Scott A. Sinder
202 429 6289
ssinder@steptoe.com

1330 Connecticut Avenue, NW
Washington, DC 20036-1795
202 429 3000 main
www.steptoe.com

Steptoe

December 21, 2020

M E M O R A N D U M

TO: **The Council**

FROM: **Scott Sinder**
Kate Jensen

RE: **2021 Omnibus – Initial Analysis of the "No Surprises Act" & Related Health Care Transparency Provisions**

The year-end package includes the long-awaited "surprise medical billing" fix. The surprise billing provisions are designed to protect consumers from surprise medical or "balance" bills from out-of-network (OON) providers in certain situations. The final package also includes several new transparency requirements, most notably a broker disclosure obligation that encompasses all brokers and consultants to an employer health plan (including service providers like third-party administrators and pharmaceutical benefits managers) and that requires up-front disclosure of any compensation expected to be received (both directly and indirectly) in connection with services provided to that plan

The most contentious piece of the "surprise billing" legislation was the payment resolution mechanism that would apply when providers and payors cannot agree on the amount of the payment. Providers favored a strict arbitration process; payors favored a price benchmarking approach. As detailed below, the legislators took an arguably middle ground approach based on the initial establishment by each payor of a "qualifying payment amount" which is the median price of the payments they have contracted to make for the same item or service in the same geographic region to in-network providers.

When OON services covered by the new law are provided, the payor can respond to the initial request for payment by offering to pay the pertinent "qualifying payment amount". If after a negotiation period the parties cannot agree on a payment amount, the dispute is submitted to a special arbitrator who in resolving the dispute must first consider the applicable "qualifying payment amount" and the information submitted by the disputing parties about why deviations from that amount are warranted.

Both payors and providers have lodged objections to the approach but it should create some stickiness for those median contracted rates as they will be the point of departure for both the covered OON payment discussions and dispute resolution process.

All of the balanced billing provisions take effect on January 1, 2022 and there will be extensive rulemaking proceedings during the first half of 2021.

The details of the "No Surprises Act" and the related transparency provisions are discussed in detail below.

Analysis

1. "No Surprises Act"

Patient Balanced Billing Protections

Specifically, the new law caps cost-sharing obligations for patients who receive OON care to their applicable in-network levels (and requires plans to make up the difference) in the following circumstances:

- For emergency services performed by an OON provider and/or at an OON facility and for post-stabilization care after an emergency if the patient cannot be moved;

- When non-emergency services are performed by OON providers at in-network facilities (includes hospitals, ambulatory surgical centers, labs, radiology facilities and imaging centers); and

- For air ambulance services provided by OON providers.

These first two sets of requirements apply to facility-based providers, including hospital emergency departments and independent free-standing emergency facilities for the emergency services provisions, and hospitals, hospital outpatient departments, critical access hospitals, ambulatory surgical centers, and any other facilities specified by the Secretary of the Department of Health and Human Services (HHS) for the non-emergency services provisions.

There is an exception to the balanced billing prohibition for non-emergency services performed by OON providers at in-network facilities if the providers do not provide "ancillary services" which are defined to include:

- emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- items and services provided by assistant surgeons, hospitalists, and intensivists;
- diagnostic services unless they are exempted by rule; and
- items and services provided by non-participating providers if there are no participating providers at the same facility who can furnish such items or services).

The rule barring balanced billing applies for non-"ancillary services" providers unless the patient receives at least 72 hours in advance of the appointment (or for appointments made within the 72 hour window, on the same day on which the appointment is made) oral and written notification that includes the following:

- Notification of the provider's OON status;
- A statement that consent to receive such services from an OON provider is optional and that the services may be received from a provider that can do so under the in-network cost structure;
- A good faith estimate of the amount the patient will be charged if s/he consents; and
- In the case of an OON facility, a list of any in-network providers at that facility who can provide the same item or service.

The patient also must sign the notice to consent to the treatment by the OON provider and the patient must be provided a copy of the signed consent form.

States may impose other OON provider obligations that go above and beyond the federal statutory requirements. States also are charged with enforcing the federal provider requirements and providers are subject to penalties of up to $10,000 per violation. HHS has authority under the statute to enforce the provider requirements in any State in which the State opts not to do so itself. The Department of Labor also has enforcement authority if it identifies patterns of balanced billing violations under a group health plan or group insurance coverage offered by a health insurer.[1]

Determining The Amount The Plan/Insurer Must Pay To The OON Facility/Provider

To determine the amount the patient's plan owes the provider(s) when the OON rules apply, the legislation imposes three different rules –

1. If the care is provided in a State that has a law in place that would apply on its own terms to determine the amount the plan would owe to the provider, the State law applies;
2. If the care is provided in a State that participates in the All-Payer Model Agreement, then the amount the Sate approves under that system (it is our understanding that there are only two current adopters of that Model Agreement – Maryland and Vermont) and
3. If there is no applicable State rule, then the law lays out a process for determining the appropriate out-of-network rate to be paid.

For care provided in States with no applicable rule and for air ambulance services disputes, the law prescribes the following process:

1. The provider or facility submits an invoice to the care recipient's insurer or health plan for payment for the items or services received;

[1] There also are plan participant protection provisions restricting health insurers and plans from restricting access to in-network pediatric and ob/gyn care and from imposing any pre-authorization or referral requirements for such care.

2. Within 30 calendar days after receiving that invoice, the insurer/health plan must send an initial payment to the provider or issue a notice of denial of payment;
3. During the 30 days after the initial payment or the notice of denial of payment is received, the provider, facility, insurer or health plan may initiate open negotiations in an effort to agree on a payment;
4. Within 4 days after the expiration of the 30-day negotiation period, any of the parties may initiate the new formal Independent Dispute Resolution Process (IDR) by submitting a notice to the other party and to HHS;
5. Within 3 days after the IDR initiation notice has been provided, the parties must jointly select a certified IDR entity (if the parties cannot agree, then HHS will select the IDR entity);
6. Within 10 days after the date the certified IDR entity is selected, the parties shall each submit an offer for a payment amount for the item or serviced furnished by the provider or facility and supporting information;
7. Within 30 days after the date the certified IDR entity is selected, the IDR entity is required to issue its payment determination by selecting one of the offers for payment submitted by the parties (so-called "baseball style arbitration");
8. The IDR determined payment must be made within 30 days of the rendering of that determination.

The amount that the insurer/health plan is required to pay initially if it does not issue a denial of payment is the "qualifying payment amount" for that item or service within that same geographic region. The "qualifying payment amounts" are the median payment amounts for the same/similar items or services paid by the insurer or the plan within the same "insurance market" within the same "geographic area." Self-insured plans are defined as a separate "insurance market" (along with the individual, small-group and large-group markets). There will be audit processes for reviewing "qualifying payment amounts" on both a random basis and in response to provider complaints.

If the payment amount is disputed and the IDR process is followed, the IDR entity is required to determine the applicable "qualifying payment amount" and other additional information. In a change from prior drafts, the IDR entity must consider any of the following information if it is submitted:

- the level of training, experience and quality and outcomes measurements of the provider or facility;
- the provider/facilities market share in the geographic region in which the item or service was provided;
- the acuity of the individual receiving the item or service and the complexity of furnishing it; whether the providing facility is a teaching facility; and
- demonstrations by the parties of the extent to which they engaged in good faith efforts to enter into network agreements.[2]

[2] The factors vary slightly for air ambulance payment disputes as vehicle type (including clinical capability level) and population density of the pick up location also are required to be considered.

The law also explicitly bars the IDR entity from considering the amount the provider invoiced, o the provider's "usual and customary charges" or the amount public payors pay for the item or service in the course of making its determination.

A few other points are worth noting:

- The IDR entity's decision is final and generally may not be appealed.
- The parties may batch together in a single proceeding similar items and services for which there is a payment dispute in the same geographic market. One important issue for self-insured plans that we plan to address during the rulemaking proceedings is whether they can jointly participate in the batching process if they are all utilizing the same preferred provider network and contracted provider rates within that network.
- The same parties may not commence another IDR process for the provision of an item or service within 90 days of receiving an IDR payment determination for the same item or service (although they may commence a new IDR process for those items or services after that 90 day period concludes even for items or services provided before or during that 90 day window).
- The "losing" IDR party (i.e. the party whose payment amount offer was not selected) must pay the IDR entity costs/fees.
- All IDR parties will be assessed a program fee by HHS to cover the HHS costs of administering the program.
- All of the details of the process are subject to agency rulemakings with a statutory deadline for putting the initial rules in place of July 1, 2021.
- HHS is required to publish information on a quarterly basis reporting on all of the details of the payment disputes resolved through the IDR process (number; sizes of the participating parties; extent to which the final payment determination varied from the "qualifying payment amount"; the amount of HHS's administrative fees and the total fees paid to certified IDR entities).

Other "No Surprises Act" Provisions

The bill includes several new transparency obligations for group health plans and health insurance issuers:

- On any physical or electronic plan and on insurance identification cards, the amount of the in- and out-of-network deductibles and the out-of-pocket maximums that apply to such plan or coverage and plan telephone number and website contact information all must be disclosed;

- An advance explanation of benefits must be provided to a requesting health care provider or facility or to a requesting plan participant, beneficiary, or enrollee that states whether the provider or facility is in-network for the item or service to be provided, the contracted rate for that item or service, a description on how an individual may obtain the item or service from an in-network provider.

- Price comparison guidance which must be offered by telephone and made available on an internet website of the plan or issuer that enables an enrolled individual to compare the amount of cost sharing for which s/he would be responsible for paying with respect to the furnishing of specific items or services by any provider.

- Establish processes to update and verify provider directory information at least every 90 days; respond within 1 day to enrollee questions about providers' in-network status; and maintain on a public website a database of all in-network providers and facilities and directory information for each of them. The plan must pay any extra costs that would be incurred by an enrollee that relies on any inaccurate directory information.

- In addition to plans/insurers, healthcare providers and facilities all must make publicly available information about the federal law's (and any applicable state's) prohibitions and rules on balance billing and contact information for appropriate state and federal agencies to report any problems.

Providers also are required to inquire of each individual requesting treatment whether they are enrolled in a plan and to provide notice of a good faith estimate of the expected charges for furnishing the requested item or service.

The bill also directs several studies to be conducted, including a study on the effects of the Act and its impact on provider and plan integration, overall health care costs, and access to care, and a separate study on the impact of the Act on network participation, State surprise billing and network adequacy requirements, access to providers and health insurance plans (premiums, out-of-pocket costs and network adequacy). The GAO also is directed to undertake separate, stand-alone studies on the adequacy of provider networks and on the performance of the IDR process.

And finally, the bill establishes several advisory committees including committees on:

- State All Payer Claims Databases standardized reporting formats (there also is $50 million authorized to assist States with the establishment of such Databases)

- Ground Ambulance Services and Patient Billing

2. Beyond The "No Surprises Act" – Other Transparency Requirements for Brokers and Others

Broker/Consultant compensation disclosures

Consistent with language in a prior Senate HELP Committee bill, the package requires disclosure of direct and indirect compensation by brokers/consultants who:

- Enter into a contract or arrangement with a group health plan; and
- Reasonably expect to receive at least $1,000 in direct or indirect compensation (whether paid to the broker, an affiliate, or subcontractor) for any of the following services:

- Brokerage services (e.g., help with selecting insurance products, recordkeeping services, benefits administration, wellness services, compliance services, TPA services, etc.); or
- Consulting (e.g., development or implementation of plan design, insurance product selection, medical management services, TPA services, PBM services, etc.).

The disclosure must be provided in writing to a responsible plan fiduciary "not later than the date that is reasonably in advance of the contract date" and any extension/renewal date, and must include:

- A description of the services to be provided to the plan;
- *If applicable*, a statement that the broker/consultant plans to offer fiduciary services to the plan;
- A description of all direct compensation the broker expects to receive (in the aggregate or by service);
- A description of all expected indirect compensation (including: vendor incentive payments, a description of the arrangement under which the compensation is paid, the payer of the compensation, and any services for which the compensation will be received);
- Separately, any transaction-based compensation (e.g., commissions, finder's fees) for services and the payers and recipients of the compensation; and
- A description of any compensation the broker/consultant expects to receive in connection with the contract's termination (and how any prepaid amounts will be calculated and refunded upon termination).

The "descriptions of compensation" may be expressed as a dollar amount, a formula, or a per capita charge for enrollees. If these methods cannot reasonably be used, the broker may use a good faith estimate and supporting explanation, methodologies, and assumptions.

Brokers/consultants have 60 days to update the disclosure based on new information. They also must provide, upon request from a plan fiduciary or administrator, "any other information relating to the compensation received in connection with the contract or arrangement." Good faith errors and omissions in the disclosure will not be considered a violation if they are corrected within 30 days of the broker/consultant becoming aware of them. Plan fiduciaries must report brokers/consultants to the Department of Labor if they do not comply with these requirements.

These new disclosure requirements go into effect one-year from the date of enactment, which should roughly be January 1, 2022.

Other transparency requirements

Within one year of enactment of the law and annually thereafter, the law requires group health plans/issuers to report to multiple federal agencies on their pharmacy benefits and costs, and costs of other healthcare services; specifically, among other things:

- Number of enrollees
- States in which the plan is offered

- 50 most common brand prescription drugs dispensed by pharmacies for claims under the plan and the total claims paid for each drug
- 50 most costly drugs by total annual spending and the annual amount spent for each of the 50 drugs
- 50 drugs with the greatest year-over-year cost increase for the plan and the change in amounts paid by the plan
- Total spending
- Total spending by the plan broken down by:
  - Types of cost (e.g., hospital, primary care, specialty care, provider and clinical service costs, prescription drugs, wellness) and
  - Plan and enrollee spending on prescription drugs
- Average monthly premiums paid by the employer and the enrollees
- Impact on premiums and out-of-pocket costs associated with rebates, fees or other payments by drug manufacturers to the plan or the plan's administrators, and certain specifics about those rebates/payments.

Finally, the legislation prohibits providers, TPAs, and other network service providers from banning/contractually prohibiting:

- provision of provider-specific cost or quality of care information;
- electronic access to de-identified claims and encounter information for each enrollee in a plan; or
- sharing of the above information/data with business associates in accordance with HIPAA standards.