Thompson Coburn's
Annual Labor, Employment and
Employee Benefits Law Seminar

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TCHR CHANGING TIDES

Rogue Waves

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Background to No Surprises Act

- Research suggests that 1 in 6 emergency room visits resulted in a surprise bill
- 37% of in-network hospital admissions
- Example of a surprise bill
  - Individual visits emergency room of an in-network facility
  - Out-of-network physician involved in care
  - Plan pays the agreed rates (in/out-of-network)
  - Out-of-network physician “balance bills” the participant for additional fees
- PE/Specialties
  - Emergency
  - Anesthesiology
  - Radiology

Overview

- Patient protections banning balance billing
  - In-network facility, out-of-network provider
  - Out-of-network emergency services
  - Air ambulance services
  - Others
- Dispute resolution
  - How much does the plan pay the provider for services?
  - Independent arbitration if parties can't agree
- Data and plan requirements
  - Educational notices (website/EOB)
  - Provider directory requirements
  - Advance EOBs
  - Air ambulance claims information

What's Not Covered

- Ground ambulance providers
- Services at certain facilities that are not "health care facilities"
  - Hospitals, hospital outpatient departments, critical access hospitals and ambulatory surgery centers
  - Visiting an out-of-network physician office would not be covered by the Act
- Excepted benefits
- Retiree-only plans

Enforcement

- NSA amended:
  - PHSA (HHS)
  - ERISA (DOL)
  - Internal Revenue Code (IRS)
- Each agency has its own enforcement mechanisms
  - HHS (or State) enforcement, civil monetary penalties of $162 pp / pd
  - DOL (or individuals) may sue to enjoin
  - IRS may impose excise tax of $100 pp / pd

Patient Opt-In

- Procedures scheduled 72 hours in advance
- Notification from provider of out-of-network status
- Cost estimates (also from plan)
- List of in-network providers
- Consumer signature, acknowledgement and acceptance

Regulations Status

- Part I – July 1, 2021
- Part II – September 30, 2021
- Future guidance
  - Data reporting on air ambulance
  - Advance EOBs

Highlights of Part I (Emergency Services)

- No prior authorization
- No participating provider limits
- In-network cost sharing; in-network deductible and OOP
- No limits on conditions
- No balance billing

Highlights of Part I (Participating Facilities)

- Applies to non-emergency services by non-participating providers at in-network facilities
- In-network cost sharing; in-network deductible and OOP
- No balance billing

Highlights of Part I (cont'd)

- If a plan covers air ambulance services, OON providers are treated similarly to the rules for OON providers at network facilities
- Disclosures to providers regarding initial payments and IDR process
- Model disclosure to participants
- Disclosure requirements for providers (uninsured / self-pay)

Highlights of Part II

- Dispute resolution
  - Applies to services for which balance billing is now banned
  - Timelines and procedural requirements
- External review requirements for participant claims
  - Compliance with the Act eligible for review
  - Applies to grandfathered plans
- Reporting requirements for arbitration entities

Highlights of Part II (Dispute Resolution)

- Either entity may initiate 30-business-day negotiation period
  - Notice sent within 30 days of payment/denial
  - Mandatory negotiation period
- Initiate IDR
  - Within 4 business days of conclusion
  - Mutual selection or government selection of arbitrator
- Submission of payment offers and related information
- Arbitrator selects an offer

Highlights of Part II (Dispute Resolution)

- Selection of offer
- Must consider:
  - plan's median in-network rate (qualifying payment amount)
  - circumstances like the provider's level of training or experience
  - any information the parties provide or the arbitrator requests.
- Cannot consider:
  - provider's "usual and customary rates" (billed charges)
  - reimbursement rates paid by public payers (CMS)
- Presumption in favor of offer closest to QPA

Highlights of Part II (Dispute Resolution)

- Various fees and costs
- Single claim versus batched claim
- Prevailing party refunded (most) costs
- Shared costs if settlement reached
- Costs are a range
  - adjusted for inflation
  - $250-700 all in (2022)

Challenge to Part II

- Various providers and provider organizations
- At least 6 suits in various jurisdictions
- Targeting
  - IFR process
  - Dispute resolution rules – “thumb on the scale”
- At least one constitutional challenge to NSA

Status of Part II Challenge

- Partial success
  - Procedural – IFR itself
  - Weighting toward QPA not based on statute
- Court in the Eastern District of Texas
- Other cases have temporarily stayed proceedings
- Court ordered administration to re-enter rulemaking process

Next Steps for Agencies

- Administration expected to revise rules and appeal
- Goal is a new final rule by May
- Concern that widely varying arbitration rulings could result
- Will costs continue to rise?

Impact on Dispute Resolution

- Dispute resolution rules in the NSA remain in effect
- Only impacted the rulemaking providing the guidance on the process
- Parties are still required by law to follow the statutory arbitration process
- Plans will need to continue to implement, with more uncertainty

Guidance on Data and Plan Requirements

- Proposed rule issued in September 2021
- Air ambulance providers must submit data:
  - transportation and medical costs
  - ambulance bases and aircraft
  - the number and nature of air ambulance transports
  - payor data
  - claims denials
- Plans and issuers to report information about claims data for air ambulance services

ID Card Issues

- Plan sponsors must include:
  - INN and OON deductible and OOP max
  - Telephone number and internet address for assistance
- May use a Quick Response (QR) code on the card or through a hyperlink on a digital ID card
- Good faith standard pending additional guidance

State Issues

- Similar state laws
  - Surprise billing protections implemented by several states
  - Applicable to insured plans
  - Remain in force to the extent protection is greater than federal rules
- All-payer claims databases
  - 23 states
  - Collect information on costs and health care system in a geographic area
  - ERISA preemption
  - Impacted by NSA

APCDs

- Federal grants to states to establish or improve
- DOL to provide guidance on standard reporting format
- Statute refers to “voluntary” reporting
- Self-insured remain exempt
- Relevance to surprise billing
  - Inform state rules
  - Part of consideration for QPA

What to Watch

- Interim-final/proposed rules may be finalized
- New proposed rules will be issued
  - Legal challenges
  - Additional areas
    - Pharmacy benefit and prescription drug reporting
    - Advance EOB
- New sub-regulatory guidance may be issued