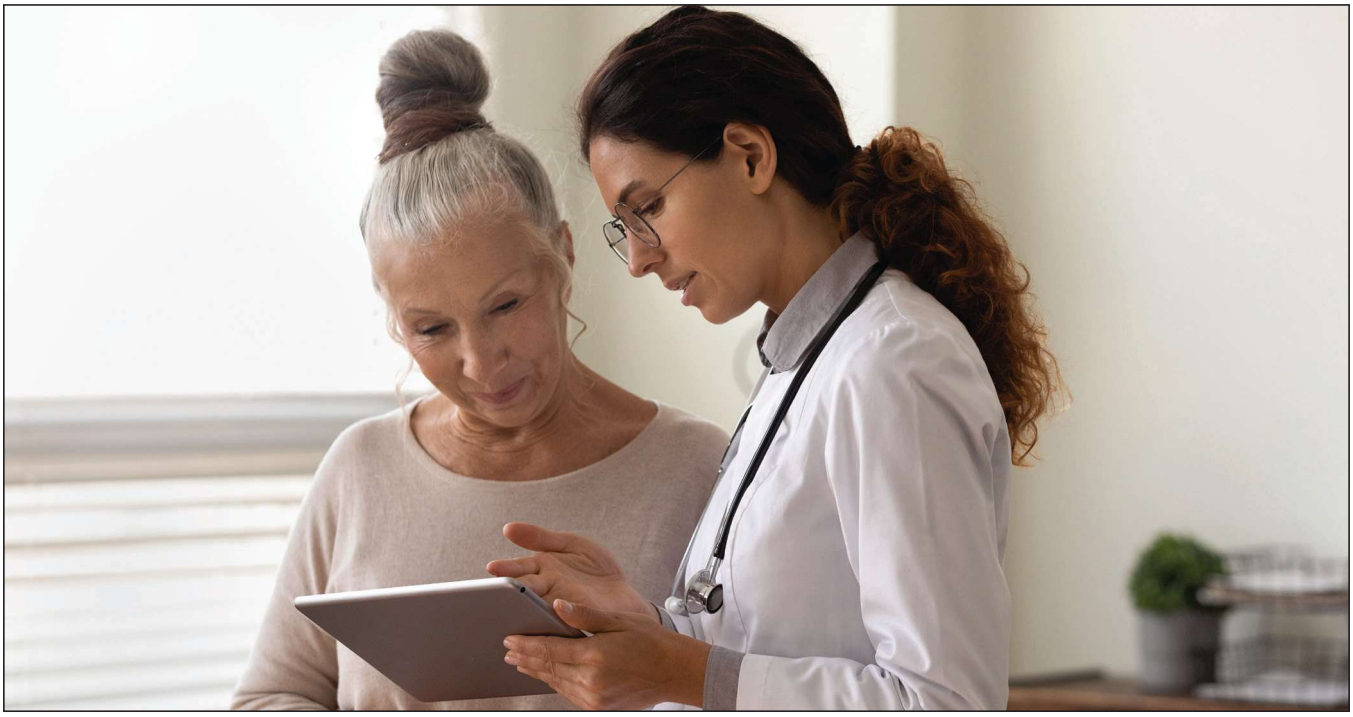
UNDERSTANDING HEALTH PLAN RIGHTS AND COMPLIANCE STRATEGIES IN RESPONSE TO THE NO SURPRISES ACT



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Employer-sponsored health plan administrators need to understand their rights under the No Surprises Act and how to leverage price-transparency mandates designed to reveal the true cost of provider health services before receiving care and submitting a claim. Benefits consultants and specialists are uniquely positioned to advance the knowledge base and provide a clear presentation of the opportunities and challenges.

Introduced as part of the Consolidated Appropriations Act, the NSA applies to participants in group and individual health plans by protecting them from balance-billing for certain emergency services and care received from out-of-network providers at in-network facilities.

Compliance with the NSA remains a top priority for employee health plans as plan sponsors and administrators need to respond to new federal healthcare regulations, administer/comply with the Independent Dispute Resolution (IDR) process and stay abreast of litigation challenges to the IDR process. For example, health plans are now subject to new disclosure requirements and, once regulations are issued, plans will be required to provide detailed information about expected out-of-pocket costs for scheduled services in the form of an Advanced Explanation of Benefits.

Beyond compliance, the NSA is an opportunity for employers to leverage NSA rights and provisions, such as the Transparency in Coverage final rule. Multiple strategies enable plan administrators to take advantage of price transparency, capitalize on cost-containment initiatives, and reveal the true cost of provider health services before participants receive care. This insight has potential to transform utilization of health services, putting the economic purchasing power and decision making in their hands.

A strategic response can also act to lower risk, reduce costs and achieve savings. This involves (re)positioning and encouraging participants to take a healthcare consumerism approach to cost savings—one that engages and empowers employees in their healthcare decisions and puts them in the driver's seat.

To address complex issues surrounding the NSA, plan sponsors may call upon their health insurance brokers and administrators to provide strategic guidance.

WHAT BENEFITS SPECIALISTS NEED TO KNOW ABOUT THE NSA

What is or is not an emergency bill under the NSA? The definition of emergency services was expanded by the NSA to include pre-stabilization services provided after the patient leaves the emergency department and is admitted to a hospital. For services in an emergency department of a hospital or an independent freestanding emergency department, a plan cannot limit services for emergency medical conditions solely on the basis of diagnosis codes—for example, ignoring symptoms presented by the patient.

Benefit specialists will want to ensure that coverage does not impose any administrative requirement or limitation on coverage for emergency services received from nonparticipating providers and emergency facilities that is more restrictive than those applied to network providers or emergency facilities. Benefit specialists will also want to review the status of urgent-care-center contracts. The NSA expands the protections to include emergency services provided at an independent freestanding emergency department or urgent care center permitted/licensed by state to provide emergency services.

When does post-stabilization care become emergency services under the NSA? Post-stabilization services are considered emergency services under the NSA unless the following are met:

- The attending emergency physician or treating provider determines that the patient can travel using nonmedical or nonemergency transportation to an available participating provider or facility located within a reasonable distance based on the patient's medical condition and that the transfer will not cause the patient any other unreasonable burdens. Unreasonable travel burdens include barriers such as the ability to pay for a taxi, access to a car, safely taking public transit, or the availability of public transit.

- The patient must be in a condition to receive notice from the provider of the transfer and provide consent as determined by the attending physician or treating provider.

Can in-network primary care physicians order tests from an out-of-network lab? The NSA protections apply to lab tests rendered in connection with emergency services at an in-network facility. This creates an additional hurdle for laboratories that generally are not privy to the specific context in which a test was ordered. Should a lab test be performed as part of an emergency service, regardless of whether the treating facility or provider is in-network, the laboratory is prohibited from balance-billing the patient more than the in-network amount.

What is or is not a healthcare facility for purposes of the NSA? The NSA broadly define facilities as inpatient hospitals, critical access hospitals, hospital outpatient departments and ambulatory surgery centers. Some state statutes also include skilled nursing facilities, infusion centers and dialysis centers, among other sites, or include services like diagnostic imaging or laboratory services. At least two state laws also extend surprise-billing protections to services delivered in physician offices or other outpatient settings. NSA also adds protections where state laws were not comprehensive, such as for facilities omitted from certain state laws (like critical access hospitals in Nevada) and excluded medical services (such as nonsurgical, nonemergency services provided in Virginia facilities).

THE DISPUTE-RESOLUTION PROCESS

In the first six months, the Independent Dispute Resolution (IDR) process got off to a rocky start as the number of disputed claims submitted was nearly five times the anticipated annual estimate—and only one in 30 of those claims was resolved. Further, litigation challenged certain aspects of the IDR process. On February 10, 2023, HHS announced a temporary halt to reimbursement decisions under the NSA, pending review of a court ruling that ruled the IDR regulations unfairly favored payers. HHS later clarified that determinations may be made for all claims with a date of service of October 25, 2022, and earlier.

DISTINGUISHING BETWEEN "SURPRISE" AND "UNEXPECTED" BILLS

Participants broadly define "surprise" when it comes to medical bills—beyond the "balance-bill" for charges by an out-of-network provider. Data compiled by the Health Care Cost Institute confirms that in 2017, about 16% of emergencies and included a "balance-bill." Otherwise, only a small percentage of balance-bills would be covered under the NSA. Yet, 16% of insured adults ages 18-64 say they have received a "surprise" bill related to care received from an out-of-network provider. And one-third of insured adults ages 18-64 say there has been a time in the past two years when they received an "unexpected" medical bill.

Clearly, "surprise" ≠ "unexpected." But benefit specialists can offer solutions that reduce both.

A STRATEGIC AND COMPLIANT RESPONSE

As with health reform, most plan sponsors amended their plans to comply with the NSA. A "compliance-only" approach adds to administrative burdens and increases the cost of coverage by treating certain out-of-network expenses as if incurred in-network. While most failed to strategically address the NSA, benefit specialists now have an opportunity to identify the impact of NSA compliance and prompt consideration of the most effective plan design that fulfills the requirements of the NSA and Transparency in Coverage final rules to create a competitive advantage.

Fully optimizing plan value requires a holistic approach to plan design, as well as initiating changes to ensure the most effective strategies are implemented to meet NSA requirements and support the health and wealth of participants.

REFERENCE-BASED PRICING

One of the best strategic responses to NSA compliance is the adoption of reference-based pricing, a benefits cost-management option that avoids unreasonable or excessive provider charges. RBP "done right" minimizes NSA compliance via a strategic response that will reduce healthcare costs for both the plan sponsor and participants, today and tomorrow.

RBP primarily uses Medicare pricing multiples as a benchmark to establish reasonable payments for services to providers, although plans may use other pricing benchmarks. Broadly, this creates a ceiling for payments and establishes a standard of integrity and transparency for service payments. Because the NSA has no bearing on initial payments to the provider, existing cost-containment strategies such as RBP are still valid under the new provisions. In addition, most RBP plans don't use traditional network providers, therefore will see little effect. In fact, the NSA will likely increase interest in RBP models because they often eliminate excessive charges shouldered by employers and employees.

However, plan administrators should be prepared to address restrictions of the legislation by adopting RBP plans that prioritize the patient. In response to the NSA's new protections, many providers will attempt to ameliorate the reduction in billed charges. And, because more expenses will be paid in-network, patients are most likely to feel the cost of a compliance-only response once it shows up as a future increase in employee contributions.

Cost increases can be offset by emphasizing a RBP model that negotiates billed charges on a per-item basis. Providing patients with a strong repricing mechanism will further empower the transparency and protection afforded to them

by the NSA. Adoption of a "pure" RBP plan, one that does not contract with providers (or only contracts with primary care physicians) should remain mostly unaffected by NSA since there is no median in-network rate on which to calculate a qualified payment amount (QPA)—a NSA-required reimbursement rate that in network plans is usually substantially higher than the RBP maximum covered charge. A "pure" RBP structure may avoid unreasonable or excessive provider charges, potentially lowering both the cost of coverage and employee point of purchase cost sharing.

PRICE TRANSPARENCY

Transparency in Coverage requires health plans to disclose negotiated rates for in- and out-of-network rate history and drug-pricing information. The goals are the same in terms of prompting healthcare consumerism: ensuring participants have access to the information necessary to incorporate financial criteria into their decisions regarding medical services. This puts price information in the hands of consumers and other plan stakeholders, and ensures participants are empowered with the critical information they need to make informed healthcare decisions.

The mandated provision of an online tool needed to access pricing information through their health plans requires real-time cost estimates for covered services and items, including pharmacy. Paper versions must be available upon request. Initially, for plan years beginning on or after January 1, 2023, the online tool must provide cost estimates for 500 shoppable services. In the future, for plan years beginning on or after January 1, 2024, the online tool must provide cost-share estimates for all covered services.

ADVANCED EOB

One part of the NSA transparency rule that would empower participants to be healthcare consumers is the Advanced EOB requirement. Because guidance has yet to be issued, the Advanced EOB is not required at this time. Done right, the Advanced EOB would likely be the most effective prompt of consumerism, as it would provide participants options for reducing their out-of-pocket expense, in turn lowering the cost to the plan.

Nothing stops plan administrators from introducing the Advanced EOB on a voluntary basis before regulations are issued.

Once regulations are issued, the NSA mandates that providers must give patients advanced notice of their network status and a good-faith estimate of costs for scheduled services. The Advanced EOB requirement is designed to give advance notice to participants of how a claim for future, scheduled medical services might be processed—and, most important, what the plan expects to pay and how much the participant will pay out of pocket for a particular test or procedure.

The NSA requires health plans and insurers to provide an Advanced EOB when requested in advance of treatment. The requirement applies whether these non-emergencies scheduled medical services are to be delivered in or out-of-network. The Advanced EOB must be issued within certain timeframes after the provider submits to the plan or insurer a good-faith estimate of charges for each service.

Because the Advanced EOB is the only document that would give a participant sufficient information to make an informed decision on pending treatment, a forward-looking, strategic response to NSA compliance would prompt plan sponsors and their claims administrators to add the Advanced EOB now, before regulatory guidance is issued, to gain an additional competitive advantage.

Visit aequum's dedicated NSA Website https://knowthenosurprisesact.com for current federal rules and regulations, resources that support health plan compliance, and valuable updates on current litigation, news and developments.

1 www.congress.gov/bill/117th-congress/house-bill/2617
2 www.cms.gov/newsroom/fact-sheets/no-surprises-understand-your-rights-against-surprise-medical-bills
3 www.cms.gov/newsroom/fact-sheets/transparency-coverage-final-rule-fact-sheet-cms-9915-f
4 www.bpslaw.com/how-medical-testing-laboratories-must-comply-with-the-federal-ban-on-surprise-billing/#:~:text=The%20%E2%80%9CNo%20Surprises%20Act%E2%80%9D%20(,her%20health%20plan's%20network%2C%20resulting
5 www.commonwealthfund.org/publications/fund-reports/2022/oct/no-surprises-act-federal-state-partnership-protect-consumers#:~:text=Abstract,enforce%20these%20new%20consumer%20protections.
6 https://healthcostinstitute.org/out-of-network-billing/how-common-is-out-of-network-billing

Christine Cooper is the CEO of aequum LLC and the co-managing member of Koehler Fitzgerald LLC, a law firm with a national practice. Founded in 2020, aequum serves third-party administrators, medical cost-management companies, stop-loss carriers, employer-sponsored health plans and brokers nationwide, defending medical balance-bills and delivering savings to employer-sponsored health plans. Christine is an avid runner and Ironman and is active in a variety of community affairs.