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INTERIM JOINT COMMITTEE ON BANKING AND INSURANCE

SEPTEMBER 20, 2022

WHAT IS THE NO SURPRISE ACT?

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The No Surprise Act prohibits out-of-network providers from balance billing commercial insurance members.

WHAT IS THE NO SURPRISE ACT?

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Balance billing, sometimes called surprise billing, is a medical bill from a healthcare provider billing a patient for the difference between the total cost of services being charged and the amount the insurance pays.

WHAT IS THE NO SURPRISE ACT?

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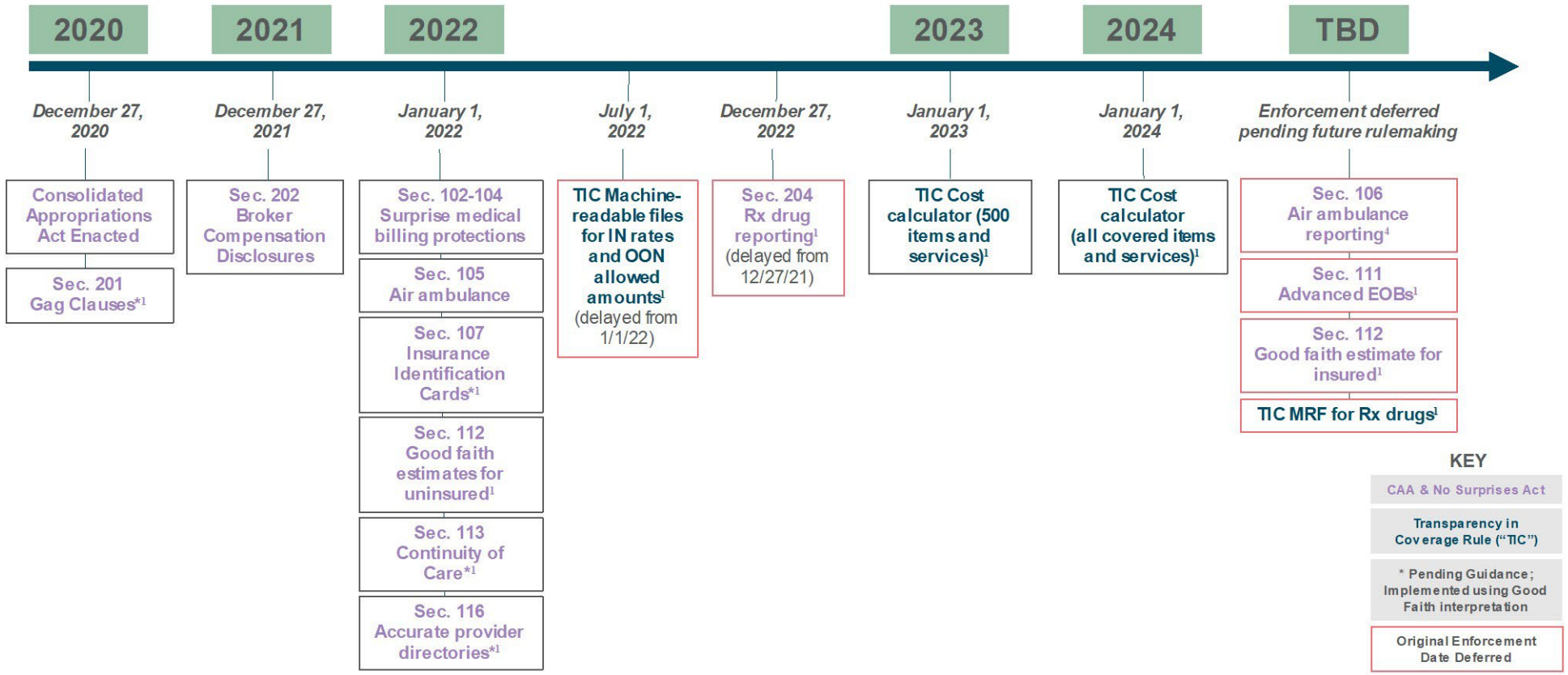
Key Dates: No Surprises Act & Transparency in Coverage Rule



BASIC PROTECTIONS OF THE NO SURPRISES ACT

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***No Surprises Act* protections** – including transparency requirements and protection from balance billing – apply to plan years beginning January 1, 2022.

- **Emergency Services:** Prohibits surprise bills for most emergency services even if prior authorization could not be met or emergency resources were out of network.
- **Cost Sharing:** Prohibits out-of-network cost-sharing (out-of-network coinsurance or copayments) for most emergency and some non-emergency services.
- Consumers cannot be charged more than in-network cost-sharing amounts for these services.

BASICPROTECTIONS OF THE NO SURPRISE ACT

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Out of Network Costs for Authorized Facility: Bans out-of-network charges and balance bills for certain additional services (like lab work) furnished by out-of-network providers as part of a patient's visit to an in-network hospital or other facility.

Patient Education: Requires that health care providers and facilities furnish patients with a "plain-language" notice explaining the applicable billing protections, who to contact if they have concerns that a provider or facility has violated the protections, and that patient consent is required to waive billing protections (i.e., you must receive notice of and consent to being balance billed by an out-of-network provider).

WHO IS COVERED?

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Individuals or entities covered by the NSA include:

- Group health plans (fully insured/self-insured)
- Group and individual health insurance issuers
- Carriers under the Federal Employees Health Benefits program
- Health care providers and facilities
- Air ambulance service providers

NSA does not apply to individuals insured by:

- Medicare/Medicaid
- Indian Health Services
- TRICARE

WHAT SERVICES ARE SUBJECT TO PROHIBITION

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Non-emergency services if:

- Provided by out-of-network providers
- At certa in in-network facilities
  - Hospitals, including outpatient departments &critical access hospitals (CAHs), & Ambulatory Surgical Centers (ASCs)

Emergency services and related post-stabilization services if:

- The emergency services (with respect to an emergency medical condition) are out-of-network, and
- Provided at a hospital or freestanding emergency department
  - Emergency medical conditions (including mental health or substance use disorder) manifesting itself by acute systems of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result (i) in serious jeopardy to the individuals (or unborn child's) health, (ii) serious impairment to bodily function, or (iii) serious dysfunction of a bodily organ or part.
  - Services covered include those necessary to evaluate and stabilize the patient, including any medical screening.
  - Post-stabilization services are observation, inpatient, or outpatient care provided as part of the emergency care visit after the patient is stabilized.
- Air ambulance services from out-of-network

WHAT IS THE QPA?

The Qualifying Payment Amount (QPA) ***is a measure of locally negotiated market rates, defined as the median of all contracts with participating providers in that geographic region for the same or similar item or service.***

A consumer's cost-sharing is determined based on what the terms of in-network cost-sharing are for the plan in which they are enrolled.

Under the law and regulations, the determination of in-network cost-sharing will be based on either the recognized amount as set by state law or, for plans governed solely by the *No Surprises Act*, the Qualifying Payment Amount (QPA).

RESOLVING PAYMENT DISPUTES

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INDEPENDENT DISPUTE RESOLUTION

A health insurance provider or health plan that receives a claim from an out-of-network provider will attempt to issue a payment or denial of payment to the out-of-network provider. This initial payment may end the dispute entirely. Alternatively, a provider or facility that believes they are entitled to a higher payment amount may elect to begin an open negotiation process created by the *No Surprises Act*.

If, after 30 days of open negotiation between the plan and provider or facility, no mutually agreeable reimbursement amount is determined, a party may elect to pursue IDR.

The *No Surprises Act* requires binding, final-offer IDR (arbitration) in which both parties submit final offers as to the reimbursement amount and a Certified IDR Entity licensed by the U.S. Department of Health and Human Services (HHS) makes a determination. Certified IDR Entities are required to consider the following factors in making a determination:

RESOLVING PAYMENT DISPUTES

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- The QPA, which is generally the insurer's median in-network rate for similar services in that geographic region as of 2019, inflated forward by the Consumer Price Index for All Urban Consumers (CPI-U);
- Demonstrations of good faith efforts (or lack thereof) to reach a network agreement and any contracted rates between the two parties during the previous four years; and
- Market shares of both parties, patient acuity, and the level of training, experience, and quality of the clinician, or the teaching status, case mix, and scope of services offered by the facility.

SURPRISE BILLING

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Services in Scope
- OON Emergency Services
- Non-par providers @ INN facility*
- OON Air Ambulance Services

Consumer Protections
- Ban on Balance Billing
- INN Cost Sharing
- INN Accumulators
- No Prior Auth of Emergency services

Notice & Consent
- Advance notice required
- Ancillary providers excluded
- Cost estimate included
- HHS required form
- Option for INN care

Payment Determinations
- Baseball style IDR
- Associated Fees
- Final Rule released 8/19

*The following in -network facility types are in scope: a hospital, a hospital outpatient department, a critical access hospital, an ambulatory surgery center.

INDEPENDENT DISPUTE RESOLUTION (IDR) Process

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Payment Determinations

FIRST, the QPA

THEN, additional credible information

30 business days to decide

IDRE Written Decisions

Required for all payment determinations

Payments Between Parties

Required within 30 calendar days

CAA TRANSPARENCY PROVISIONS

PROVIDER DIRECTORIES & INSURANCE ID CARDS

Provider Directories – good faith compliance pending further rulemaking

- Updated online directories, or printed upon request: verify info every 90 days and removal of nonresponsive providers; 2 businessdays for updated provider information
- Provider info to be included in directory: name/address/specialty/phone number/digital contact info (i.e., email address and/or URL)
- Must ensure members who receive inaccurate information that a provider is in-network and can only be liable for in-network cost-sharing

CONSOLIDATED APPROPRIATIONS ACT TRANSPARENCY PROVISIONS

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PROVIDER DIRECTORIES & INSURANCE ID CARDS

Insurance ID Cards– good faith compliance required pending further rulemaking

- Must include in and out -of-network deductibles and out-of-pocket maximum limitations
- Contact information for the consumer to call with questions must be included

CONSOLIDATED APPROPRIATIONS ACT TRANSPARENCY PROVISIONS

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Advance Explanation of Benefits (AEOBs)– Delayed pending future rulemaking

The plan or issuer must provide the following information (electronically or by mail, as requested by enrollee or participant) for scheduled services upon receipt of a provider's Good Faith Estimate (GFE) :

- The network status of the provider or facility;
- The contracted rate for the item or service, or if the provider or facility is not a participating provider or facility, a description of how the individual can obtain information on providers and facilities that are participating;
- The Good Faith Estimate (GFE) received from the provider;
- A GFE of the amount the plan or coverage is responsible for paying, and the amount of any cost - sharing and progress towards deductibles and out - of- pocket maximums; and
- Disclaimers

Timing to produce an AEOB: not later than one business day after the date on which the plan or coverage receives such notification (or such request)

CAA TRANSPARENCY PROVISIONS

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SEC. 204 PART 1 PRESCRIPTION DRUG SPEND REPORTING

Group health plans and issuers are required to submit prescription drug data, which *can* be aggregated for each state and market statement

- First reports for years 2020 and 2021 are due on December 27, 2022. Thereafter, reports will be due on June 1 for the preceding year and include:
  - The 50 brand prescription drugs most frequently dispensed by pharmacies
  - The 50 most costly prescription drugs
  - The 50 prescription drugs with the greatest increase in expenditures from the past year
  - Prescription drug rebates, fees, and any other remuneration for each therapeutic class of drugs and for each of the 25 drugs that yielded the highest amount of rebates
  - The total reduction in premiums and out-of-pocket costs associated with such rebates, fees, and remuneration

CAA TRANSPARENCY PROVISIONS

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SEC. 204 PART 2 HEALTHCARE SPEND REPORTING

Group health plans and issuers are required to submit GENERAL plan & coverage info including:

- Beginning & End dates of the plan year; and
- The number of participants, beneficiaries, or enrollees, as applicable; and each state the plan or coverage is offered.

Additionally, plans and issuers are required to submit TOTAL SPENDING by plan or coverage broken down by:

- Type of costs, including hospital costs and provider and clinical service costs; for primary care and specialty care separately; and
- The average monthly premiums paid by participants, beneficiaries, and enrollees and paid by employers on behalf of participants, beneficiaries, and enrollees, as applicable.

CAA TRANSPARENCY PROVISIONS

SEC. 204 PART 1 PRESCRIPTION DRUG & OTHER HEALTH BENEFIT SPEND REPORTING

The Departments issued updated guidance and subsequent reporting instructions that:

- Delayed enforcement to December 27, 2022
- Data aggregation by state and market
- Less granular prescription drug reporting
- Removal of pharmacy and medical data from files to prevent reporting duplication
- Nonenforcement provisions for reporting data elements that plans/issuers do not have

HOSPITAL TRANSPARENCY FINAL RULE

EFFECTIVE JANUARY 1, 2021: HOSPITAL REQUIREMENTS FOR DISPLAYING STANDARD CHARGES

Comprehensive machine-readable file

Includes all hospital "standard charges" (gross charges, payer-specific negotiated charges, cash prices, and the de-identified minimum and maximum negotiated charges) for all items and services in a single data file that can be read by other computer systems.

DISPLAY OF SHOPPABLE SERVICES IN A CONSUMER-FRIENDLY MANNER; UPDATED ANNUALLY

- Includes payer-specific negotiated charges, cash prices, and de-identified minimum and maximum negotiated charges for at least 300 "shoppable services."
- Defines "shoppable services" as services that can be scheduled by a health care consumer in advance.
- CMS will specify 70 services and the hospital will select 230 services.

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HEALTH PLAN CHECKLIST

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Health Plan Surprise Billing and Price Transparency Implementation Checklist

IMPLEMENTATION: DECEMBER 27, 2020

Prohibition on Gag Clauses on Price and Quality Data (Public Health Service Act § 2799A-9)

- Ensure that plan-provider contracts do not contain gag clauses on price and quality data and that, if they do prohibit disclosures, they include "reasonable restrictions."

IMPLEMENTATION: JANUARY 1, 2022

Balance Billing Protections

- Identify surprise billing situations and (assuming the provider has not obtained member notice and consent to balance bill) ensure that claims are processed so that providers may not charge members greater than the in-network cost-sharing amount.

Independent Dispute Resolution (IDR)

- Ensure the plan is prepared to engage in the IDR process for payers and nonparticipating providers to settle any payment disputes.

Health Plan ID Card Transparency Requirements

- Ensure that the amount of in-network and out-of-network deductibles and out-of-pocket limitations are listed on members' plan ID cards.

Continuity of Care

- Ensure the plan is prepared to meet the obligation to provide patients with certain active and complex care needs (i.e., a "continuing care patient") up to a 90-day period of continued coverage at in-network cost-sharing to allow for a transition of care when the patient's provider leaves the network.

Provider Directories

- Maintain current network provider directories (online, or within one business day of an inquiry). Enrollees who are provided with incorrect network status information about a provider prior to a visit will be responsible for only the in-network cost-sharing amount.
- Validate the accuracy of provider directory information every 90 days.

HEALTH PLAN CHECKLIST (cont.)

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IMPLEMENTATION: JANUARY 1, 2022 (Cont.)

- [x] **External Review With Respect to Surprise Medical Bills**
  - Allow members to use the plan's external review processes to determine whether surprise billing protections are applicable upon an adverse determination by the plan.

IMPLEMENTATION: JULY 1, 2022

- [x] **Transparency in Coverage (TiC)**
- [x] **Protections Against Provider Discrimination**

IMPLEMENTATION: DECEMBER 27, 2022

- [x] **Pharmacy Benefit and Drug Cost Reporting**

IMPLEMENTATION: JANUARY 1, 2023

- [x] **Price Comparison Tool**

IMPLEMENTATION: DELAYED PENDING RULEMAKING

- [x] **Advanced Explanation of Benefits (AEOB)**
  - Good Faith Estimate – Providers (for insured patients)
  - AEOB – Payers
  - Provide an AEOB containing information regarding providers, their network status and estimated costs at least three days ahead of a scheduled service when a provider transmits a good faith estimate. Implementation of these rules is delayed until rules are published.

AIR AMBULANCE USE AND SURPRISE BILLING

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- Air ambulances are typically used to transport patients from the scene of an injury or an accident to hospitals, or between hospitals, particularly in critical situations when the time to treatment is urgent or when patients cannot safely travel by ground ambulance transportation.

- While the number of air ambulance transports is low - roughly 1 per 1,000 privately insured people per year and 1 in 350 Medicare beneficiaries, available evidence suggests there has been an increase in bases (where aircraft are stationed, typically airports or helipads) and providers/suppliers' (particularly independently owned and operated companies) in recent years and a shift towards for-profit entities.

Footnote / Source text goes here

AIR AMBULANCE USE AND SURPRISE BILLING

- Patients typically do not have a choice in air ambulance providers, potentially leading to large out-of-pocket costs for privately insured or uninsured patients.
- Air ambulance providers are not allowed to send balance bills (when an out-of-network provider bills an individual for the difference between the billed charge and the amount paid by their plan or insurance) to Medicaid or Medicare patients.
- NSA extends the same protections to privately insured individuals, effective January 1, 2022.

Footnote / Source text goes here

LITIGATION

BASIS AND MAJOR CLAIMS OF PENDING LITIGATION

- At least 8 cases in 5 different jurisdictions challenging the rebuttable presumption of QPA. Many also challenge the process used by the agency under the Administrative Procedure Act.
  - PHI Health, Association of Air Medical Services, AMA, AHA, etc. all challenging on various grounds.

These plans already prohibit balance billing.

Footnote / Source text goes here

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THANK YOU!

We invite your questions, and comments.