Georgetown University Health Policy Institute

CENTER ON HEALTH INSURANCE REFORMS

Implementing the No Surprises Act: Implications for States

NAIC Regulatory Framework Task Force

July 28, 2021

Jack Hoadley and Katie Keith

About Georgetown's Center on Health Insurance Reforms (CHIR)

- A team of experts on private health insurance and health reform
- Conduct research and policy analysis, provide technical assistance to federal and state officials and consumer advocates
- Based at Georgetown University's McCourt School of Public Policy
- Learn more at https://chir.georgetown.edu/
- Subscribe to CHIRblog at http://chirblog.org/
- Follow us on Twitter @GtownCHIR

Georgetown University Health Policy Institute

CENTER ON HEALTH INSURANCE REFORMS

No Surprises Act: An Overview

- Public Law 116-260, signed December 27, 2020
  - Included in the Consolidated Appropriations Act, 2021

- Most provisions are effective for plan years beginning on or after January 1, 2022

- Bars out-of-network bills in emergency and certain non-emergency situations and by air (but not ground) ambulances
  - Patients responsible for in-network cost sharing only
  - Cost sharing payments count toward the in-network deductible and out-of-pocket limit

- Federal officials must undertake significant amount of rulemaking and create new systems for complaints and independent dispute resolution (IDR)

Georgetown University Health Policy Institute
CENTER ON HEALTH INSURANCE REFORMS

Federal Rulemaking Process

- First quad-agency interim final rule (IFR) released on July 1, 2021
  - Issued by HHS, Treasury, Labor, and OPM
  - Included draft standard notice and consent waivers, model disclosures for patients
  - Effective date of the IFR: September 13, 2021

- IFR focused on both patients and regulated entities
  - Patient-focused provisions = how to calculate cost-sharing, notice-and-consent waivers, complaints process
  - Regulated entities-focused provisions = how to calculate the qualifying payment amount, disclosure requirements, communication between insurers and providers

- More federal rules are coming (more to come on that)

Scope of Protections: Insurers

- The No Surprises Act **applies** to:
  - Health insurers offering group or individual health insurance coverage
  - Grandfathered and grandmothered (or transitional) plans or policies
  - Student health insurance
  - Traditional indemnity plans
  - Self-funded group health plans
  - Non-federal governmental plans
  - Church plans
  - Federal Employees Health Benefits Program coverage

- The No Surprises Act **does *not* apply** to:
  - Short-term limited duration insurance, excepted benefits, account-based plans (e.g., HRAs), retiree-only plans

Scope of Protections: Providers

- **Emergency care provided in in-network or out-of-network facilities**
  - Statute includes EDs and independent free-standing EDs
  - IFR extends to urgent care centers licensed by state for emergency services
- **Post-stabilization services until the patient can travel using nonmedical or non-emergency medical transportation**
  - Protections apply regardless of *where* in a hospital the services are furnished
  - Strong patient protections for waivers in these circumstances - patient must be able to travel using nonmedical/nonemergency transportation, patient gives informed consent, in-network facility is within a reasonable distance, no unreasonable travel burdens, etc.
- **Air ambulance services**
  - Includes helicopters, fixed-wing air ambulances, inter-facility transports
  - Includes plans or coverage that cover air ambulance benefits (even if no current in-network air ambulance providers)

Scope of Protections: Providers

- **Non-emergency care at in-network facilities provided by out-of-network providers**
  - Definition of health care facility
    - Statute defines facilities as hospitals, hospital outpatient departments, critical access hospitals, and ambulatory surgical centers
    - IFR does not identify additional types of facilities but poses questions about urgent care centers, retail clinics
  - Definition of in-network facility as direct/indirect contractual relationship with a plan or issuer for nonemergency care
    - IFR: single case agreements are included
  - Protections extend to the entire "visit" to an in-network facility
    - Includes devices, imaging services, lab services, etc. for in-network care even if those services are provided by out-of-network providers

Notice and Consent Provisions

- Patients can knowingly and voluntarily agree to be balance billed by out-of-network providers but only for:
  - *Non-emergency* care from an out-of-network provider
  - Out-of-network *post-stabilization* services

- Protections <u>cannot</u> be waived:
  - When there is no in-network provider available
  - For urgent or unforeseen care
  - When services are delivered by providers in designated specialties, e.g., anesthesiology, radiology, hospitalists, intensivists
    - IFR did not identify additional providers that cannot ask for a waiver
  - For post-stabilization services except as noted above

Notice and Consent Provisions

- Statute requires at least 72-hour advance notice for consent waivers
  - IFR clarifies that consent must be obtained at least 3 hours before time of appointment if appointment occurs within 72 hours of scheduling
- Content of the notice and when it must be obtained
  - E.g., Providers and facilities must include a good-faith cost estimate, inform patients of the option to seek or ask for in-network care, and provide a list of in-network providers at the facility
  - E.g., Forms must be translated into 15 most common languages in the state (with some flexibility) and cannot be buried with other documents
  - E.g., Patients can refuse to provide or revoke consent at any time
- IFR accompanied by a draft standard notice and consent form
  - Seeking comment; interest in potential models in use by states

Qualifying Payment Amount

- Defined in statute as the median of the plan or insurer's contracted rates for the item or service in that geographic region
- Relevant as the basis for cost sharing (coinsurance and under the deductible) where no specified state law applies
- Used as a factor in the federal IDR process
- IFR spells out definitions and methodology
  - Minimizes influence of outlier prices that could skew QPA higher
  - Reduces need to rely on alternative methods to calculate QPA where insurer has insufficient information
  - Did not choose adopt to base regions on QHP rating areas
  - Uses larger regions based on MSAs and non-MSA areas in a state

Specified State Laws

- "Specified state law" is one that provides for a method for determining the amount of payment to an out-of-network provider (whether payment standard or arbitration)
  - State method used to determine payments for health plans regulated by the state and services to which state law applies
  - State method also used to determine cost-sharing amounts
- IFR: States with self-funded opt-in programs can maintain those programs
- If state law does not apply, the No Surprises Act applies
  - Cost sharing will be lesser of the QPA or a provider's billed charges
  - Payment disputes will be resolved under the federal IDR process

Enforcement on Insurers

- State departments of insurance are the primary enforcers of provisions that apply to insurers and fully insured health products
- Federal government enforces in states that fail to substantially enforce the law (HHS) and for self-funded group health plans (DOL)
- HHS proposes a consolidated complaints process for patients that have been balance billed
  - Seamless way to file complaints, without a patient needing to know whether their balance bill falls under state or federal jurisdiction

Enforcement on Providers

- Same framework for enforcing the provisions that apply to providers (including air ambulances)
  - State officials are responsible for enforcing the provisions against providers but HHS will do so where a state chooses not to or fails to substantially enforce the law
  - HHS can impose civil monetary penalties of up to $10,000 per violation if a provider sends a balance bill that violates the law (penalties can be waived in certain circumstances)

- Law is silent on which state agency is responsible for enforcing provider provisions – unless addressed through rulemaking

Other Issues Addressed in the IFR

- Regulated entities must comply with new notice requirements:
  - Post a publicly available notice about the NSA's protections on websites and on EOBs for out-of-network care
  - Prominently display this information in a publicly accessible location (for providers and facilities)
  - IFR accompanied by a draft model disclosure form → Urges states to develop model language to convey state-specific requirements
  - Air ambulances do not have to make the same disclosure but are encouraged to provide clear, understandable info about the law
- Guardrails on initial payment amount for out-of-network services
- Disclosures about the QPA

Key Considerations for States

- **Scope of Protections.** State laws can be more consumer protective, as long as they don't "prevent the application of federal law." Example provisions where some state laws differ
  - IFR clarifies that state provisions that do not allow waiver of protections by the consumer are allowed
  - IFR recognizes that state laws vary on the scope of providers covered (out-of-network facilities, certain specialties)
  - Federal law is generally more protective for post-stabilization services

- **Enforcement.** Are states prepared to enforce these requirements on both insurers and providers (including air ambulance providers)?

Key Considerations for States

- **Specified State Law.** Which state laws qualify as a "specified state law" and when would they apply? IFR determines applicability in specific scenarios, such as:
  - Federal method applies for items or services not state regulated
  - Federal method applies for claims involving multiple states
  - State method applies where laws allows opt-in by ERISA plans
- **Cost Sharing Protections.** Cost sharing is also determined under state laws
  - Especially relevant for coinsurance and under deductibles
  - Do states allow arbitration decisions to change cost sharing?
  - Do state rules for in-network medians rates differ from federal QPA?

Future Steps for Implementation

- We anticipate **at least two more rules** in 2021:
  - Independent dispute resolution process (interim final rule)
  - Enforcement and air ambulance data reporting (proposed rule)

- Additional rulemaking will occur over time on other No Surprises Act requirements such as accurate provider directories, gag clauses, PBM reporting requirements, etc.
  - No rulemaking before 2022 effective date, but entities must still comply and adopt a good faith, reasonable interpretation of the statute

Resources

Jack Hoadley, Research Professor Emeritus, jfh7@georgetown.edu

Katie Keith, Associate Research Professor,
katie.keith@georgetown.edu

Georgetown University Center on Health Insurance Reforms

Website: https://surprisemedicalbills.chir.georgetown.edu/

Health Affairs blog on IFR:
https://www.healthaffairs.org/do/10.1377/hblog20210706.903518/full/

Commonwealth Fund blog with link to detailed summary of law:
https://www.commonwealthfund.org/blog/2020/surprise-billing-protections-cusp-becoming-law

Website on surprise medical bills:
https://surprisemedicalbills.chir.georgetown.edu/

Georgetown University Health Policy Institute
CENTER ON HEALTH INSURANCE REFORMS