CAA Requirements: Implications for Health Plans, Employers, Providers, and Consumers

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United Healthcare

Consolidated Appropriations Act (CAA)

CAA – No Surprises Act	Overview	Date
Surprise Medical Billing	Addresses member cost-sharing, balance billing and Independent Dispute Resolution (IDR) for OON emergency services, certain OON providers and INN facilities, and air ambulance. The law applies to medical bills for covered services related to 1) OON emergency at a hospital or facility; 2) items and services provided by certain OON health care providers at an INN facility; 3) OON air ambulance	Plan years on/after 1/1/22
Independent Dispute Resolution (IDR)	Process to settle disputes related to reimbursement for No Surprises Act services. IDR involves a neutral third party that settles reimbursement disputes between parties. Party that loses IDR pays the other party's IDR expenses. Requires extensive knowledge of law, data, reporting, analysis, reporting, and brief preparation.	Plan years on/after 1/1/22
Plan ID Cards	Requires INN and OON deductible and out-of-pocket maximum on ID cards. Requires phone numbers and the website address where members may obtain support and network facility and provider information. Plans are asked to use good faith and reasonable interpretation to meet 1/1/22 dates.	Plan years on/after 1/1/22
Patient Protections: Advance Cost Estimate (ACE) External Appeals	Providers must ask patients if they have coverage when scheduling appointments and send estimated service/cost notice to insurer/plan. Then insurer/plan sends an Advance Cost Estimate (ACE) to member with estimated member responsibility. On hold pending future rulemaking. Insurer/plan required to offer external review for surprise bill member disputes.	Pending rulemaking Plan years on/after 1/1/22
CAA – Transparency	**Overview**	**Date**
Removal of Gag Clauses	Health care contracts shall not prohibit electronic access of provider information, access to de-identified claims and encounter information or sharing information with others. Plans are asked to use good faith and reasonable interpretation to meet 1/1/22 dates.	Attestation required 12/28/21
Broker Compensation Disclosure	Direct and indirect compensation information must be disclosed to employer prior to purchase. Broker discloses to group plans; carrier discloses in individual market.	Effective 12/27/21
Pharmacy Benefits and Costs Reporting	Requires insurers/health plans to annually report information on prescription drug benefits and costs to the Tri-Agencies. Report on hold pending additional guidance in 2022.	Pending rulemaking
Mental Health Parity NQTL Reporting	Insurer/plans must develop and disclosure to state and federal regulatory agencies information on NQTLs upon request. Insurer create report for fully insured plans.	Effective 2/10/21

CAA Topics- Focus For Today's Discussion

- Advance EOBs
- Provider Directories
- Mental Health Parity
- Surprise Billing

Advance EOBs

- Insurers and plans that receive a notice from a provider or facility that a member has scheduled services are required to provide an advance Explanation of Benefits (EOB) to the member. The notice can be in writing or electronic at the option of the member. The federal agencies have delayed enforcement pending release of future rulemaking.
- The EOB must disclose the following:
  - Whether the provider/facility is in-network
  - If the provider/facility is out-of-network, how the member can obtain information on in-network providers/facilities
  - The provider's good faith estimate of the charges
  - A good faith estimate of what the member would be expected to pay
  - A good faith estimate of the member's cost-sharing accumulation to date
  - Whether the item/service is subject to any medical management requirements
  - A disclaimer that the cost-sharing amounts are estimates
- The notice must be provided to the member 1 business day after the insurer/plan is notified by the provider. If the service is scheduled at least 10 business days in advance or if the member requests the EOB, the insurer/plan must provide the notice no later than 3 business days after the provider/facility notice or member request.

Provider Directories

- Federal requirements apply to health insurance issuers in the individual and group markets and group health plans, effective for plan and policy years on or after 1/1/2022
- Federal requirements do not preempt state provider directory requirements
- Insurers/plans must establish:
  - Verification process
  - Response protocols for member inquiries
  - Provider directory database
- Creates obligations for providers to submit information to insurers and plans when they join a network, terminate network status or there is a material change
- Insurers and plans must verify and update provider directory information in the database not less frequently than once every 90 days; information is removed if not verified
- Insurers and plans must update “material changes” two business days after receipt of information from providers
- If a member receives inaccurate information through the database, a provider directory or in response to an inquiry about the network status of a provider or facility, member cost-sharing is treated as in-network if the item or service would have been covered in-network

Mental Health Parity

- Health insurers in the individual and group markets and group health plans must perform and document comparative analyses of the design and application of Non-Quantitative Treatment Limits (NQTLs)
- The analyses must include:
  - The plan or coverage terms related to NQTLs;
  - Factors used to determine the application of NQTLs to behavioral health and substance use disorder benefits;
  - Evidentiary standards for the factors; and
  - Comparative analyses with NQTLs for medical/surgical benefits
- No later than 45 days after enactment the NQTL comparative analyses must be available on request to applicable state and federal regulators and enrollees. The federal agencies can request additional information to support the analyses and determine the analyses are not in compliance with the reporting requirements.
- Insurers/plans have 45 days to bring the analyses into compliance. The agencies have 45 days to review the insurer/plan corrective action. If they determine the insurer/plan is still not in compliance, the insurer/plan must notify enrollees of the failure within 7 days after notification by the agency.
- The tri-agencies (DOL, HHS, and Treasury) are required to develop compliance guidance for insurers/plans including examples

Surprise Medical Bills

- Effective for policy and plan years beginning on or after January 1, 2022
- Applies to individual and group insurance markets, self-funded group plans, and the FEHBP. Grandfathered and transition plans are included.
- Addresses member cost sharing, balance billing, and dispute resolution for three out-of-network (OON) provider categories:
  - Emergency services at OON hospital emergency departments and free-standing emergency facilities
  - Services provided by OON providers at in-network (INN) facilities
  - OON air ambulance services
- State law methodology for determining member cost-share and reimbursement amounts control (e.g., for health insurers). If no state law, follow federal rules.

Surprise Medical Bills – Consumer Protections

OON Provider Obligations to Members

- Prohibited from balance billing members for emergency items/services
- OON providers at INN facilities that provide “ancillary services” are prohibited from balance billing. Ancillary services are related to emergency medicine, anesthesiology, pathology, radiology, neonatology, labs/diagnostic services, and where there is no INN provider available.
- OON non-ancillary service providers can balance bill if they:
  - Provide members with advance notice that they are OON
  - Estimate the charges for any item/service
  - Obtain written acknowledgement from the member that they received the notice

Insurer Obligations to Members

- No prior authorization on emergency services
- No coverage limits or additional cost-sharing for OON emergency services that are more restrictive than those applied INN
- Apply any member cost-sharing for OON services to INN deductibles and cost-sharing limits
- Member cost-sharing for OON services is based on the “recognized amount” determined by:
  - Applicable state law
  - In states with an All-Payer Model Agreement (APMA), the amount pursuant to the agreement
  - If the state does not have a law or APMA to determine the payment amount, the lesser of the billed amount or “qualifying payment amount”

Surprise Medical Bills - “Qualifying Payment Amount”

- Member cost-sharing and Independent Dispute Resolution (IDR) determinations are based in part on the “qualifying payment amount” (QPA) which is the median contract rate for the item/service in a geographic region
- The QPA is based on the median contracted rate as of 1/31/2019 with a cost-of-living adjustment
- The QPA is established for each OON item/service covered by an insurer in a specified market (individual, small group, large group) and for all plans of a self-funded group plan sponsor (or all plans administered by the third-party administrator of the group health plan sponsor)
- Federally defined terms include:
  - Median contracted rate
  - Same or similar items/services
  - Geographic regions

Surprise Medical Bills - Provider Payment

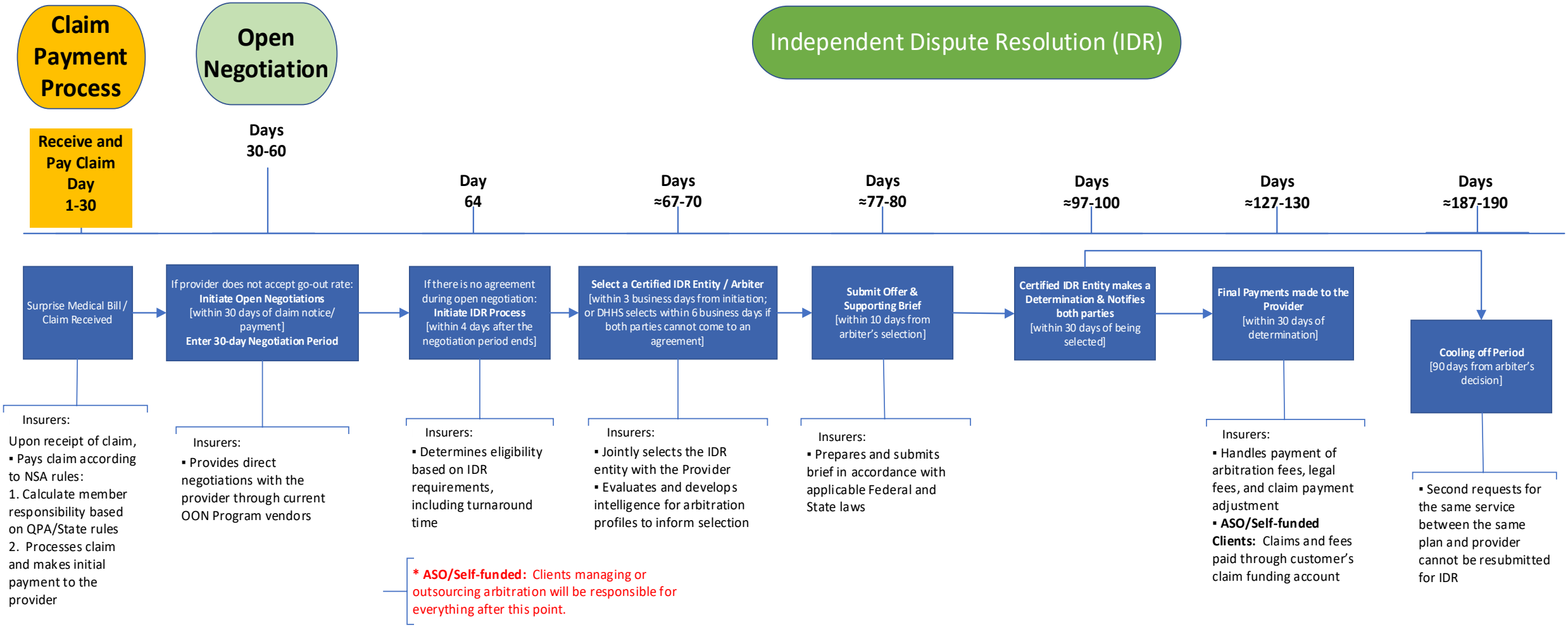
Insurer Payments to OON Providers

- OON providers are paid the difference between the member cost-sharing and the OON reimbursement rate determined by:
  - State law methodology or All Payer Model Agreement
  - If no state law or APMA, either an agreement between insurer/plan & provider or Independent Dispute Resolution if parties cannot agree

Independent Dispute Resolution (IDR)

- Parties have 30 business days to negotiate and may initiate IDR if negotiations fail
- IDR entities must select the final offer made by the parties that is closest to the QPA unless credible information demonstrates that the QPA is materially different from the appropriate reimbursement
- The IDR entity cannot consider the billed amount, government program rates or usual and customary charges
- IDR costs are paid by the parity whose offer was not selected

Surprise Medical Bills - End-to-End Timeline



▪ Timelines are estimates "up to" maximum allowed.

Surprise Medical Billing – Applicable State Laws

- Law that provides a methodology for determining the total amount payable by the insurer/plan (i.e., either a specified amount or through an arbitration process)
- Law must apply to the specific type of coverage, OON item/service, and OON provider/facility (e.g., if state law does not include OON neonatologist or emergency post-stabilization services, CAA process controls)
- Law must apply to the specific coverage (e.g., health insurer and/or HMO). State laws that permit self-insured employers to opt-in are not pre-empted by the CAA.
- State law may not allow resolution of air ambulance surprise billing disputes (i.e., CAA process controls)

CAA Rulemaking Status

Rulemaking/Guidance to Date

- Surprise Billing Part 1 Interim Final Rule (7/13/21)
- Surprise Billing Part 2 Interim Final Rule (10/7/21)
- Tri-Agencies FAQs Part 49 (8/24/21)
- Request for Information on Reporting Rx Benefits (6/23/21)
- Reporting Rx Benefits Interim Final Rule (11/23/21)

FAQs Part 49 delayed enforcement related to transparency in coverage, price comparison tool and good faith cost estimates, and provided an enforcement safe harbor related to many provisions including plan ID cards, provider directories, and balance billing

Expected Future Rulemaking

- Provider Nondiscrimination Proposed Rule (December 2021)
- Plan ID Cards
- Advance EOBs
- Provider Directories
- Continuity of Care

CAA Regulatory Enforcement

Potential Regulatory Enforcement Action / Litigation for Non-Compliance with the following CAA Provisions: Surprise Billing, IDR, Air Ambulance, ID card, Provider Discrimination, Advance EOB, Continuity of Care, Price Comparison Tool, Provider Directories, Gag Clause Prohibitions and Mental Health Parity

Plan Type	Regulator / Litigant
Fully-insured plans	State Departments of Insurance (or HHS if states fail to substantially enforce requirements)
Fully-insured plans in states where HHS retains enforcement authority (MO, OK, TX, and WY) Non-ERISA, self-funded governmental plans (e.g., states, school districts, etc.)	HHS/CMS
ERISA group health plans (fully insured and self-funded)	DOL ERISA Plan Members
Group health plans (fully insured and self-funded) Church plans	Treasury/IRS