four plan years.

Interim Final Rules require the IDR entity to "select the offer closest to the QPA unless the [entity] determines that credible information submitted by either party clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate," thus creating a rebuttable presumption which favors the QPA.

The IDR entity cannot consider the usual and customary charges, the chargemaster rate, or the payment or reimbursement rate made by public payors. Providers that improperly balance bill patients may be subject to state enforcement actions (which will vary by state) or, if the state takes no action, federal civil penalties up to $10,000 per incident.

Risk to RBP

Interim Final Rules require the arbitrator in the IDR process to presume that the "qualifying payment amount" is "the appropriate in-network rate." So, where network provider and network facility contracts incorporate reimbursement rates that exceed the RBP schedule for out-of-network providers, the plan is likely to be at risk in two ways:

- First, in-network point of purchase cost sharing (deductibles, copayments, etc.) will apply, and
- Second, the plan will pay providers based on the median contracted rate.

The NSA does not dictate the initial payment to the provider. This means that existing OON cost management strategies, including reference-based pricing, are still valid. Because of the required negotiation and potential arbitration, payors should consider how existing strategies compare to QPA amounts (where NSA applies) and evaluate whether refinements to their approach may be warranted. Ideally, payors will reimburse these claims at a level that manages cost while minimizing the need for post-payment negotiated or arbitrated adjustments.

RBP bases insurance payouts on a multiple of Medicare pricing. Medicare pricing collects data on prevailing costs for medical services from CMS's Healthcare Provider Cost Reporting Information System, benchmarking them against relevant types of hospitals and settings, calibrating by severity level and applying a margin factor. This establishes a common payment ceiling, achieving transparency through consistent use across health networks.

With RBP, the employer pays a set price for each health care service instead of negotiating prices with providers. When a provider bills for the service, the payer remits the set amount. If the provider is dissatisfied with the payment, they can bill the patient for the unpaid portion of the claim, known as balance billing.

Federal and state law permit most payers to use RBP for out-of-network claims, but any plan subject to network adequacy rules may not use this as a comprehensive payment strategy. Only employer-based plans regulated under ERISA may use RBP as a comprehensive payment strategy.

What are the Practical Effects of this Legislation?

The NSA may prompt a significant expansion in the prevalence of RBP plans since RBP often eliminates the negative effects of excessive charges otherwise shared by the employer and the participant, but some risk remains.

RBP plans that use narrow networks or have negotiated contracts with certain providers and plans that utilize RBP as the mechanism to price out-of-network claims will be affected by the NSA legislation. In both instances, there would exist a network rate pursuant to which the "qualifying payment amount" could be calculated.

The most effective way to address this legislation may be to adopt a "pure" RBP plan that puts the patient in the driver's seat as a health care consumer. Pure RBP plans that do not contract with providers should remain unaffected by NSA because there aren't any out-of-network claims; nor is there any determination of a median in-network rate.

There is a tremendous opportunity for pure RBP Plans to expand in the healthcare market now that the NSA has taken effect. Pure RBP Plans eliminate the negative effects for both the employer and the patient discussed below. We are mindful, however, that often regulatory agencies have infrequently adopted regulations that seemingly extend the reach of legislation or conflict with the legislation's express language. Litigation challenging some of the regulations would be "no surprise."

Note that as of December 2021, litigation is pending in front of the US Supreme Court which may reign in federal agencies' authority to interpret code provisions. Today, applying a process known as "Chevron Deference," an agency has considerable latitude in creating regulatory and sub-regulatory guidance. The pending litigation may impact the deference given to agencies. *(American Hospital Association v. Becerra)*

Plan costs are expected to increase because of NSA, in three ways:

- Increased administrative expenses,
- The potential for reduced cost sharing as expenses that were previously subject to out of network cost sharing will be paid in-network, and
- In-network providers who currently charge below-median rates are likely to increase their charges, while other providers will increase their demands for higher reimbursement rates – given the new treatment of non-network providers (likely resulting in an increase in the median contracted amount).

Participant costs are expected to increase because of NSA, in two ways:

- Because more expenses will be paid in-network, the plan sponsor may respond by increasing the in-network point of purchase cost sharing (deductibles, copayments, out of pocket expense maximum, etc.), and

- Participant contributions will likely increase as the cost of coverage increased, where the costs are shared between the employer and the participants.

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Removing the patient from the process, as intended by the NSA, only hides the fact that patients will indirectly absorb the increase in costs via higher premiums and patient responsibility.

How should TPAs and Employers Address the NSA?

The NSA includes provisions that promote transparency. Health plan members are entitled to advance information about how services will be covered before they are provided. Health plans must also provide an advanced explanation of benefits and maintain accurate provider network directories.

The most effective way to address this legislation may be the adoption of a pure RBP plan that puts the patient in the driver's seat. A provider is no match for a well-represented patient. A successful RBP Plan should have the following components:

- Carefully drafted plan documents that strengthen the rights of the patient to dispute bills
- Avoidance of network or contracted fees
- A defensible repricing mechanism
- A robust patient advocacy process that includes legal representation

With these components in place, we believe that the best results can be achieved for both the plan and the participants. Another effective alternative would deploy a limited network of providers – such as a network of primary care providers.

Your Medical Billing Partner

Given the limited protection provided by the NSA, members of self-funded health plans might best prepare by considering how best to incorporate new information on fees that are part of the new transparency requirements. Coupling that information with fair, consistent, and predictable price information and advanced explanations of benefits may enhance the opportunity presented by plans that incorporate reference-based pricing. Beyond simple compliance, strategic actions that fully realize the opportunity the NSA offers can manage costs while providing a better employee healthcare benefit experience to plan sponsors and their participants.

This is where the right partner can make a big difference.

aequum is a first-of-its-kind tech-driven company in the complex field of medical billing that protects health plans and its members through advocacy and data-driven solutions that identify, manage and reduce risk. As our name suggests, meaning "what is fair and just," we were formed in 2020 with a clear mission: *help our members achieve fairness by leveling the playing field of complex medical billing.*

aequum represents RBP plans in the defense of balance bills and recovering overpayments. Our goal is to show the financial advantage of RBP and confirm that through its use both the plan sponsor and its members paid less. Our experience to date with successful outcomes validates the benefits of RBP to control costs, reduce spending and gain potential savings. Acting on behalf of 325 self-insured health plans and their participants nationwide, we have successfully resolved 6,000+ claims – saving over $31 million (97.2%) of disputed charges.

It is important for employee benefits specialists, especially those who administer self-funded health plans, to understand the NSA's provisions and interim final rules. aequum can help navigate new federal and state laws and adds additional layers of protection through our software and data-driven solutions. As your medical billing partner, we are here to support your concerns and prepare your plan for success in 2022.

Learn more about aequum and its performance milestones at aequumhealth.com.

***This information is based solely on the language set forth in the Consolidated Appropriations Act. The legislation, including the deadlines and timelines contained therein, the types of claims and entities covered, is subject to modification upon drafting and implementation of regulations. aequum will continue to update its partners as the proposed and eventually final regulations are made publicly available.*

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About aequum, LLC

Founded in 2020, aequum LLC serves third-party administrators, medical cost management companies, stop-loss carriers, employer-sponsored health plans and brokers nationwide to protect plan participants, improve employee satisfaction with their health care plans, and generate plan and participant cost savings. aequum LLC helps patients defend medical balance bills and brings savings to employer-sponsored health plans by providing administrative and other services to its partners. In addition, its sister organization, Koehler Fitzgerald LLC, provides legal advocacy to plan participants. Visit aequumhealth.com.

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