A Segal Health Compliance Webinar

No Surprises Act Interim Final Rule

Important New Information Plan Sponsors Need to Know

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Segal

Today's Presenters

Kathryn Bakich
SVP and Practice Leader
National Compliance, Health

Ed Kaplan
SVP and National
Practice Leader, Health

Jamaca Mitchell
Consultant, National
Compliance, Health

Agenda

Overview of No Surprises Act

What's in the Interim Final Rule?

How will payment for emergency services change?

What should plan sponsors do next?

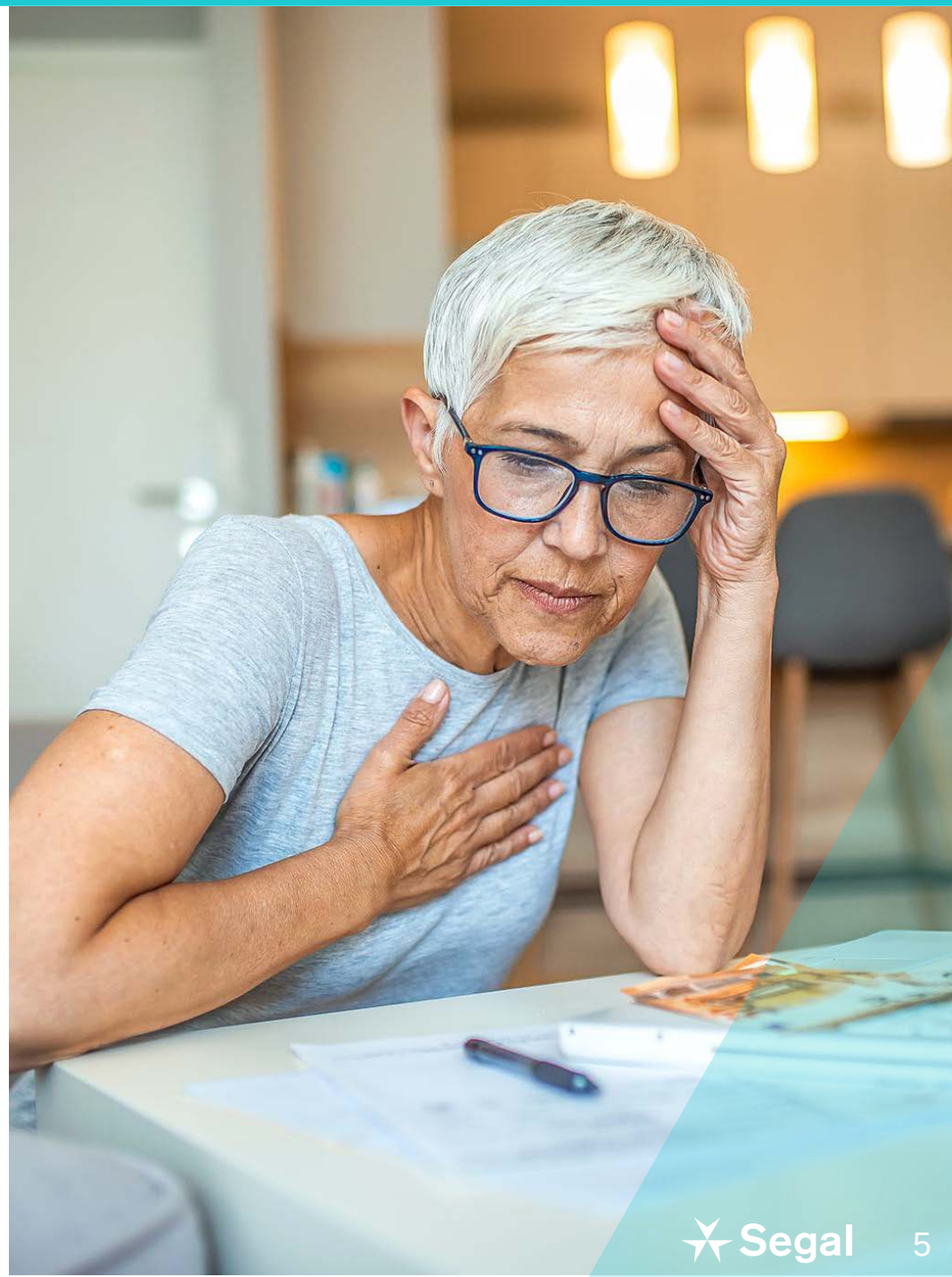
Overview of No Surprises Act

No Surprises Act

Enacted December 27, 2020 as part of the Consolidated Appropriations Act, 2021, Public Law 116-260

Applies to most group health plans and insurers, including grandfathered plans

Retiree-only plans, excepted benefits, Health Reimbursement Arrangements (HRAs) exempt



What Drove this New Law?

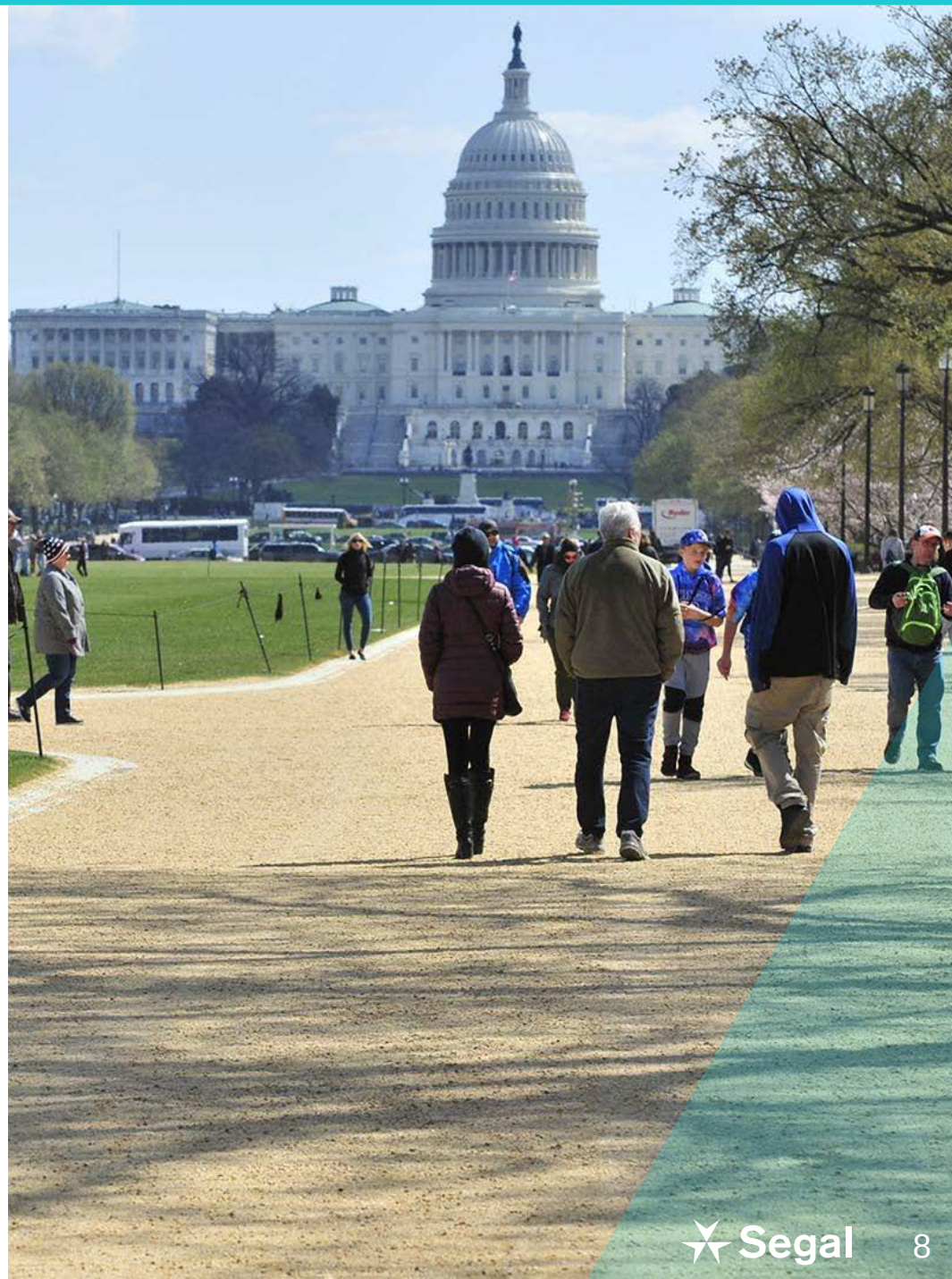
- Patients were plagued by this long-recognized problem
- Patients and plan participants are exposed to huge financial burdens
- There was no legal standard to limit charges for non-contracted providers
- A few bad apples- notably where limited competition exists
- Media coverage created political opportunity

Ultimately the law will protect consumers

What's in the Interim Final Rule?

What's in the Interim Final Rule?

- Departments of Health and Human Services, Labor, and Treasury published an Interim Final Rule (IFR) on July 13, 2021 implementing Part I of the federal No Surprises Act (NSA)
- IFR has 60 day comment period
  - Comments due by 5 p.m. on **September 7, 2021**
- Generally, the NSA and IFR are effective for plan years beginning on or after January 1, 2022

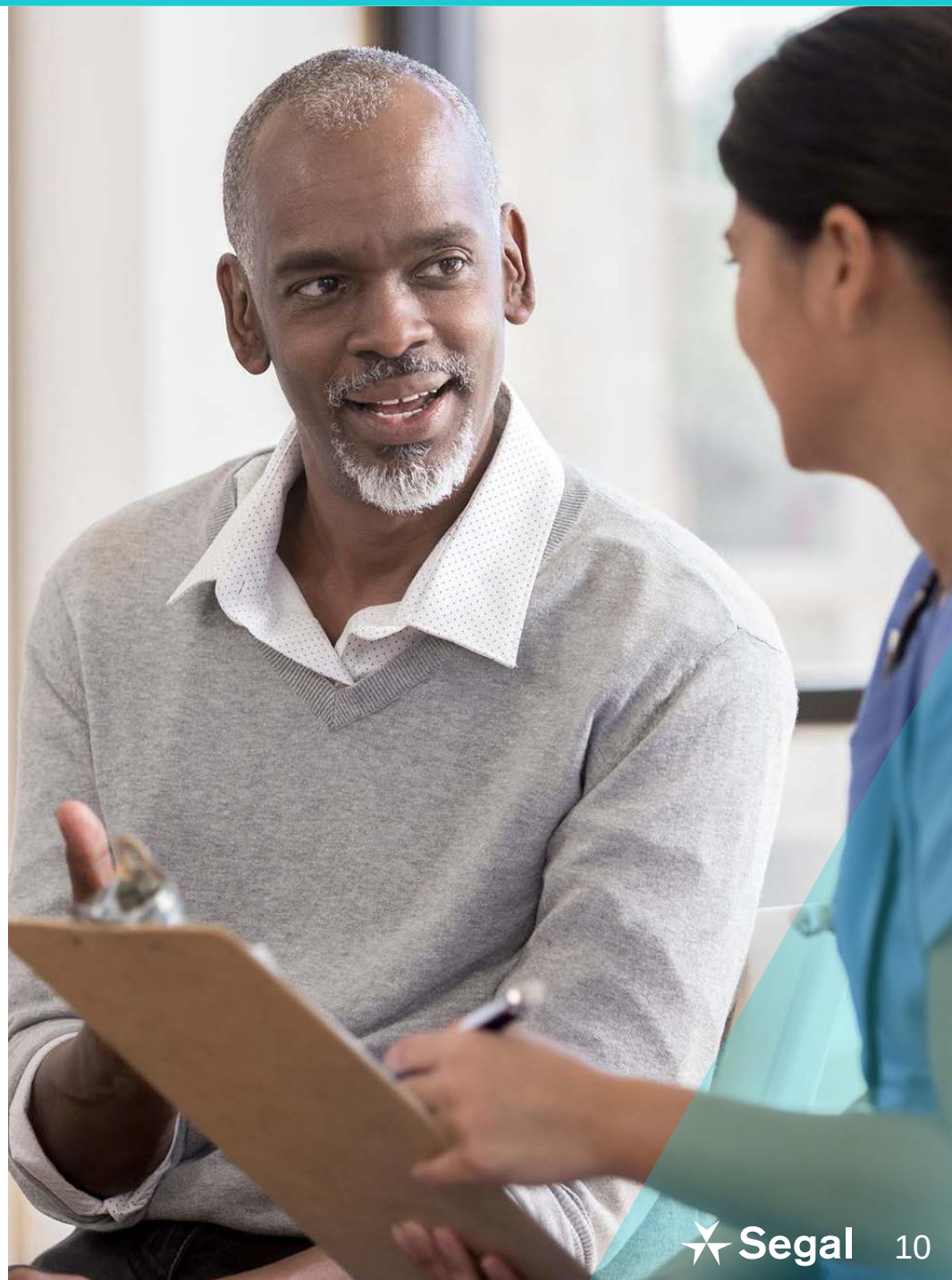


What Does the IFR Cover?

- Applicability of the No Surprises Act to group health plans
- Requirements that emergency services must be paid in the same manner both in and out of network
- Protection of participants against balance billing
- How to calculate the median in-network contracted rate used for both cost-sharing and calculating the Qualifying Payment Amount
- Rules prohibiting nonparticipating providers, facilities and air ambulance services from balance billing participants
  - Unless certain notice and consent requirements are satisfied

What Does the IFR Cover?

- Plan obligations to provide notices to participants
- Protections against air ambulance balance billing
- Extension of certain ACA patient protections to grandfathered health plans
- Establishment of new complaint process to address violations



What Doesn't the IFR Cover?

Rules likely to come later in 2021 on:

- Federal Independent Dispute Resolution (IDR) process
- Price comparison tools
- Reporting requirements related to air ambulance services
- How providers will provide plans with a good faith estimate of expected charges and a patient/provider dispute resolution process

This rule will establish the process for providers to submit estimated fees, which triggers plan obligations to provide an Advanced Explanation of Benefits.

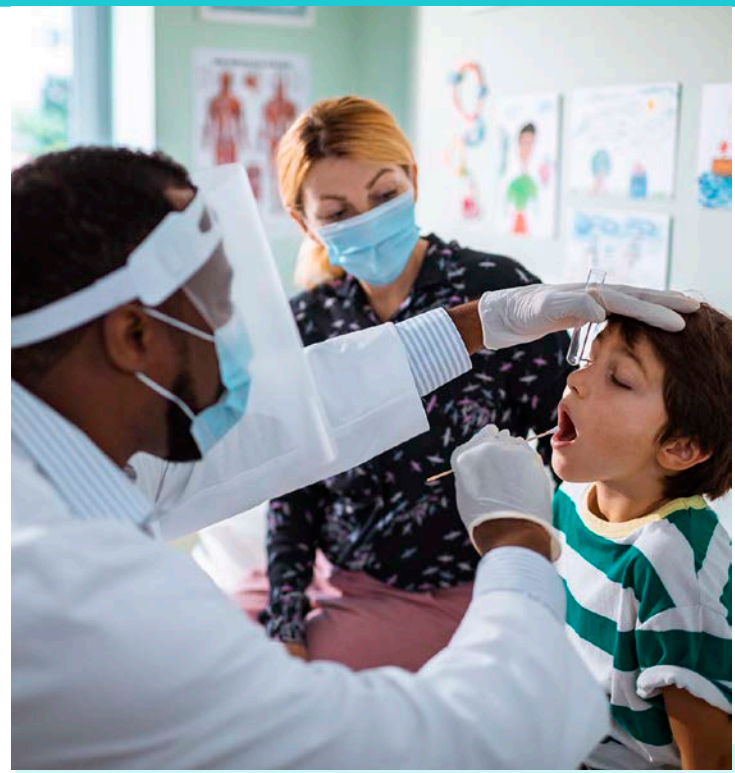
What's coming in 2022?

Rules concerning the following likely will be issued in 2022

- ID cards
- Continuity of care
- Accuracy of provider network directories
- Prohibition on gag clauses
- Pharmacy benefit and drug cost reporting

Plan sponsors must comply in good faith and based on a reasonable interpretation of the law.

New Rules for Emergency and Non-Emergency Services



Participants will be protected from balance billing by out-of-network (OON) providers and are only responsible for in-network cost-sharing for:

- Emergency services furnished at nonparticipating providers or emergency facilities
- Non-Emergency services furnished by nonparticipating providers at in-network facilities
- Nonparticipating air ambulance services

ACA's Emergency Room payment rules (applicable to non-grandfathered plans) are repealed

Emergency services

Defined broadly to include medical screening provided in the ER and services provided in any department of the facility to screen, treat, and stabilize the patient

New Payment Rules Apply to a Range of Care

Hospital

Independent freestanding emergency facility

- Applies to urgent care if facility is state-licensed to provide emergency care

Services provided within any hospital department until the patient is stabilized

Services performed post-stabilization

- If the patient cannot be transported using non-medical transportation

“Prudent Layperson” Definition of Emergency Medical Condition

Plans must use “prudent layperson” definition of “emergency medical condition”

- Medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment or serious dysfunction of any bodily organ or part
- Includes placing the health of a woman or her unborn child in serious jeopardy

Plans can no longer deny an emergency service based solely on a diagnostic code

Coverage Rules that Directly Impact Participants

A group health plan must cover emergency services and certain non-emergency services:

- Without any prior authorization determination, even if services are out-of-network
- Without regard to whether the health care provider or facility is in-network
- Without imposing any administrative requirement or limitation on coverage that is more restrictive than in-network restrictions
- Without imposing greater cost-sharing requirements for out-of-network services

Coverage Rules that Directly Impact Participants

- Calculate participant cost-sharing requirement based on the recognized amount for such services
- Count participant cost-sharing for out-of-network emergency services toward any in-network deductible or in-network out-of-pocket maximums (including the annual limitation on cost sharing) in the same manner as if the care were provided in-network
- Without regard to any other term or condition of the coverage other than the exclusion or coordination of benefits

Timing and Payment

Group Health Plans must meet the following timing and payment requirements

- Plans must send an initial payment or a notice of denial of payment to the provider or facility within 30 calendar days of the nonparticipating provider sending the bill
- The 30 day calendar period begins on the date the plan or issuer receives the information necessary to decide a claim for payment for the services
  - i.e., Plan does not have to pay until a clean claim has been received
- Must ultimately pay a total plan or coverage payment to the nonparticipating provider or nonparticipating facility that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services less any initial payment amount

How will payment for emergency and non-emergency services change?

Out-of-Network Reimbursement Rates
Current State

Most Network Providers offer several options for setting out-of-network provider reimbursement:

Set based on a percentile of a national database (e.g. 80th Pct. of Fair Health	**Set based on a multiple of Medicare (e.g. 200% of Medicare)**	**Use billed or submitted amounts**

Out-of-network provider billed rates can be 5 to 7 times higher than network contract rates for some procedures.

Calculating the Cost-Sharing Amount for Emergency and Non-Emergency Services

The cost-sharing amount for emergency and certain non-emergency services must be equal to the recognized amount, which is one of the following in order of priority:

- An amount determined by an applicable All-Payer Model Agreement
- An amount determined by a specified state law that governs both the plan and the service
- The lesser of billed charges or the Qualifying Payment Amount (QPA), which is the median of the contracted rates of the plan or issuer for the item or service in the geographic region

Methodology for Calculating the QPA for Emergency and Non-Emergency Services

The QPA for 2022 is the median of the plan's contracted rate on January 31, 2019 (adjusted), for the same item or service that is provided by a provider in that specialty in that geographic region, adjusted for inflation

Special Rule: Self-insured plan sponsors have a choice whether to calculate the contracted rate based on their self-insured group health plans or the entirety of self-insured group health plans administered by the same entity (including a third-party administrator) that is responsible for calculating the QPA on behalf of the plan

Determining the Geographic Region

A geographic region is generally defined as one region for each metropolitan statistical area (MSA) in a state and one region consisting of all other portions of the state

- For air ambulance services, a geographic region means one region consisting of all MSAs in the state and one region consisting of all other areas

Special rules apply if a plan does not have sufficient information to calculate the median

Calculating the Median Contract Rate

- Plans must use at least three contracted rates to calculate the median
- Each single contract is considered when calculating the median rate
  - Ad hoc agreements designed to address a unique situation are not included in the calculation
- Plans that use bundled or capitated rate arrangements must still calculate a median rate based on their underlying fee schedule or the price they use for internal reconciliation

Finding the Median Contracted Rate

Assume three contracted rates for a self-insured plan for a service in a specific geographic region are:

$475	**$490**	**$510**

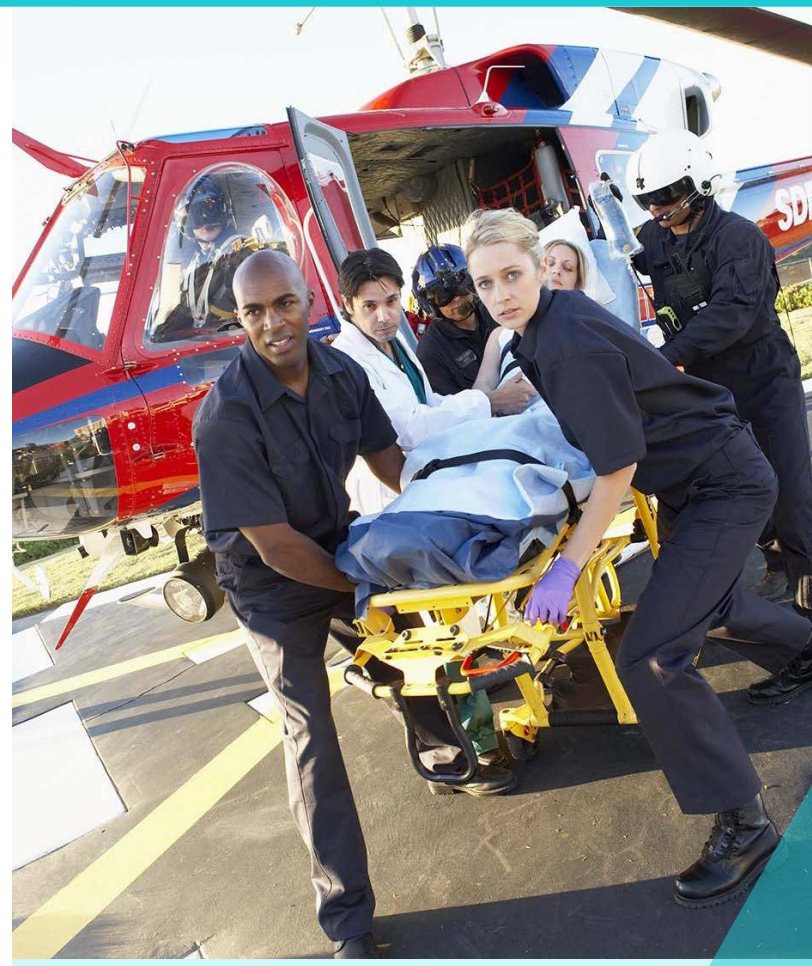
The median contracted rate for this service is $490.

Coverage Requirements for Air Ambulance Services

The law applies even if there is no contracted provider

A group health plan must cover air ambulance services in the following manner:

- Cost-sharing must be the same as if the services were provided by a participating provider of air ambulance
- Cost-sharing must be calculated for a nonparticipating provider based on the lesser of the QPA or the billed amount



Independent Dispute Resolution

If the group health plan and the OON provider cannot reach an agreement on the OON payment, the amount the health plan has to pay the OON provider is determined through an independent dispute resolution (IDR) process

There is no threshold amount for claims to go to the IDR process

The process is “baseball style,” meaning that the IDR reviewer picks one of the parties’ offers

Losing party pays IDR costs

Independent Dispute Resolution

The IDR reviewer must consider certain factors in making its decision, including the median in-network rate for the service, as well as other information the parties provide

The IDR reviewer cannot consider UCR, billed charges, or Medicare/Medicaid rates in making its decision

Cost Implications for Plan Sponsors and Plan Participants

Plan Participants will generally see lower cost-sharing for emergency care

- Typically out of network cost sharing is 30% to 40% of the allowed amounts submitted
- Under the new law, patients will see cost share limited to emergency copays and in-network cost sharing (0%-20% of much lower allowed charges)

Plan Sponsors are expected to see small savings

- CBO estimates approximately 1% savings
- Depends on level of benefit differences today, out-of-network utilization rates and long term results or influence of Independent Dispute Resolution

Notice and Consent Exception for Emergency Services and Non-Emergency Services

Coverage, timing, payment and balance billing requirements, will not apply to certain emergency and non-emergency services if the provider meets the notice and consent requirements

Providers who obtain consent are required to inform the plan that the notice and consent criteria have been satisfied

Notice and consent should be applied in limited circumstances, where the individual knowingly and purposefully seeks care from a nonparticipating provider, such as deciding to seek care from a physician the patient already knows.

Notice and Consent Exception for Emergency Services and Non-Emergency Services

Plans may rely on the provider's information unless and until the plan or issuer knows or reasonably should know that the notice and consent was not properly and timely given and received

Notice and Consent exception does not apply to hospital-based ancillary services providers, including emergency medicine providers, pathologists, anesthesiologists, radiologists, assistant surgeons and hospitalists

Participant Notice of Rights

Group health plans must give individuals a notice about their rights under the No Surprises Act

The Departments have published a model notice that may be used for this purpose

The notice must be posted on the plan's website and be included on each explanation of benefits for an item or service covered by the No Surprises Act

Choice of Health Care Professional
Grandfathered Plans

The No Surprises Act extends patient protections for choice of health care professionals to grandfathered health plans.

Therefore, effective January 1, 2022 grandfathered plans must do the following:

- **In-Network Provider:** To the extent a group health plan requires or provides for an individual to elect an in-network primary care provider, the group health plan must permit an individual to choose any available in-network primary care provider.
- **In-Network Pediatrician:** To the extent a group health plan requires or provides for an individual to elect a pediatrician to a pediatrician for a child, the group health plan must permit the individual to choose an available in-network pediatrician.

Choice of Health Care Professional
Grandfathered Plans

Access to In-Network Obstetrical and Gynecological care

A group health plan may not require authorization or referral for obstetrical or gynecological care from an in-network provider who specializes in obstetrics or gynecology; and

A group health plan must treat obstetrical and gynecological care and the ordering of related obstetrical and gynecological items and services from an in-network as if authorized by the primary care provider.

Grandfathered Group Health Plans

Must use the “Prudent Layperson” standard for emergency medical conditions

Required to implement patient protections for choice of provider, pediatricians, and OB/GYN

What do Plan Sponsors need to do next?

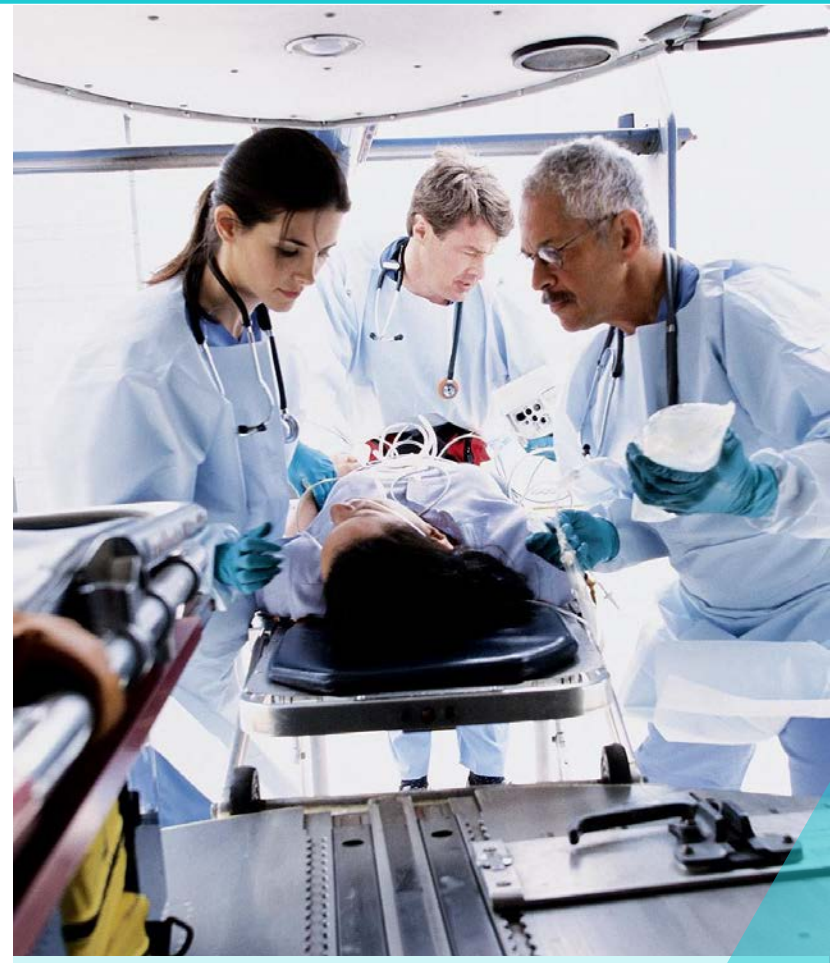
What Does This Mean for Your Costs for Emergency Care?

Participants will be protected from Surprise Bills

Participant cost-sharing is based on a new formula

Plans have to make an initial payment to providers and facilities, but that amount is not established in the rule

- Will the plan's existing out-of-network payment rules still be effective?
- What will be the cost implications of the new payment rules?



What do Plan Sponsors Need to Do Next?

- Find out what payment changes your service providers plan
- Determine impact on plan finances
- Amend plan documents
- Get ready for regulations on Independent Dispute Resolution process later this year
- Create plan for good-faith compliance with remaining rules

Compliance Plan

No Surprises Act and Final Transparency Rule

This information is for educational purposes and is based upon guidance available as of February 16, 2021. Additional guidance is anticipated prior to the implementation effective dates, which may impact the contents of this document. Plan sponsors should consult with Legal Counsel as to the applicability of these laws to their plan and its operations.

Action	Responsible Party	Effective Date	Plan Actions
Identify Applicability			
Identify scope of applicability of Act to the group health plan			
Monitor federal regulations and guidance throughout implementation period			
Plan/SPD Amendments			
Some items listed may sound familiar to non-grandfathered plans. However, the new rules are more expansive than the rules under the Affordable Care Act. Therefore, all plans should review current provisions to determine whether modifications are necessary. 1. If non-grandfathered, amend plan to eliminate ACA emergency room payment rules 2. Amend plan rules to cover emergency services without prior authorization 3. Amend plan rules to apply cost sharing in the same manner at participating and non-participating providers and facilities, both subject to and accumulating to the in-network deductible and out-of-pocket maximum. 4. Define: • Emergency medical condition using the prudent layperson standard • Emergency department of a hospital to include an independent freestanding emergency department. • Emergency services 5. Amend plan to set forth standards for payment to a non-network provider or facility 6. Modify External Review procedures to include determinations regarding emergency services and air ambulances		Plan years beginning on or after January 1, 2022	

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Thank You

Kathryn Bakich
kbakich@segalco.com / 202-833-6494

Ed Kaplan
ekaplan@segalco.com / 212-251-5212

Jamaca Mitchell
jmitchell@segalco.com / 202-833-6448