NORTHEAST
BUSINESS GROUP ON HEALTH

The Federal No Surprises Act: What Employers Need to Know Now

Tuesday, October 5, 2022
12:00 - 1:00 PM ET

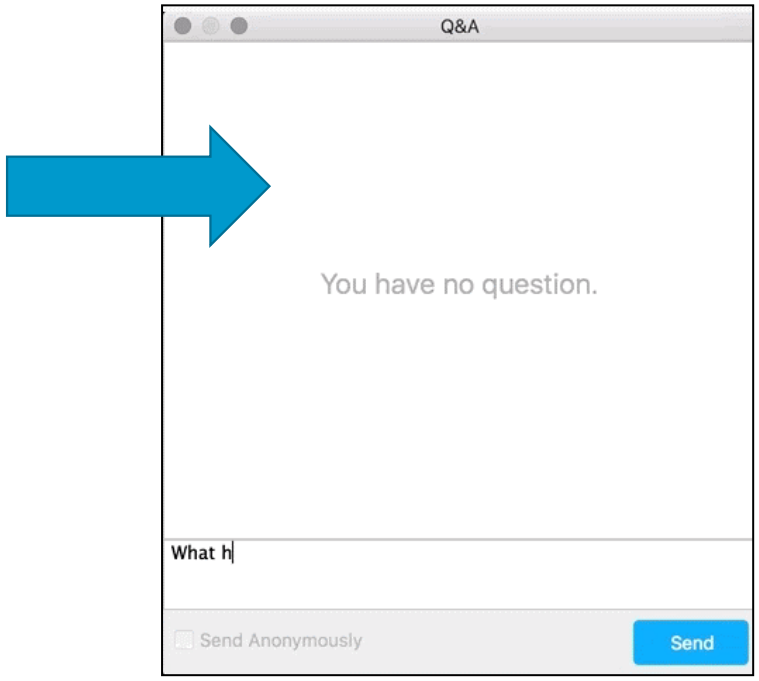
Webinar Procedures

All lines will be muted

Please submit all questions using the “Q&A” dialog box

Email Diane Engel at dengel@nebgh.org with any issues during this webinar

The recording and a PDF of the slides will be shared



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Federal no surprises act:
What to know and do

Damian A. Myers, Nixon Peabody LLP

October 5, 2021

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Federal no surprises act

AGENDA

- **No Surprises Act**
  - Surprise billing protections
  - Continuity of Care
  - Advance EOB
  - ID Card Cost Sharing Disclosures
  - Price Comparison Tool
  - Provider Directory Requirements
  - Other Transparency Improvements

Surprise billing

Impact on Health Plans

- **Consolidated Appropriations Act included the "No Surprises Act"**
  - Addresses issue of surprise billing from out-of-network (OON) providers
  - Examples – OON in the emergency situation and OON providers working within in-network (INN) facilities
- **Participants must receive INN cost-sharing level when:**
  - Emergency services received at an OON facility (including free-standing ERs)
    - A note about free-standing ERs and Air Ambulances
  - "Ancillary" services received at an INN facility by an OON provider (e.g., anesthesiologist, lab work)
  - Non-emergent care received at an INN facility by an OON provider without informed consent
- **INN cost-sharing will accumulate against INN deductibles and out-of-pocket**
- **INN cost-sharing when design has coinsurance based on "recognized amount" (based on state law, "qualifying payment amount, or with approval by state)**
- **Providers cannot balance bill participants above INN cost-sharing (i.e., no surprises)**

Surprise billing

Impact on Health Plans

- **Plan Requirements**
  - Plan must make initial payment to provider or initial denial notice to provider with 30 days
  - If dispute occurs, arbitration process is required (i.e., “Independent Dispute Resolutions” or “IDR”)
    - After initial payment or denial made, 30 days to negotiate
    - In the absence of agreement, parties then submit payment offer to arbitration
    - Arbitrator will select one of the offers
    - Arbitrator may consider several factors, but may not consider usual & customary rates, billed charges, or Medicare rates
    - Losing party pays cost of arbitration
  - Note – for fully insured plans, some states have laws that dictate different procedures that what is describe above

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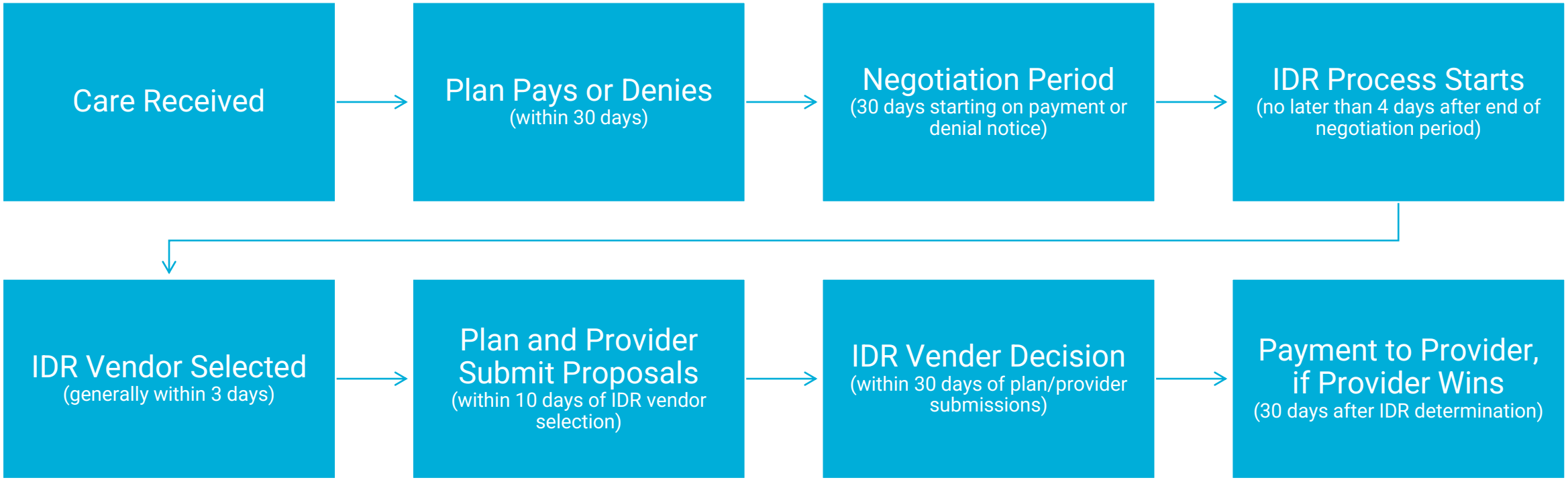
Surprise billing

IDR Process, in general



Surprise billing

Impact on Health Plans

- **Voluntary Use of OON Provider**
  - In the case of non-emergency service provided by an OON provider in an INN facility, the patient can consent to the use of an OON provider (and will be billed accordingly)
    - Patient must be notified within 72 hours before services obtained
    - Notification must have a cost-estimate
    - Notice must identify available in-network options
  - Patient cannot consent to OON provider in this case if:
    - There are no INN providers at the facility
    - Services are for unforeseen or urgent issues
    - The provider is of the type not typically selected by the patient (e.g., anesthesiologist)

Surprise billing

Impact on Health Plans

- **Next Steps:**
  - Effective January 1, 2022
  - Two sets of regulations issued – more to come
  - Contact TPAs to ensure steps are being taken to comply
  - Ensure TPA agreements are amended before January 1, 2022 to allocate responsibility and cost
  - Amend health and welfare plan documents/SPDs to describe surprise billing procedures (consider model DOL disclosure)
  - Participant communications regarding OON services

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Continuity of care

Protecting Patients During Network Development

- Normal network management by TPAs results in providers moving in and out of particular networks
- This can be disruptive to plan members who are undergoing a course of care when network changes occur
- Effective January 1, 2022, if a provider contract is terminated, impacted participants must receive notification that the provider will no longer be an INN provider and that the participant can elect continued patient care with that provider for a transitional period
- If the participant elects to continue such care, it must be at the same level of benefits as if the provider remained an INN provider
- The transition period of continued care starts on the date the plan gives notice of the provider's network status change and ends on the earlier of (1) the end of the 90-day period starting on that date and (2) the date on which the participant is no longer a "continuing care patient"

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Continuity of care

Protecting Patients During Network Development

- **A “continuing care patient” is any individual who:**
  - Is undergoing a course of treatment for a serious or complex condition from the provider or facility;
    - If an acute illness, it is serious or complex if it requires specialized medical treatment to avoid the possibility of death or permanent harm
    - If a chronic condition, it is serious or complex if it is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.
  - Is undergoing a course of institutional or inpatient care from the provider or facility;
  - Is scheduled to undergo nonelective surgery from the provider or facility with respect to such surgery;
  - Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
  - Is or was determined to be terminally ill and is receiving treatment for such illness from the provider or facility

Continuity of care

Protecting Patients During Network Development

- **Next Steps:**
  - Agency guidance indicates that no regulations will be issued before January 1, 2022 – good faith compliance is required
  - Ask TPAs whether current continuity of care provisions differ from No Surprises Act requirements
  - Request and review copies of continuity of care notices from TPA
  - Review SPDs and issue new SPDs or SMMs if necessary

Advanced eob

Improving Cost Transparency

- **Health plans will be required to provide EOBs in advance of services when requested by a participant or provider**
- **If provider makes request within 10 days of the service, advance EOB must be provided within 1 business day. If request make 10 or more days from the service, advanced EOB must be provided within 3 business days**
- **If participant requests advanced EOB, it must be provided within 3 business days**
- **Advanced EOBs must include detailed information regarding the cost of the services and cost-sharing requirements**

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Advanced eob

Improving Cost Transparency

- **Advances EOBs should contain the following information:**
  - Network status of the provider or facility (INN or OON)
    - If INN facility or provider, the contracted rate (based on billing and diagnostic codes)
    - If OON, information on how participant can get more information on network providers
  - Good faith estimated cost of the services
  - Good faith estimate of the amount the plan will cover
  - Good faith estimate of the amount of any cost-sharing the participant may be required to pay
  - Good faith estimate of the cost-sharing accumulation as of the date of the notice
  - Information regarding medical management requirements (e.g., prior authorization)
  - Disclaimer noting that the information is only an estimate
  - Any other relevant information

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Advanced eob

Improving Cost Transparency

- **Next Steps:**
  - Agency guidance provides for no enforcement until regulations are issued
  - Requires provider and TPA system integration to properly function – infrastructure improvements are needed
  - Once it becomes effective, health plan documents should be amended to describe the right to an advanced EOB
  - TPA agreements should be amended to allocate responsibility and cost

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Cost sharing disclosures on id

Improving Cost Transparency

- **Starting January 1, 2022, any hard copy or electronic participant identification card must contain the following:**
  - INN and OON deductible
  - Out-of-pocket maximum amounts (both INN and OON)
  - Contact information where assistance can be received
- **Many ID cards do not currently have this information, although it is often available online**
- **Many TPAs have websites that will also show accumulation toward deductibles and out-of-pocket maximums (this service will be required after January 1, 2023)**
  - Cost-sharing and provider rates for 500 services required to be posted by January 1, 2023 (all services by January 1, 2024)

Cost sharing disclosures on id

Improving Cost Transparency

- **Next Steps:**
  - Recent agency guidance indicates that regulations will not be issued before January 1, 2022 – good faith compliance required
  - ID card showing major medical deductible and OOP maximum on card, with website or phone number where other cost sharing information can be obtained will be deemed compliant until regulations are issued
  - Regulations will address how complex plan designs should be handled
  - Plans should contact TPAs to ensure that new IDs will issued (if necessary to comply) by the end of the year

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Price Comparison Tool

Improving Cost Transparency

- **Health plans must make available by phone or on a website a tool through which participants can compare out-of-pocket costs for a specific item or service**
- **Comparisons based on plan year, location, and participating providers**
- **Next Steps**
  - Originally set to be effective January 1, 2022. However, conflicts between prior regulations and No Surprises Act require further agency consideration.
  - No enforcement prior to January 1, 2023
  - Many TPAs already have price comparison tools available on their websites. Plans should check with the TPAs to find out if current tools will comply or if changes are necessary. Plans should also ask if TPAs have the capability to handle this requirement over the phone.

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Provider directory accuracy

Ensuring Accurate INN Provider Identification

- **Effective January 1, 2022, plans must take steps to ensure that provider directories are available online and that they are accurate.**
- **In accurate information on a provider directory will mean that participants relying on that information will only be required to pay cost-sharing and INN levels.**
- **Plans must establish a verification process:**
  - At least once every 90 days, plan verifies that the provider directory is accurate; corrections made within 2 days
- **Plans must establish a response protocol:**
  - If participant requests network status of a provider or facility, must be provided within 1 business day after the request received (and such communication must be kept in the participant's file for 2 years)
- **Plans must establish provider database:**
  - Most insurance carriers and TPAs already have this, but network provider directories must be available on a public website

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Provider directory accuracy

Ensuring Accurate INN Provider Identification

- **Next Steps:**
  - Recent guidance indicates that regulations will not be issued by January 1, 2022. Good faith compliance is required.
  - Agencies state that a plan will not be deemed to be non-compliant if procedures are in place to ensure that covered individuals are only charged INN cost-sharing amounts will inaccurate provider director information was relied on
  - Plans should amend TPA agreements to allocate responsibility to TPAs and to contain appropriate protection from penalties

Broker/Consultant compensation

New Fee Disclosure Rules for H&W Plans

- **Consolidated Appropriations Act includes new fee disclosure requirements for health plan brokers and consultants – effective December 27, 2021**
- **Similar to rules that have been applicable to retirement plans under ERISA Section 408(b)(2)**
- **Applies to medical plans, as well as "excepted benefits" like dental, vision, FSAs, HRAs, etc.**
- **Brokerage services (if fees expected to be $1,000 or more):**
  - Selection of insurance products (including vision and dental), recordkeeping services, medical management vendors, benefits administration, stop-loss insurance, pharmacy benefit management services, wellness services, transparency tools and vendors, group purchasing organization preferred vendor panels, disease management vendors and products, compliance services, employee assistance programs, TPA services.
- **Consulting services (if fees expected to be $1,000 or more):**
  - Similar to above, but also services related to development or implementation of plan design.

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Broker/Consultant compensation

New Fee Disclosure Rules for H&W Plans

- **Direct compensation must be paid from plan assets to be subject to disclosure**
  - Employer contributions are not plan assets unless deposited into a trust
  - Participant contributions are always plan assets
  - Contract/plan language should state that broker/consultant fees always paid by employer contributions
- **Indirect compensation must also be disclosed**
  - Generally amounts received from source other than employer or plan assets
- **What must be disclosed?**
  - Service description
  - Fiduciary status
  - Compensation expected (direct and indirect), compensation type/arrangement, and termination fees
- **Failure to get disclosure could require corrective action and cause prohibited transaction**

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Broker/Consultant compensation

New Fee Disclosure Rules for H&W Plans

- **Next steps:**
  - Regulations should be issued in coming months
  - Review all contracts with consultants and brokers
  - Analyze method of payment (are fees paid by plan assets?)
  - Request disclosures for all direct and indirect compensation for brokers and consultants getting more than $1,000
  - Amend broker and consultant agreements as necessary
  - Consider plan language regarding payment of fees
  - Monitor fees and periodically conduct benchmark analysis to ensure fees are reasonable

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Prescription drug benefit reporting

Addressing Prescription Drug Costs

- **Health plans will be required to submit reports the Departments of Treasury, Labor, and Health and Human Services containing information related to pharmacy benefits and drug costs**
- **Consolidated Appropriations Act lists 10 requirements for the reports:**
  - Plan year dates, number of enrollees, and each state where covered participants reside
  - Top 50 dispensed brand name drugs and total number of paid claims for such drugs
  - Top 50 most costly prescription drugs by annual spending and the amount spent for each of the drugs
  - Top 50 prescription drugs with greatest YOY cost increase and what those increases were to the drugs
  - Total spending on health care services by the plan, broken down by hospital costs, health care provider and clinical service costs for primary care and specialty care, prescription drug spend (plan and employees), and other medical costs
  - Average monthly premium paid by plan and enrollees
  - Any impact on premiums by rebates, fees, and other payments made by drug manufacturers to the plan, PBMs or TPAs, including amounts paid for each therapeutic class, and amounts paid for the 25 drugs yielding the highest rebates
  - Any reduction in premiums or out-of-pocket costs associated with rebates

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Prescription drug benefit reporting

Addressing Prescription Drug Costs

- **Next Steps:**
  - First reports originally due December 27, 2021 and then each June 1 thereafter
  - Recent agency guidance delays effective date to June 1, 2023 so that the agencies can consider conflicts between prior agency guidance and the No Surprises Act
  - Once regulations are issued (most likely in late 2022), plans will need to work with PBMs to ensure reporting is completed
  - Plans should amend PBM agreements to add this reporting as a service and allocate responsibility for penalties if PBM fails to comply
  - Plan sponsors should review plan documents and SPDs to check language related to use of rebates and other payments from drug manufacturers and other service providers

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