SELF-FUNDED HEALTH PLANS CAN OPTIMIZE VALUE WITH NO SURPRISE!

Written By Christine Cooper

Federal legislation that took effect more than two years ago, on January 1, 2022, empowered self-funded health plan participants with specific protections against certain charges by out-of-network providers. It also enabled participants to access prices charged by providers in the past.

Participants do not know, in advance, what the provider will charge for its services. Other than office visits, preventive services, and certain Rx, they generally don't know, in advance, what their plan will pay or what their out-of-pocket costs will be.

This is the result of the complexity of healthcare. Participants won't know the billing codes, whether the plan will accept all of those charges, what portion of the billed charges are eligible under the plan, and how deductibles, copayments and coinsurance will apply. Many times, when participants receive a bill for the balance they owe, it will be a complete surprise.

Participants are often "surprised" whenever they get a "balance bill," expected or unexpected, regardless of whether the balance bill meets state or federal law's definition of "surprise."

This is an opportunity for claims administrators to assist plan sponsors in actions that will achieve greater value at a lower cost where participants are more engaged with their health coverage.

LEGISLATIVE EFFORT TO MANDATE PRICE TRANSPARENCY

A combination of U.S. government agencies issued its final rules on pricing transparency with the goal of reducing consumer confusion. The Centers for Medicare & Medicaid Services (CMS) also issued guidance.

Under the final rules, hospitals and other providers are required to make pricing information available online. The new rules also require plans to offer online tools that include personalized information regarding members' cost-sharing responsibilities for covered items and services, including prescription drugs.

PROVIDER TRANSPARENCY RULES

Hospital price transparency is intended to provide pricing in advance of receiving services. This information is intended to enable patients to shop and compare prices across hospitals and estimate the cost of care before going to the hospital. Each hospital operating in the United States is required to provide clear, accessible pricing information online about the items and services they provide in two ways:

- As a comprehensive machine-readable file with all items and services
- In a display of shoppable services in a consumer-friendly format

PAYER TRANSPARENCY RULES

New requirements for payers under CMS Transparency in Coverage require payers to disclose in-network provider rates for covered items and services, out-of-network allowed amounts and billed charges for all covered items and services and negotiated rates and historical net prices for covered prescription drugs administered by providers.

Starting in 2023, payers had to provide an internet-based price comparison tool that allows members to receive an estimate of their cost-sharing responsibility for a specific item or service from a specific provider or providers for 500 items and services. Price comparison tools must include all services, including prescription drugs, starting this year.

Plans subject to the rule include individual and group plans (self-insured and level-funded). These rules do not apply to account-based group plans and programs (HRAs, FSAs, HSAs). Payers not in compliance could face fines of up to $100 per day for each violation and for each individual affected by the violation.

PROTECTION AGAINST SURPRISE BILLING

Typically, balance billing occurs when patients receive care from an out-of-network provider.

For example, a patient may receive emergency care from an out-of-network facility. Or a patient may be directly billed by an out-of-network physician even when the patient is receiving medical care at an in-network facility. These are often high-dollar costs. They constitute the difference between what a provider charges and the amount covered by the plan.

The balance comes as an unpleasant surprise as the balance bill often arrives after all benefits have been paid and after the participant has paid their deductible, copayment or coinsurance.

While in-network providers generally agree to accept the plan's determination of covered charges, out-of-network providers are under no legal obligation to do so.

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Percent of Providers Who Bill Out-of-Network, Prior to the No Surprises Act

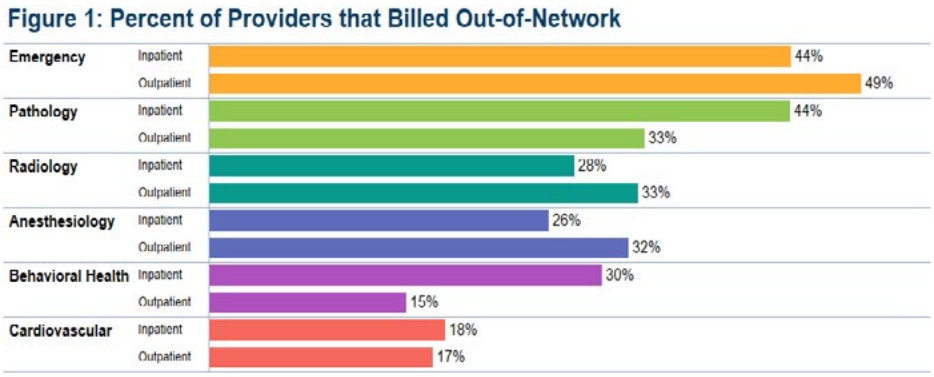


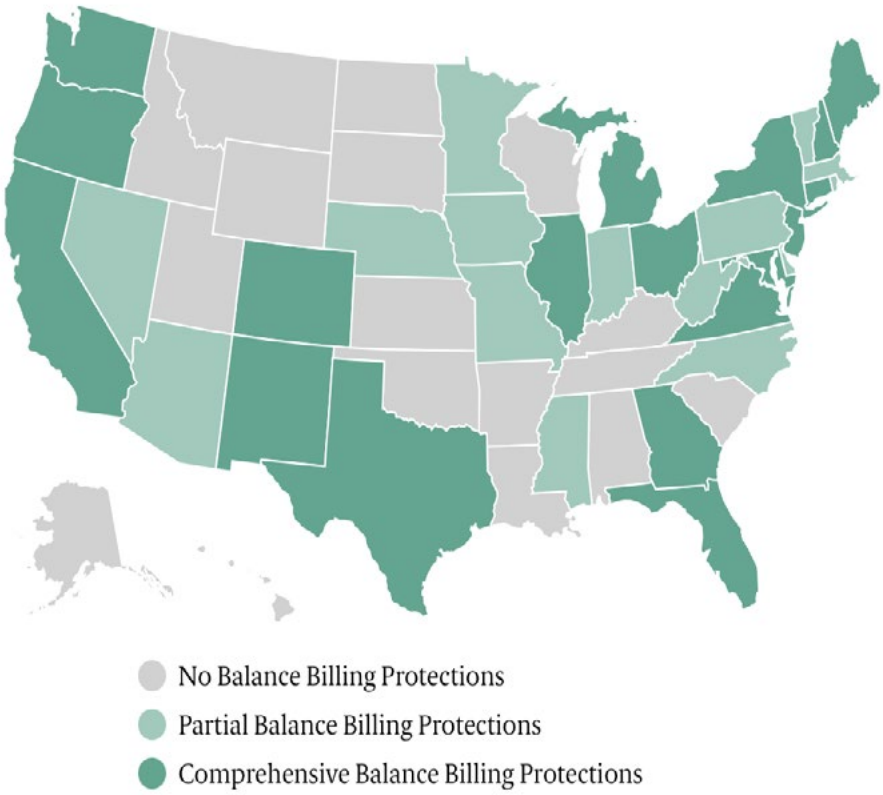
Table Source: Health Care Cost Institute

However, according to this 2020 Health Care Cost Institute study, most providers who bill out of network do so less than 10 percent of the time.

Prior to the No Surprises Act, more than 30 states had state-level protections against balance bills for fully insured plans. However, states do not have regulatory authority over self-insured plans, which are subject to the Employee Retirement Income Security Act (ERISA). As a result, more than 70% of Americans do not benefit from these state law protections.

Map: State Laws Protecting Consumers Against Balance Billing, Prior to the No Surprises Act, As of February 5, 2021

Map Source: Maanasa Kona et al., Center on Health Insurance Reforms, Health Policy Institute, Georgetown University.



Some states responded to the Not Surprises Act by updating their own legislation and protections regarding Balance Billing. Four states, Colorado, Georgia, Illinois and Washington, updated their state law to better align with or exceed NSA protections. Three states, Maryland, Vermont and West Virginia, consolidated NSA enforcement authority in the department of insurance. Two states enacted or revised laws governing payment for out-of-network services – Illinois and New York.

Beginning January 1, 2022, all healthcare providers were required to make information on patients' rights regarding balance billing publicly available. The No Surprises Act (NSA) specifically applies to out-of-network provider services delivered at in-network facilities, as well as emergency services, regardless of location. Providers will be prohibited from balance-billing members for items and services received in three situations: emergency, out-of-network, non-emergency services at in-network facilities and out-of-network air ambulances.

The NSA establishes an Independent Dispute Resolution (IDR) system. This is a form of arbitration where the out-of-network provider is unwilling to accept the payor's determination of the covered charge.

NSA FINAL RULES

The tri-agencies published final rules in the federal register on August 26, 2022.

Combines the interim final rules Part 1 and Part 2, plus the final rules:

- Preclude balance billing of participants by out-of-network providers who deliver services in a network facility, provide emergency services regardless of location, and provide air ambulance services,
- Require claims for services subject to the No Surprises Act qualify for in-network benefits,
- Implement the good faith estimate requirement,
- Implement the Qualified Payment Amount (QPA) and Independent Dispute Resolution (IDR) requirements and processes.

While the legislation and rules and the sub-regulatory guidance in the form of FAQs greatly expand participant protections, including expanding the definition of emergency services, it is important to note that Balance Billing was not completely eliminated. It may still occur where a non-network provider delivers non-emergency services and ground ambulance transportation at a facility that is not in the network.

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IMPLEMENTATION HAS SUFFERED MANY CHALLENGES

Among all the challenges of implementing the NSA, three stand out:

- Initially, there was widespread hospital non-compliance with transparency requirements,
- The most effective consumer tool created by the No Surprises Act is the Advanced Explanation of Benefits, which was to take effect for plan years beginning on or after January 1, 2022; however, the requirement has been suspended pending Department of Labor regulations, and while those regulations were once a priority, they apparently aren't anymore.
- Whatever Congress was thinking, the IDR process is an all but complete failure. During the period between April 15, 2022 and June 30, 2023, 490,000 IDR disputes were initiated — more than 22 times the number of disputes anticipated by the Departments of Health and Human Services, Labor, and Treasury (the "Departments"). Worse, more than 60% of the disputes still have not been decided.

THE KEY LEGAL CHALLENGES

Since the passage of the No Surprises Act (NSA), nearly 20 federal lawsuits have been filed against the Department of Health and Human Services (HHS), challenging statutory provisions, agency regulations and guidance, and adjudications made through the provision of an Independent Dispute Resolution (IDR) process.

A ruling in the case of Texas Medical Association v. HSS declared the regulatory guidance outlining the method to determine the Qualified Payment Amount (QPA) was unlawful. A court order vacated certain portions of QPA regulations and related guidance. Read more here.

The federal government prevailed at summary judgment in the case of Association of Air Medical Services v HSS, marking the government's first major victory in the string of challenges to the NSA. The court found that certain government regulations on how to define and calculate the QPA for air ambulance services were consistent with the NSA.

Given Ongoing litigation and NSA uncertainties, administrators of self-insured plans should consider employing "pure" reference-based pricing designed to avoid the administratively cumbersome and costly IDR process.

Additional details on NSA litigation can be found here.

A STRATEGIC AND COMPLIANCE-ORIENTED RESPONSE TO NSA

Health plans need to understand their rights under the price transparency mandates and NSA legislation designed to reveal the true cost of provider health services before receiving care and submitting a claim. Plan sponsors should work with claims administrators to ensure plans are amended as necessary to comply with the No Surprises Act – and updated as necessary because NSA provisions continue to evolve with litigation and additional sub-regulatory/FAQ guidance.

Fully optimizing plan value requires a holistic approach to plan design, as well as initiating changes to ensure the most effective strategies are implemented to meet NSA requirements and to support the 'health and wealth' of participants. The most effective way to respond to the NSA is through a combination of strategic and compliance-oriented approaches.


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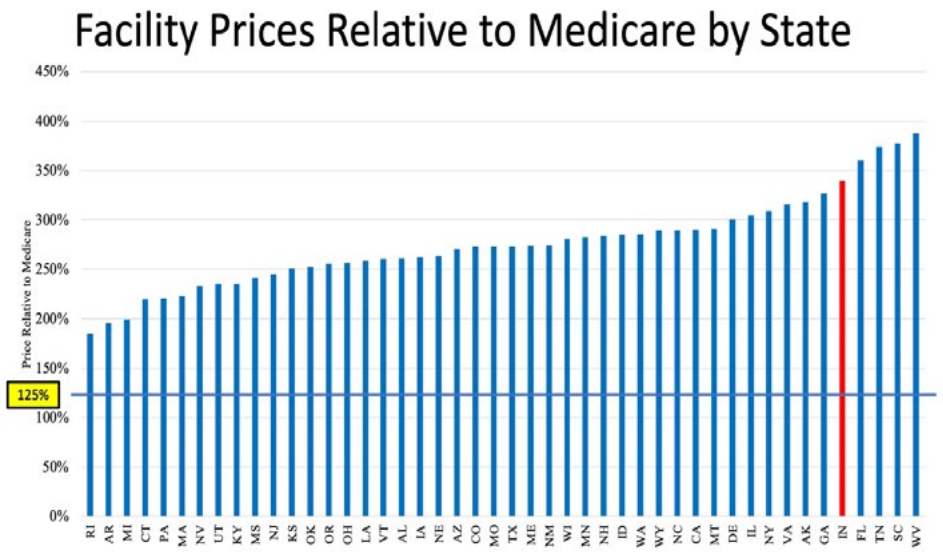
REFERENCE-BASED PRICING: A SELF-FUNDED PLAN'S MVP (MOST VALUABLE PROVISION)

Even with greater transparency, price variations can still exist across hospitals and providers. To mitigate this, many self-funded health plans have adopted reference-based pricing (RBP) strategies. RBP strategies typically base health plan fees on a multiple of Medicare pricing. This establishes a benchmark fee schedule and payment ceiling. Plan sponsors and participants benefit from the consistent application across all providers and health networks.

FACILITY PRICES RELATIVE TO MEDICARE BY STATE



While RBP can offer value by leveling the playing field, risks remain RBP plans that use narrow networks or have negotiated contracts with certain providers and plans that utilize RBP as the mechanism to price out-of-network claims will still be affected by the NSA legislation. In both instances, there would be a network rate that could be used to calculate a Qualifying Payment Amount (QPA).

The most effective way to address the NSA legislation may be to adopt a "pure" RBP plan that puts the patient in the driver's seat as a healthcare consumer. Pure RBP plans that do not contract with providers should remain unaffected by NSA because there aren't any out-of-network claims, nor is there any determination of a median in-network rate. NSA may prompt a significant expansion in the prevalence of pure RBP plans since RBP often eliminates the negative effects of excessive charges – charges that would otherwise be shared by the employer and the participant.

Adopting a "pure" RBP structure, coupled with tech-driven data support, may avoid unreasonable or excessive provider charges – potentially lowering both the cost of coverage and employee point of purchase cost sharing. Given the wide variation of provider charges for the same services, without any difference in quality, a pure RBP design offers an opportunity to avoid excessive and unreasonable provider fees and charges.

NSA GUIDANCE ON REFERENCE-BASE PRICING FOR EMERGENCY SERVICES

The Department of Labor (DOL), the Department of Health and Human Services (HHS), and the Internal Revenue Service (IRS) issued a set of FAQs addressing the NSA, including how the NSA applies to plans that incorporate RBP:

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- Non-emergency services provided by out-of-network providers at in-network facilities;
- Out-of-network emergency services; and
- Out-of-network air ambulance services.

For each plan, the No Surprises Act specifically defines the Qualifying Payment Amount (QPA) as:

> "the median of the contracted rates recognized by the plan … that are offered within the same insurance market … as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan) … for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished…"

A "pure" RBP plan has no network, so there are no in-network facilities. There are no contracts with providers. Consequently, there is no Qualified Payment Amount (QPA), and the NSA will simply never apply to non-emergency services under an RBP plan.

Plans and insurers that use RBP, however, cannot limit or exclude spending towards emergency services from a provider that does not accept the RBP. This out-of-pocket spending must count toward the annual out-of-pocket maximum. In the latest guidance, federal officials extend this to post-stabilization services that are included in the definition of "emergency services." Thus, plans and insurers should not limit or exclude spending on providers that do not accept an RBP when that spending is on NSA-covered post-stabilization services.

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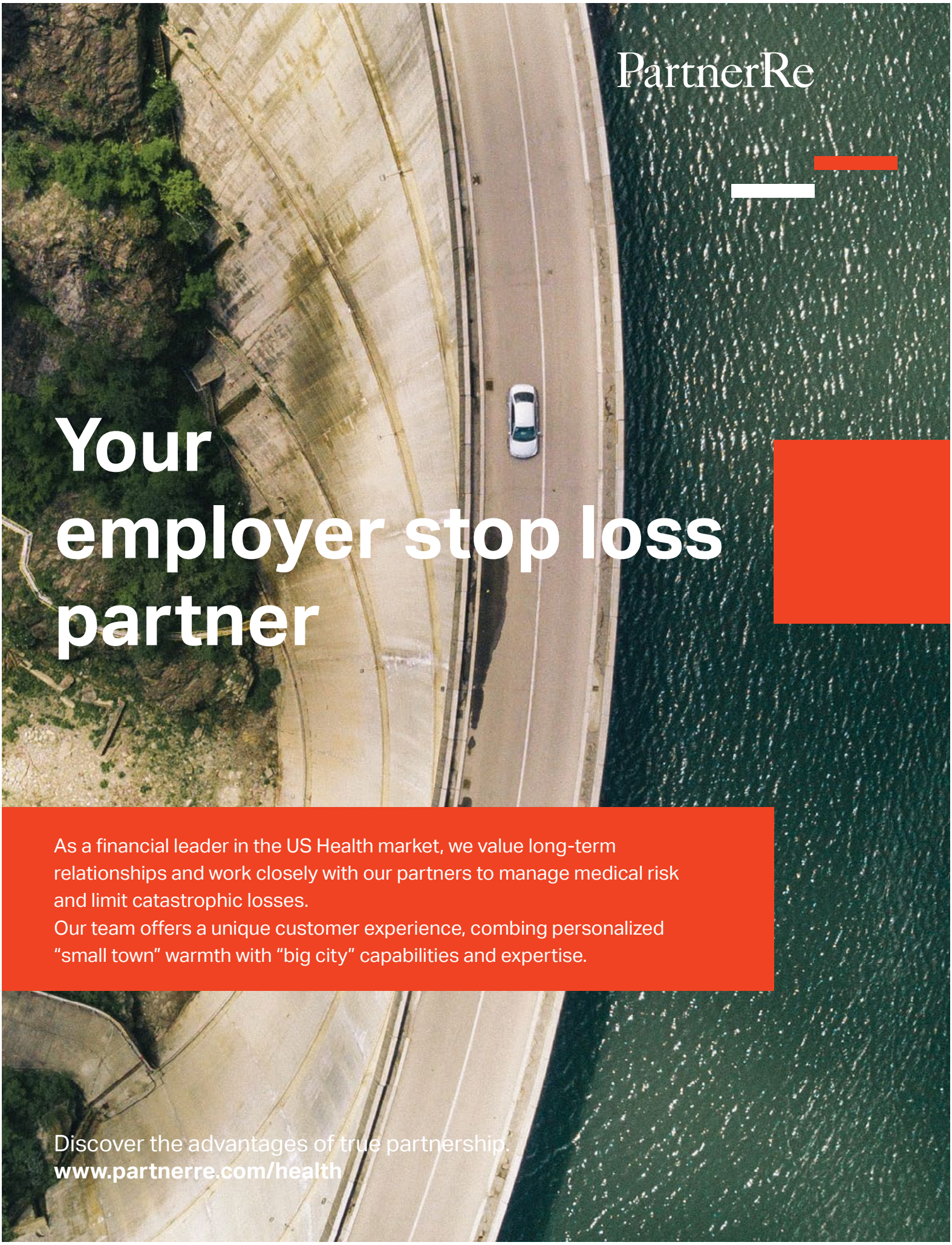
If emergency or non-emergency services are otherwise covered by the plan or policy but provided by an out-of-network provider, the NSA's protections apply even if the plan or policy does not otherwise include coverage for out-of-network items or services. As such, a closed network plan or insurer might end up providing benefits for out-of-network care because of the NSA.

We are mindful that government agencies adopt regulations that extend the reach of or conflict with the original text of the legislation. That's why litigation challenging Part I, Part II, and the Final Rule of the Requirements Related to Surprises Billing (the "Rules") issued by the Department of Health and Human Services under the federal NSA was no surprise.

While we wait for further guidance, the parties should use their best judgment and provide complete and detailed submissions to the IDR Entities. An even better practice is to adopt a reference-based pricing plan, which allows the parties to avoid certain NSA provisions (including the IDR process) and potentially eliminate the negative effects of excess charges otherwise shared by the employer and the participant.

A NEW GENERATION OF INNOVATIVE SERVICE SUPPORT

Compliance will remain a top priority for administrators. Achieving and staying compliant will require new levels of support from medical billing partners equipped with digital solutions to alleviate administrative burden. An innovative billing partner strategically employs information technology and data to support plan administrators with powerful intelligence, enabling a stronger defense against complex billing and greater success in efforts to recover overpayments. Online data analysis tools provide real-time pricing and insights by harnessing data electronically – allowing fee comparisons that identify fair and reasonable prices.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FINDING THE RIGHT MEDICAL BILLING PARTNER

It's important to look for a medical billing partner that is an agent of change, one that embraces innovation and advocates for "what is fair and just" in the marketplace. The right partner also provides value-added services to a health plan through turnkey solutions, administrative support, and legal representation. This support assistance will be invaluable in helping plan administrators navigate complex federal and state healthcare regulations and advocacy of complex medical billing issues.■

Christine Cooper is the CEO of aequum LLC and the Co-Managing Member of Koehler Fitzgerald LLC, a law firm with a national practice. Founded in 2020, aequum serves third-party administrators, medical cost management companies, stop-loss carriers, employer-sponsored health plans and brokers nationwide, defending medical balance bills and delivering savings to employer-sponsored health plans. Find aequum at aequumhealth.com.

TIPS FOR NSA COMPLIANCE

- Understand how implementation of NSA provisions and IFRs affect the cost of coverage and the self-funded plan's revenue cycle.
- Analyze any differences between the code and regulatory guidance, as well as identify any gaps where there appears to be insufficient guidance or outstanding issues.
- Confirm current processes, procedures, agreements and contracts with emergency and ancillary providers to determine potential areas of concern and risk exposure.
- Know how changes will impact plan design and clarify the process for resolving claims disputes with out-of-network providers.
- Include disclosure requirements on EOBs and ensure communication materials and plan documents (plan document, SPD, SBC, etc.) are updated as necessary.
- Understand options plan sponsors can deploy to leverage this new legislation for the benefit of both the participants and the plan.

After confirming compliance requirements, identify actionable rewards and benefits solutions that will leverage provisions to optimize the outcome from compliance – for both the participants and the plan sponsor. Communicate plan updates so members and their dependents can fully understand their healthcare coverage and provider options.