INTERIM FINAL RULING FOR THE NO SURPRISE ACT MEETS INDUSTRY APPROVAL

Late last year, Congress passed the *No Surprises Act* (NSA) to address the growing disconnect in patients receiving surprise balance bills in out-of-network situations, including emergency events or with out-of-network ancillary providers in in-network settings.

On July 1st, federal departments—including Health and Human Services (HHS), Labor, and Treasury—released an interim final rule (IFR) that is the first step in issuing important guidance on this new law. This IFR, and subsequent rules expected throughout the next year, will have far-reaching effects on self-insurance plans.

THE NO SURPRISES ACT

The NSA was passed by Congress last December as part of the *Consolidated Appropriations Act of 2021* and goes into effect on January 1, 2022. The law is meant to protect consumers from the most pervasive types of surprise "balance" billing in certain out-of-network situations by limiting the amount of the bill to the cost-sharing they would have paid if the care had been from an in-network providers.

This legislation was one of the largest pieces of healthcare legislation since the passage of the Affordable Care Act, and it was passed quickly with endorsements from both sides of the aisle.

According to Barbara Lambert, internal service consultant with HUB International, "Surprise billing is a serious problem that is having a negative impact on patients. The charges from surprise medical bills can lead to a family's financial ruin. Imagine your child is ill or injured and must be airlifted to a hospital only for you to later receive a bill for more than $100,000 for the air ambulance charges. These families who have already gone through a personal trauma and are coping with any repercussions of the medical emergency are now having to deal with potential litigation or credit issues."

"Surprise billing is one of the most prevalent consumer issues in the healthcare industry," said Brian Wroblewski, executive vice president of sales and marketing with ClearHealth Strategies, LLC. "A [health plan] member may end up in an emergent site of care and whether out-of-network and having services performed by out-of-network providers, or in a network but still having out of network providers treat the member at the in-network location, the issue arises that the member had no choice of the out-of-network provider and no ability to contain costs. A provider treating this member might charge, for example, $5,000 or more for a service that ordinarily costs $250 and without the legislation, the member would be liable for all of the portion not paid by the health plan."

Surprise medical bills can cost a family thousands of dollars, even in non-emergency events. The NSA is a much-needed piece of legislation to protect patient consumers while prohibiting providers from surprise billing in situations where patients do not have the ability to choose an in-network provider.

"The legislation overall has significant positive impact on healthcare consumers as they can no longer be billed by the medical provider for any amount beyond the cost sharing associated with a rate that is based on network pricing," said Wroblewski. "This is very positive for the plan member as it goes to protect a main vulnerability of the healthcare system."

SIIA ADVOCACY AND THE IFR

Well before the NSA made it to the floor of Congress, SIIA was asked to engage on the surprise billing issue by the White House. For nearly two years, SIIA has been advocating on behalf of self-insured health plans on the topic, even encouraging Congress to consider the intricacies of self-insured plans. Immediately after the CAA was passed, the association put together the SIIA Price Transparency Working Group to better formulate industry comments, recommendations, and implementation. SIIA has also led discussions with staff from the various federal departments involved in developing the IFR.

In May, SIIA submitted an initial comment letter to the federal agencies providing recommendations and clarification on the first phase of the surprise billing rulemaking process, specifically focusing on the *Employee Retirement Income Security Act* (ERISA) preemption of state surprise billings laws, in addition to recommendations on certain terms and definitions set forth under the statute. These comments were driven by SIIA's Price Transparency Working Group which is comprised of TPAs, brokers, service providers, and stop-loss carriers.

When the first IFR was released on July 1st, the self-insurance sector was pleased to find that the guidance issued took into account much of what was addressed in SIIA's comment letter. Going so far as to follow the association's advice on ERISA preemption.

The main point of SIIA's advice was that ERISA must always preempt conflicting state law when applied to self-insurance plans. An additional point was made that self-insurance plans could opt-in to state law. The IFR agrees with SIIA's main point allowing ERISA to supersede state law as well as with the option for self-insured plans to voluntarily opt-in to state law.

The IFR also concurred with SIIA's suggestion that, as ERISA preempts state surprise billing law and any state all-payer model agreement, the only "recognized amount" to be paid to an out-of-network provider must be equal to or lesser than the qualifying payment amount (QPA).

A QPA is defined as the median of the in-network (i.e., contracted) rate in a geographic area, and serves as the focal point for a number of other implementation pieces of the surprise billing statute, including the base-line primary factor that an arbiter must consider when making a final payment determination under the federally developed arbitration/ independent dispute resolution process.

The IFR added that cost-sharing must be the same as that for in-network services and if a patient had not yet met their deductible, the patient is responsible for paying the entire QPA.

The NSA did not define the term "initial payment" and SIIA asked that the term remain undefined, or if it must be, then it should be defined by the ERISA plan document. The IFR did not require any specific minimum initial payment but suggests that a minimum payment rate could be developed. The ruling offered the advice that the initial payment should

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be an amount that the plan or issuer intends to be a full payment based on the circumstances and as required by the terms of the plan.

Under the law, when a self-insured plan and out-of-network provider cannot agree on a rate, then the rate will be determined through an independent dispute resolution (IDR) process.

One of the most important aspects of SIIA's recommendations and the IFR's guidance was the establishment of a median contracted rate as the QPA. SIIA offered that a median in-network rate for a self-insured plan should be identified through the various plans provided by the self-insurer.

The IFR agreed, and took it further, that a median contracted rate should be determined by taking into account every group health plan offered by the sponsor of a self-insured plan.

In addition, for TPAs, SIIA suggested that median in-network rates could be simplified by looking at all of the in-network rates charged by all of the TPA's self-insurance plans.

The IFR, in an effort to reduce the administrative burden imposed on sponsors of self-insured plans, will permit TPA's to determine the QPA for the sponsor by calculating the median contract rate based on all of the plans it administers.

Regarding median contracted rates for rental networks, SIIA wanted the federal departments to develop a series of categories for type of self-insured plan or provider network in order to identify a median rate for each category.

The IFR recognized the issue and decided that the contracted rates between providers and the manager of the provider network for the insurance plan would be treated as the self-insurer's contracted rates for purposes of calculating the QPA.

The geographic regions used to determine median contracted rates will follow the metropolitan statistical areas (MSA) used by both Medicare and the U.S. Census. The IFR closely followed SIIA's recommendation on this point. The IFR included the "rule of three" expansion, meaning that if a plan cannot identify three rates to

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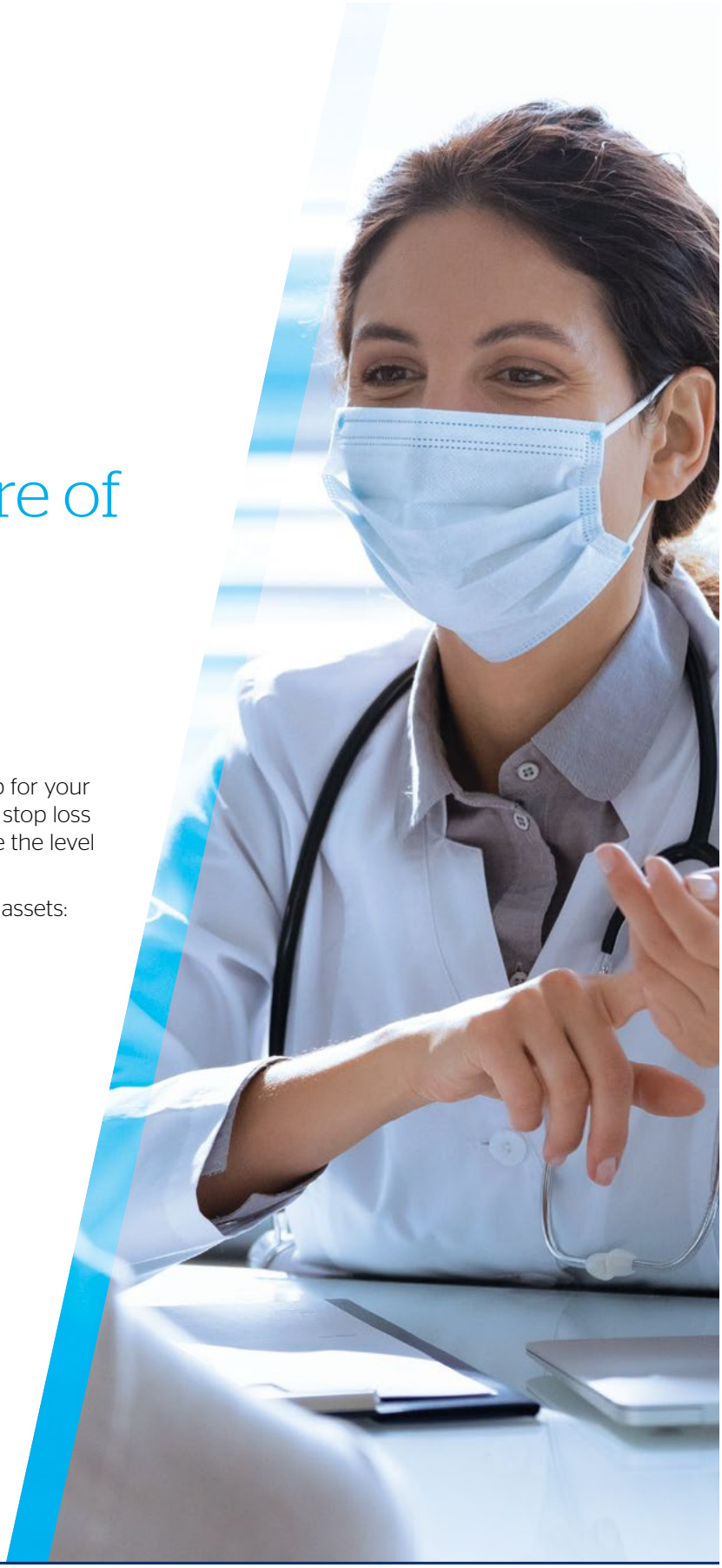

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determine a median rate within a MSA then the plan is permitted to increase the size of the MSA to include the state as a single region.

QPA determination will rely on information sharing between plan and provider. SIIA centered several comments on ensuring data sharing and accessibility between plan sponsors and service providers.

The association believes that self-insured plan sponsors and their service providers must be able to access the required pricing and health claims data so they can comply not only with the surprise medical billing requirements, but also to better comply with the "transparency in coverage" regulations.

The IFR issued clear guidelines in the steps to be taken by each in order to determine the correct rate. Much of determining QPA will be based on using databases. SIIA strongly advised that any database applying for federal approval be able to prove that they have no conflict of interest. The IFR agreed stating that the organization maintaining the database cannot be affiliated with, controlled by, or owned by any health insurance issuer, provider, or healthcare facility.

At the end of SIIA's comment letter, the association requested a good faith compliance safe harbor for implementation of the act, as there will be a number of administrative

changes that self-insurance plans will need to execute in a short amount of time. The IFR didn't formally create a safe harbor but agreed to take good faith efforts into consideration.

REACTIONS TO THE IFR

"A number of provisions within the IFR closely aligned with a number of specific SIIA recommendations from the clarity on ERISA-preemption, to the QPA methodology in looking across similar self-insured plans by administration," said Ryan Work, vice president of government relations for SIIA.

According to Troy Sisum, senior vice president and chief counsel with ELAP Services, LLC, "While the IFR still leaves much unaddressed, on the items it did address, it is far more protective of self-funded plan interests than we anticipated. From that point of view, it was a win for self-insured plans. The regulators understood that rules couldn't be fashioned solely on the commercial insurance markets, because of the differences with the self-funded markets are material."

"It is fantastic to see how closely SIIA's comments were followed, or evaluated," said Wroblewski. "I don't believe there was a point that was forgotten, but rather, the ruling for the qualified payment amount being based on contract rates in place of historical claims data was the item that seemed to not be consistent with industry norms."

Wroblewski continued, "The IFR is in line with what was expected and matched the key points that were previously addressed through the Act. And, the ability to have a review and commentary period really suggests that the goal is to 'get it right.' There are a couple confusing aspects to the IFR which have the opportunity to get addressed following the 60-day review and commentary period. The only real missed opportunity based on the IFR was the stipulation of using contract rates rather than claims history in order to calculate the network median due to the dynamics and nuances of each one as a basis for analysis."

Overall, the self-insurance sector is pleased with this initial ruling. However, from an administrative perspective there is a lot to manage. Plan administrators and contractors will bear the burden of implementing the legislative changes and updating their processes when new rulings come down.

"There are a lot of administrative requirements on plans and service providers as a result of the CAA, and the interim rules didn't address many items. There will be ongoing rulemaking throughout 2021," said Sisum.

THE NEXT FEW MONTHS

While the IFR will likely not be altered drastically by the federal departments working on it, it does allow for a 60-day comment period. SIIA's Price Transparency Working Group is already in discussion on the IFR and will be submitting comments addressing the outstanding issues and questions. In addition, SIIA expects a second rulemaking out of the federal departments surrounding the arbitration/independent dispute resolution (IDR) process sometime around September 1.

"The mechanics of the arbitration process is critical and needs to be concise," said Lambert. "Specifications on the criteria for the selection of arbitrators, along with clear guidance for settling any disputes is necessary to avoid inflated costs."

In addition to more information regarding arbitration in the future rulings, Sisum is looking for clarification on other sections of CAA including advanced explanation of benefits, provider directories, machine readable files, and more. There is also some anticipation that the final rulings will provide exceptions for health plans with unique designs that don't squarely fit withing the rules.

For Wroblewski, "We are hoping to hear more clarification on the administration of the QPA and how to reconcile administration of that amount knowing that contracted rates are hard to obtain and have many dynamics to them, including percent-off, outlier, per diem, and stop loss, to name a few. We're hoping for the QPA to be calculated using prior claims history which can then be managed across the appropriate population of claims."

A third IFR is expected in October to address emergency air ambulance charges and broker compensation. ■