Uncertainty Arises Over Federal Surprise Billing Implementation

Written By Karrie Hyatt

The implementation of the *No Surprises Act* (NSA) is causing a lot of uncertainty among self-insured health plans. Confusing matters even more is a recent Federal District Court decision that vacated part of the Interim Final Rules (IFR) that muddies the arbitration process between provider and insurer.

BACKGROUND

The *No Surprises Act* was passed by Congress in December 2020 as part of the *Consolidated Appropriations Act* of 2021 and went into effect on January 1, 2022. The law addresses 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. The *No Surprises Act* is meant 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.

Last July, the first IFR was released and was concerned primarily with qualifying payment amounts (QPA) and *Employee Retirement Income Security Act* (ERISA) preemption of state surprise billings laws.

In September, the federal departments released a notice of proposed rulemaking, titled "Reporting Requirements Regarding Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement." This release set-up data collection for these subjects for further research and clarification. Protecting patients against surprise, and high cost, air ambulance charges is one of the key components of the *No Surprises Act*.

Also in September, the second IFR (Phase II) was released and primarily pertained to the independent dispute resolution (IDR) and arbitration process for the *No Surprises Act*. It describes in detail the dispute resolution process between provider and insurer. It also issued guidance for individuals that do not have an insurance plan or prefer not to be billed through their insurance plan.

The NSA went into effect on January 1 and self-insurance plans, among other participants, have been struggling to make good faith efforts in meeting its requirements.

In addition, the Transparency in Coverage (TiC) rule, that requires health plans to make available publicly detailed information on the costs of covered items and procedures, is being implemented in roll-out phases over the next two years. Some of the TiC and NSA requirements overlap, and federal agencies have also been active in coordinating and aligning implementation mandates between now and 2024. While this is good news, the complexity and burden of various federal regulatory regimes will continue.

SURPRISE BILLING IMPLEMENTATION

Even with several rulemaking releases from the federal departments, implementing the NSA is proving burdensome to self-insurance health plans and participants. According to Mike Orth, principal, LaunchPad Health, "The new federal requirements are bringing about a significant transformation in how self-insured plans operate with the impact felt by everyone, including employers, TPAs, and vendors. Plans must now identify surprise billing claims and calculate a QPA."

"With the NSA administrators/payors, on their own and behalf of their clients, have to change systems and processes—in most cases relying on third party vendors to get it right the first time," said Bill Green, chief executive officer, Homestead Smart Health Plans. "We have been working on this since before the IFRs came out and it will be a challenge for most teams to get this right out-of-the-box. We will act in good faith and iterate for another twelve months is my guess. Our mission is to make sure our clients, the plans, have all they need from us to be successful and stay out of regulatory issues."

For Lance Lankford, vice president, Lockton Companies, "If [self-insured health plans] are fully aware of their obligations, I think they are overwhelmed given the extent of what they have to provide. There will be a lot of reliance on consultants to assist these groups, particularly as the rules are implemented and then defined and enforced."

"While much of the industry talks about the NSA, there are also requirements plans must meet under the Transparency in Coverage rules and the broader Consolidation Appropriations Act," said Orth. "These include a price transparency tool, which requires detailed cost estimates provided to members in real-time, and goes beyond the capability most plans have in place today."

A huge concern for self-insured plans is that the IDR portal is not yet active, even though the time period for the first claims to go to arbitration is fast approaching. The IDR portal will be an internet access point where insurers or providers can request arbitration and be assign IDR entity.

According to Orth, "Implementing these requirements have been especially difficult for self-insured plans in part due to the innovative network approaches we see in the self-insured space. For example, some of my clients have a network that is a combination of multiple networks managed by different vendors, such as direct contracts, a rental network, reference-based pricing, out-of-area wrap, and gap-fill. Calculating a single QPA based on contract data from these various vendors, and then defending the plan's payment in IDR is proving to be an extremely complex and resource intensive implementation."

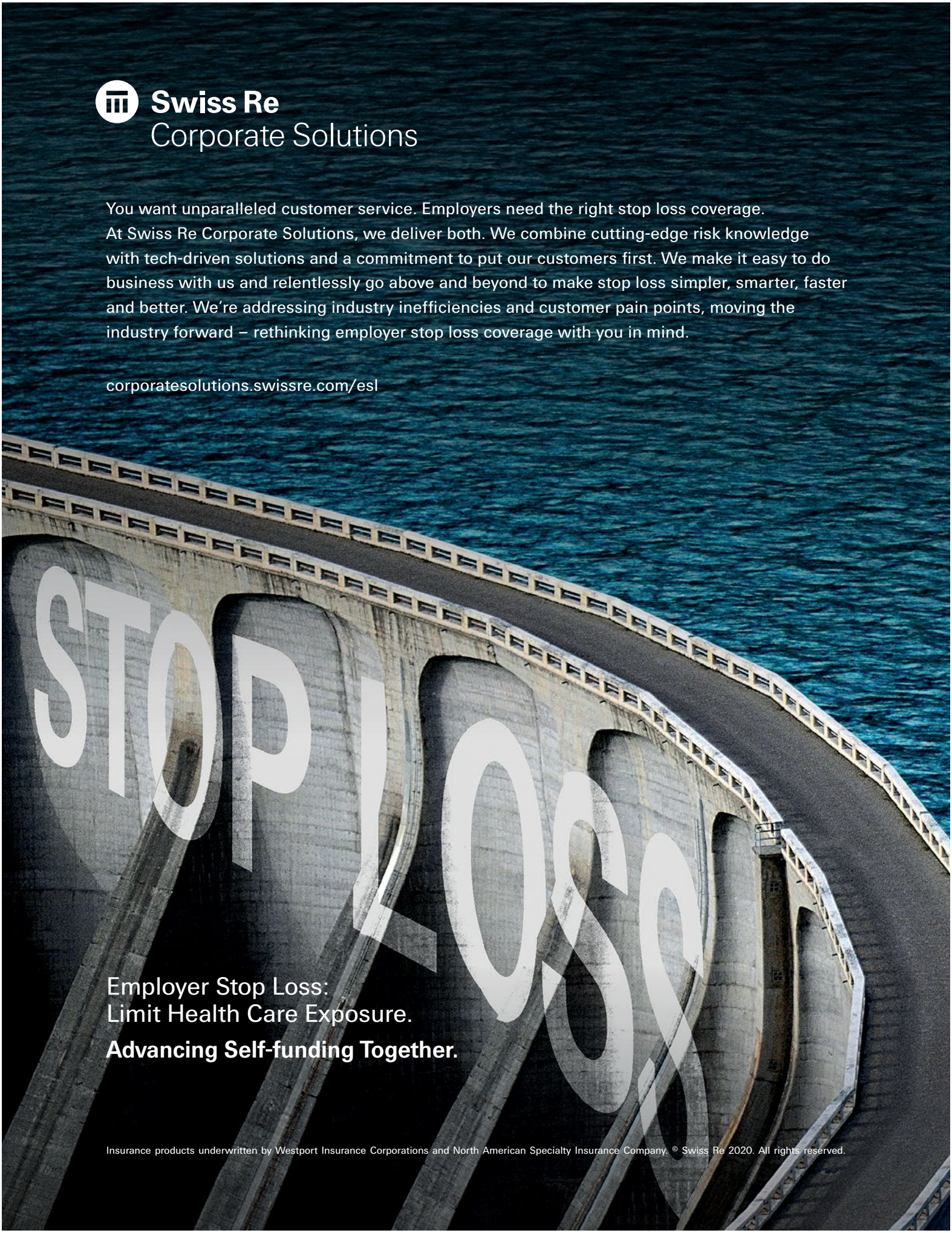
In an effort to help members implement these new policies, SIIA held the Price Transparency Forum on March 1 in Dallas, Texas. This Forum was an opportunity for those involved in self-insurance to get a better understanding of the rules and to network with peers about implementation strategies. According to Green, "Attendees and SIIAs members are all taking this seriously and we all feel under the gun."

"Very few health plans are fully prepared for these new regulations," said Orth. "This conference was timely in that our industry was able to come together at this critical time for implementation and exchange thoughts on best practices."

COMPLICATING MATTERS

While the NSA was passed as an overwhelmingly bipartisan bill by Congress and has the support of both patients and health insurance plans, the QPA section of the IFR has seen major pushback from health providers, provider networks, and their trade associations. At least six lawsuits have been filed on behalf of providers with one decision having already been handed down.

The U.S. District Court for the Eastern District of Texas decision handed down in late February regarded a suit brought by the Texas Medical Association (TMA) against the U.S. Department of Health and Human Services. The issue at stake is a rule regarding the independent dispute resolution (IDR) process and the rebuttable presumption factor within the QPA, TMA arguing that the rule is inconsistent with the legislative intent of the NSA. The judge agreed with the plaintiff and vacated the related provisions.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While the whole of the IDR process can continue as planned to resolve payment disputes, the court's decision vacated the rule that gave guidance to IDR entities related to calculating payments. If the arbiter can't use the QPA as a primary factor for determining arbitration outcomes, providers could use the process to argue for higher out-of-network payments, defeating the purpose of the NSA. This could cause higher reimbursement rates and inflationary pressures on the cost of healthcare.

"This adds yet another wrinkle on top of an already difficult implementation," said Orth, "Not to mention the short turnaround time plans have had to prepare for the IDR process. Self-Insured plans feel very strongly that the QPA will almost always reflect fair-market reimbursement rates, so it's concerning that arbiters will no longer be tied to this value. Plans are particularly concerned about an increase in the volume of IDR cases, which would inevitably lead to higher costs for consumers.

According to Lankford, "[This decision] will create more uncertainty. Prior to the decision, there was at least a belief that to move away from the QPA (however determined) would require some significant justification and reasoning. I still feel the QPA will be a significant factor in the final determination of the IDR but the initial certainty around that aspect of the process will be missing until that issue is resolved, most likely by the higher courts."

Four of the other lawsuits—filed in Washington, D.C., Illinois, and Georgia—make arguments similar to what the TMA claimed. Briefings have been held in the two cases located in Washington, D.C. with hearings to be scheduled soon. An additional lawsuit, filed in New York, makes some of the same arguments as the other lawsuits, but takes the claim further arguing that important sections of the NSA are unconstitutional and that Congress does not have the authority to legislate protection of patients from surprise balance billing.

PRICE TRANSPARENCY COMMITTEE

While SIIA has been working on price transparency concerns for a number of years, the association recently converted its Price Transparency Task Force into a formal committee. The members of the Price Transparency Committee (PTC) bring to the table years of expertise in self-insured health plans. As federal agencies work to finalize the rules for the NSA and deal with other price transparency rulings, the members on the PTC will be able to offer their shared experience.

"There will be a significant need for targeted knowledge and expertise to work with our legislators in implementing the NSA and other related legislation. The Committee can serve as a funnel for all of the issues, expertise and knowledge available from the members of SIIA to try and ensure the legislation addresses the needs of employer groups and other constituents and also works from a practical perspective once implemented," said Lankford.

"Our committee is closely monitoring the rulemaking process and communicating developments back to the rest of our industry," offered Orth. "Facilitating communication between industry and regulators is essential given that these laws have a signification impact on all of us."

For Green, the committee will offer an on-the-ground perspective. "It will assist members and regulators in understanding what is actually happening. Also, it will be able to suggest comments on new rules and proposed regulations when they come out, in part based on our shared experience. The committee can also help shape policy through SIIA's government relations team."

All three persons interviewed for this article were involved with the task force and are now members on the PTC. While they all support the focus of the committee, they are also hoping to bring more to the table. For Orth, "My focus is on helping SIIA members understand these rules while also listening to their questions and concerns and finding impactful ways to share this information with regulators."

Green would like, "To see us develop a set of best practices we can share with members. Perhaps develop a training or certification program member firms may point to when dealing with regulators and IDR entities."

"I hope that the committee is used by SIIA members as a sounding board and a resource to get concerns, questions and issues addressed so that we can pass this on to legislators and others involved in the creation and development of these various rules," said Lankford. "Ultimately, we can work together to ensure the clients and their members that we work with to save money and find the best care."

THE FUTURE OF PRICE TRANSPARENCY

The road to making price transparency an effective tool for consumers and insurers will bumpy. In the long run, price transparency legislation should work as intended, but for now the changes are burdensome for an already burdened industry.

As court decisions come in and rule-making becomes finalized, self-insured health plans will better be able to adapt to the new rules.

For Lankford, "The more information available to plans and their members as to the costs and quality of care, the better. That being said, the information will only work to that end if it is used and applied effectively. The users of the information need to have ready access to it and be able to decipher it and use it in the way it is intended, or price transparency will not do what it is intended."

Orth sees both short-term and long-term changes for the positive. "Some effects will take more time than others. For example, consumer protections will be felt more immediately, like banning surprise balance billing and ensuring consumers have access to accurate provider data," said Orth. "Requirements intended to drive costs down will take more time. For example, plans will be required to reveal in-network contract data starting in July, which will hopefully drive down costs as price variation becomes more evident. However, it's going to take time for data aggregation services to pull this information together and present it in a useful manner."

Green has a more jaundiced view of the outcome of these price transparency rules. "I think there will be some change in the short term, but providers will learn to game the new system. The law of unintended consequences is the law. For example, since the third party databases that can provide a QPA are based on billed charges claims data all providers will need to do is keep increasing the chargemaster over time to increase the amount they receive in arbitration. I don't think that is what the legislation intended. I don't think we will see the use of that data changing consumer choice in the near or medium term."

"These laws are ultimately a positive development for our industry, because they provide members with the basic tools they need to make more informed decisions about their care," said Orth. "[These laws have] the potential to drive down costs for plans. However, data itself will not drive consumerism in healthcare. We need to go beyond transparency and find ways to incentivize consumers to shop for the highest quality care at the lowest price. Transparency tools and incentives are key to driving costs down. This is just the first step."

Bill Green, Mike Orth, and Lance Lankford will be panelists on this topic at SIIA's Spring Forum in Orlando, Florida, where SIIA members can learn more. ■

Karrie Hyatt is a freelance writer who has been involved in the captive industry for more than ten years. More information about her work can be found at: www.karriehyatt.com.

KEY FEDERAL PRICE TRANSPARENCY DEADLINES

Currently in Effect

- NQTL comparative analysis/ mental health parity
- Data-sharing/prohibiting contracting "gag clauses"
- Direct/ Indirect Broker Compensation Disclosure

Good Faith Compliance

- Updating and improving provider directories
- Insurance Card Disclosure of INN/ OON Deductibles & Out of Pocket Limits
- Notice of continuity of care

Upcoming Compliance Deadlines

- Price comparison tool (combined with TIC cost-sharing tool) - 2023
- AEOB and provider "good faith" estimate notification (future guidance)
- Rx Data (reports due Dec. 27, 2022 and June 1, 2023)
- Disclosure of INN rates and OON allowed amounts – July 2022
- dedicated "Rx Drug File" Price Disclosure – Compliance Delayed
- Cost-sharing liability tool - Jan. 1, 2023 - Jan. 1, 2024 effective dates