WHO IS ON FIRST? OPERATIONAL HURDLES AND HOLES FOUND IN PORTIONS OF THE NSA

Written By Tim Callender

The Consolidated Appropriations Act ("CAA") did many things and has created obligations, questions, and confusion for many stakeholders in the healthcare space.

This article could cover COBRA topics, mental health parity topics, surprise billing, or any other number of pandora's boxes opened by the CAA, but no one wants to read a 1M word article filled with legal jargon and uncertain statements on how a pending rule or vague regulation should be interpreted.

Instead, this piece aims to spend some brief time focused on some specific obligations that have been handed down in the CAA and throw a few questions against the wall, so to speak, in the interest of starting a dialogue toward understanding how our industry might meet the obligations of the CAA.

We will not be looking at all of the obligations within the CAA but will pick out a few of my favorites as examples of the things we need to be considering as the CAA rolls out.

The CAA requirements discussed below are in no particular order and, again, have randomly been picked by me as some that seemed to have a few issues glaring right at the top. I tend to be very guilty of finding glee in identifying logistical problems, so, the requirements I decide to write about all have this in common – they will create some headaches – let's figure out how to get past those headaches.

Please note – as annoying as it might be, I may not offer big solutions to the logistical questions posed herein. But, by raising the questions, hopefully this will get us all thinking and working together to make sure our industry is poised to handle these new duties and we can find opportunity therein.

REQUIREMENT 1 – THE ADVANCED EOB REQUIREMENT OF THE NO SURPRISES ACT

The No Surprises Act is everyone's favorite portion of the CAA. That is, unless you are really excited by COBRA, then there are other portions of the CAA that might tickle your fancy a little more.

But most of us in this increasingly complicated healthcare space find balance billing, surprise billing, and pricing transparency to be pretty juicy – hence our interest in the No Surprises Act.

Contained within the NSA is a provision that requires a health plan to provide an advanced EOB any time the plan receives notice from a provider of a scheduled procedure and/or a request from a plan participant seeking an explanation of benefits regarding an upcoming procedure.

The advanced EOB is required to contain quite a swath of information, including, whether the provider is in-network or out-of-network; information on how to seek out an in-network provider, if needed; contracted rates for the relevant in-network provider; good faith cost estimates as furnished by the provider; a good faith estimate of the plan's obligation (what the plan will pay); a good faith estimate of the plan participant's cost share; deductible and out-of-pocket information related to the participant; medical management information if relevant; and a statement that the numbers provided are merely estimates.

In terms of timelines, the plan is obligated to provide this advanced EOB in 1 business day when the plan receives notice of a proposed procedure, from a provider, and 3 business days when the plan receives a notice/request from a plan participant.

This is clearly going to be an obligation that falls to the plan sponsor's contracted, third-party payer. Of course. Payers already handle the EOB work for their plan clients, typically, so it is a fair assumption this new obligation will be handled at that level as well. Knowing this obligation will fall to the third-party payer, some questions arise:

- Will payers have to increase their administrative fees to account for this new operational lift?
- What about 3rd party EOB production vendors & their relationship with the payer community – will these stakeholders be able to handle these tight turnarounds?

- What processes will a payer put in place to account for the intake of these requests whether from a provider or a member? How will plans and/or payers alert plan members to the availability of this information & that participants have a right to request this information?
- What if the contracted rates for the in-network provider are not known by the payer (I understand this should be known, but I also understand that network contracts are a bit like narwhals – we know they exist but only a few people have ever seen one).
- How will the payer go about getting a good faith cost estimate from the provider, especially with such a tight turnaround time to provide the info!

REQUIREMENT 2 – PLANS MUST PROVIDE BALANCE BILLING INFORMATION ON THEIR WEBSITES ALONG WITH A WEB-BASED, PRICE COMPARISON TOOL

This requirement will be live as of January 1, 2022, unless the regulators decide otherwise. Additionally, it should be noted that this requirement applies to both grandfathered and non-grandfathered plans alike. No getting out of this one!

Interestingly, it is not clear who will actually handle the logistics in fulfilling this requirement. Clearly the regulatory obligation falls onto a "plan," but does a plan even have the ability to comply with this requirement? It is hard to imagine that a self-funded, plan sponsor, is going to literally place balance billing support information and/or balance billing education tools on its website.

Trying to picture a random employer who makes widgets, in a factory, coordinating its HR department with its IT department to make sure that their company's website contains balance billing information and a web-based price comparison tool for health plan participants is laughable at best.

Will the insurance broker / consultant advise the plan sponsor to do this? Likely not. Where will this obligation end up then? Does it fall to the payer (TPA / ASO) to put this information on their website? How would the payer go about accomplishing this task on behalf of a plan it administers?

It seems that the contracted payers' contractual duties will be getting thicker and thicker come 2022.

REQUIREMENT 3 – CONTINUITY OF CARE

This requirement is a truly interesting one in that it states that plans are now obligated to provide in-network coverage to participants who access care from a provider that is no longer a part of the network.

Said another way, when an in-network provider leaves a network, a plan participant who was seeing that provider can continue to see that provider and the plan is obligated to provide the benefit as though the provider were still in-network, for 90 days.

The plan is also obligated to provide notice to the plan member when the plan learns of this provider network change. Now, there are obviously many more details than I've outlined here – for example, the patient must be seeking serious and complex care – the care cannot be a routine physical. But for this discussion, we will just focus on the concept of in-network versus out-of-network, for whatever reason.

On its face, this requirement makes a great deal of sense. Patients should not be financially punished because their favorite doctor chooses to leave a network. However, how can we guarantee that the plan does not become the bearer of that punishment – have we simply shifted the financial burden of paying for an out-of-network provider from the plan member to the plan?

To be more specific, what happens when the provider leaves Network A and does not contract with any network so the provider can bill at a higher rate? Suppose the provider does exactly that & begins billing at a higher rate on a number of patients seeing the provider within the 90-day continuity of care timeline.

The claims are submitted to the payer, as before, only now the third-party payer, on behalf of the health plan, must adjudicate the claims and apply the old, Network A, payment structure to the claims.

But this will leave a balance, correct? And this will cause the provider to seek reimbursement on that balance, correct? From whom?

It is clear from the intent of the CAA that this balance cannot fall onto the plan member, which means the plan itself, and/or the plan's third-party administrator, will be forced to invent mechanisms that will capture these balances – perhaps direct provider negotiations with plan funds at risk?

REQUIREMENT 4 (MY FAVORITE) – REMOVAL OF GAG PROVISIONS

The gag provision requirement prohibits plans from entering into service contracts with an entity where the contract restricts the plan from providing provider specific cost information, among other details, through a transparency tool or through other means, to plan members or those eligible to enroll in the plan. The provision goes on to also state that a plan cannot enter into service contracts where certain detailed claim information is restricted from disclosure to the plan.

This requirement seems incredibly logical – clearly, it is set up to promote transparency and assure that cost information is readily available to plan members and the plan alike. Of course, this is a great thing! But once you start thinking of the unintended, collateral impacts, the sense behind the way this requirement was put together becomes questionable.

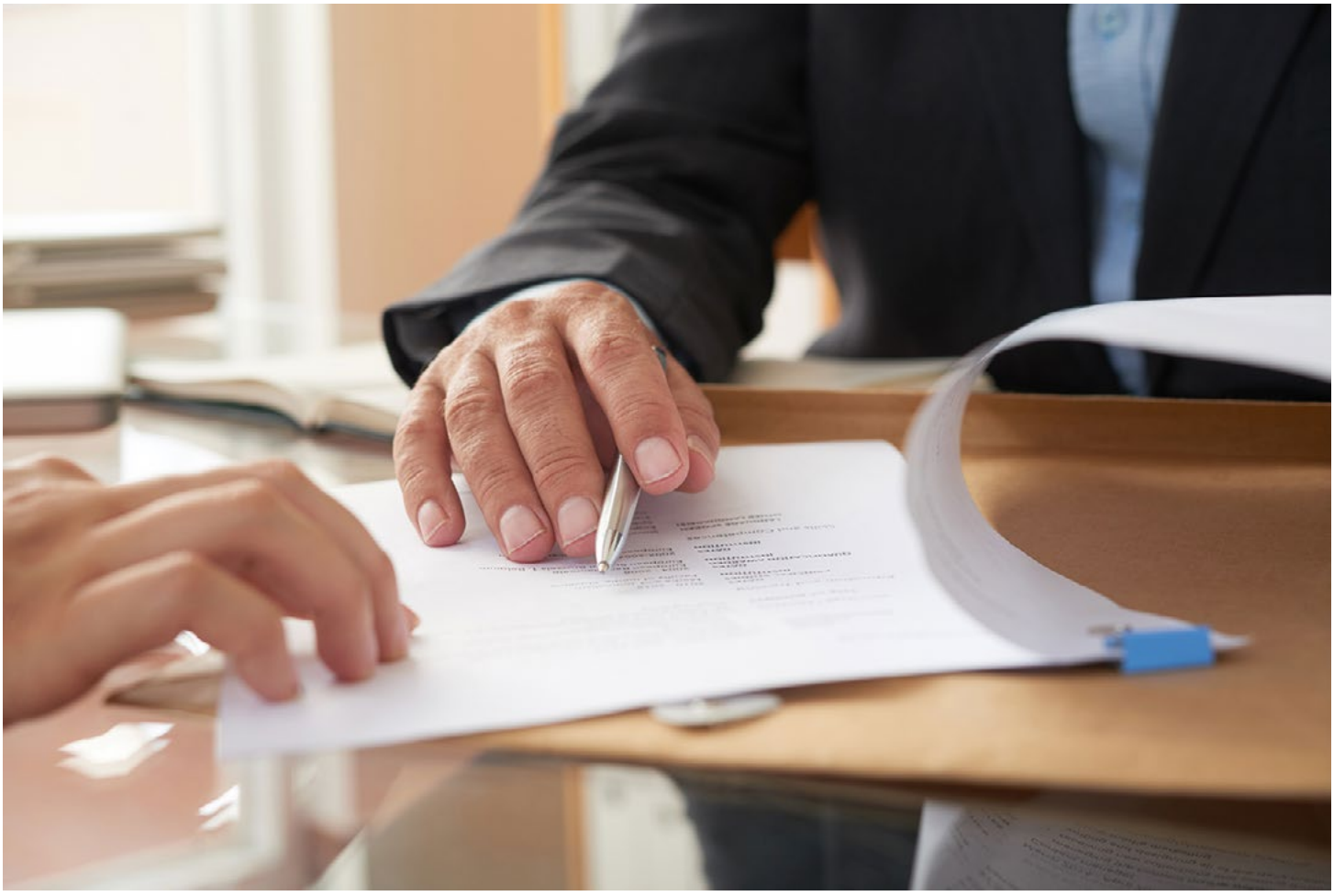
You will note that it is the PLAN who is prohibited, by this requirement, from entering into these restricted contracts. The provision does not require networks, providers, or other third parties to remove these gag provisions from their contracts.

Instead, it has shifted the burden of fighting these gag provisions onto actual health plans by outlawing a plan's ability to agree to a gag provision. This seems to put a plan in a bit of a weird situation in that the plan is now the government's policeman and will be forced to try and negotiate gag provisions out of service contracts.

What if a network, or a provider, or other third-party refuses to remove a gag provision? There is no remedy readily available to the plan other than to say, "well, ummmm… I guess we can't sign that contract then. Ok. See ya later."

Although the third party might be motivated to remove gag provisions in the interest of gaining business, there is not guarantee this will happen. Unless there is a critical mass of business being lost, third parties who value their gag provisions will likely stand firm and let some business go by in favor of protecting the information that they do not wish to share.

Or will the various, contracting parties find a way to sneak around this requirement and ruin the intended spirit? Could a TPA enter into a network contract full of gag provisions and then



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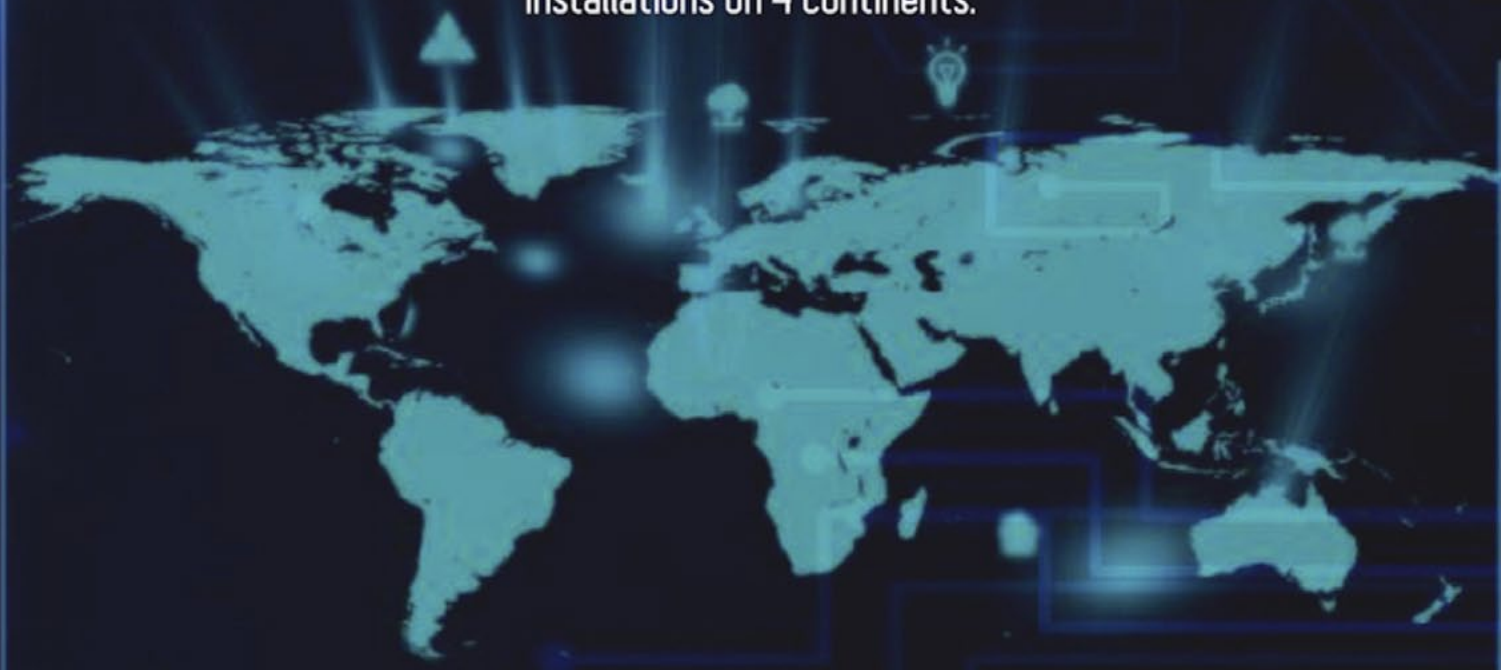

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sell the network access to a plan, via their administrative services agreement, so long as the administrative services agreement does not incorporate the terms of the network contract, thus circumventing the gag provision requirement entirely? Someone should ask a lawyer.

In closing, it is important to note that the CAA and, more specifically, the NSA, work toward some great goals that I think we all believe in. There is much more to the CAA than discussed in this brief article and it really does deserve a more detailed treatment whenever possible.

Today's goal was to raise a few questions about a very few provisions of the CAA in the hope that we will all look through the CAA, in its entirety, with questioning eyes. Not for the sake of poking holes necessarily, but for the sake of asking questions so that we can find opportunity and solutions, together, and continue to move our industry forward. ■

Tim Callender serves as the Vice President of the Client Solutions Group for The Phia Group, LLC. Prior to his current role, Tim served as a health care lawyer, staff attorney and lead PACE counsel for The Phia Group.

Before joining The Phia Group, Tim spent years functioning as in-house legal counsel for a third party administrator. Tim is well-versed in complex appeals, direct provider negotiations, plan document interpretation, stop-loss conflict resolution; keeping abreast of regulatory demands, vendor contract disputes, and many other issues unique to the self-funded industry.

Tim has spoken on a variety of industry topics at respected venues such as the Self-Insurance Institute of America ("SIIA"), the Society of Professional Benefit Administrators ("SPBA"), the Health Care Administrator's Association ("HCAA"), and the National Association of Health Underwriters ("NAHU"). Tim currently sits on the Board of Directors for HCAA as well. Prior to his time as a TPA's in-house counsel, Tim spent many years in private practice, successfully litigating many cases through full adjudication or to resolution through mediation or arbitration.

Tim holds a leadership role with The Phia Group's executive leadership team while continuing to assist on many general consulting and industry projects. Tim also employs his experience to focus on the development of new services and the enrichment of The Phia Group's existing services.

Tim received his Bachelor's Degree from The College of Idaho, prior to obtaining his Law Degree from The University of San Diego School of Law. Tim operates out of The Phia Group's office in Boise, Idaho.