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Correspondence Memorandum

Date: January 21, 2022

To: Group Insurance Board

From: Renee Walk, Lead Policy Advisor
Office of Strategic Health Policy

Subject: Consolidated Appropriations Act Update

This memo is for informational purposes only. No Board action is required.

Background

In November 2020, the federal Departments of Health and Human Services, Labor, and Treasury (Departments) finalized the Transparency in Coverage (TiC) rules that require health plans to publicly disclose health prices and estimated out-of-pocket costs through a member-facing on-line tool and publicly available, machine-readable files. These rules were issued under provisions in the Affordable Care Act, enacted in 2010.

On December 27, 2020, Public Law 116-620, the 2021 Consolidations Appropriation Act (CAA) was signed into law, enacting the No Surprises Act (NSA) and several health care related transparency provisions, including a provision to provide a consumer-facing, on-line price transparency tool. In 2021, the Departments issued several rules to implement portions of the NSA.

The selected provisions described in this memo apply to self-funded group health plans and fully insured health plans in the group and individual markets (health plans), including the Group Health Insurance Program (GHIP) overseen by the Group Insurance Board (Board). They do not apply to account-based plans like health savings accounts (HSAs) or flexible spending accounts (FSAs), excepted benefit plans which are separate from health plans, like dental-only or vision-only plans, short-term, limited duration plans, or retiree-only plans, such as Medicare Advantage plans.

No Surprises Act Provisions

The NSA protects patients from surprise medical bills which include balance billing and other adverse effects when an individual uses out-of-network (OON) providers without being properly informed of the provider's network status in advance. The NSA also requires health plans and providers to disclose cost and coverage information to patients prior to receiving services.

<ins>Surprise Medical Bills</ins>

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy Electronically Signed 01/28/2022

Eileen K Mallow

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Surprise medical bills happen when a health plan member receives a bill from an OON provider that they are not expecting. Often this takes the form of "balance billing," where the member is billed the difference between what the provider charges and what the provider is paid by the member's health plan. The NSA protects members from surprise medical bills for the following services received from OON providers:

- Emergency services including post-stabilization services,
- Non-emergency services provided in a network facility, and
- Air ambulance services.

The NSA prohibits health plans from applying cost sharing greater than the amount that would apply if the services were provided by in-network providers, and that cost sharing must be applied to the member's in-network deductible and out-of-pocket maximums. For emergency services, health plans must cover services without prior authorization.

The NSA also prohibits health care providers from billing patients for the difference between what the provider charges and the amount the health plan is initially required to pay OON providers under the NSA. If the provider and health plan do not agree on the payment amount, there is a 60-day negotiation period, followed by an independent dispute resolution process (IDR) if negotiations fail. If the final payment amount increases from the initial payment because of the negotiation or IDR process, the member is not required to pay any additional cost-sharing.

For post-stabilization services following emergency care, OON providers cannot bill patients for more than in-network cost-sharing unless they provide notice to the patient that they may be responsible for non-network cost-sharing and the patient actively consents. Non-emergency ancillary services provided by select OON specialty providers, such as anesthesiology, lab, pathology, radiology, and neonatology cannot seek consent to bill for more than in-network cost-sharing if services are provided in an in-network facility.

The surprise medical bill provisions apply to plan years starting January 1, 2022. In Wisconsin, the Office of the Commissioner of Insurance (OCI) will be the primary regulator of these provisions for both plans and providers and will work with the appropriate federal agencies when necessary to enforce. OCI will be rolling out a communications campaign through the beginning of 2022.

Good Faith Estimates and Advanced Explanation of Benefits

The NSA requires health care providers to provide a "Good Faith Estimate" of expected charges for scheduled healthcare services to a member's health plan. This estimate must include the expected billing and diagnostic codes for the scheduled services. This estimate must be provided within one business day of scheduling a service (or within three business days if the service is scheduled more than 10 business days prior to the date of service).

Upon receiving a Good Faith Estimate from a provider, health plans are required to send the member, through mail or electronic means, an Advanced Explanation of Benefits (EOB) in clear and understandable language. The Advanced EOB must include the following elements:

- Network status of the provider submitting the estimate;
- If the provider is in-network, the plan's contracted rate with that provider;
- If the provider is non-network, how the member can get information on network providers;
- The Good Faith Estimate received from the provider;
- A Good Faith Estimate of how much the plan will pay for the items or services;
- A Good Faith Estimate of any cost-sharing that would apply as of the date of notification and the amount the member has incurred toward meeting the plan's deductible and out-of-pocket maximums;
- Any other medical management related limitations, such as prior authorization or step therapy, that might apply; and
- A disclaimer that the information provided is only an estimate and is subject to change.

Generally, the Advanced EOB must be provided to a member within one business day of receipt of such a Good Faith Estimate from a provider. If the item or service is scheduled at least 10 business days before it is furnished, the plan may provide an Advanced EOB within three business days of receiving the Good Faith Estimate from the provider.

The Good Faith Estimate and Advanced EOB provisions were initially applicable starting with plan years beginning January 1, 2022. However, in August 2021 the Departments indicated they are deferring enforcement of the Good Faith Estimate and Advanced EOBs provisions until future rules are developed. As of the drafting of this memo, neither the rules nor an expected timeline have been released.

<u>Provider Directories</u>
Health plans are required to establish a provider directory database on their public website that provides information on each health care provider with which the plan has a contractual relationship. The information in the database must be verified and updated at least every 90 days, including the removal of providers the plan has been unable to verify. Further, the database must be updated within two business days if the plan receives updated information from a provider. These provisions are intended to address concerns that health plans' provider directories are frequently not kept up to date and misinform their members about a provider's network status.

The provider directory requirements in the NSA initially apply to plan years starting January 1, 2022. However, in its August 2021 guidance, the Departments indicated they do not expect to issue rules on the provider directory requirements until after January 1, 2022. The Departments indicated that pending the new rules, they expect health plans to implement the requirements using a good faith, reasonable interpretation of the law.

Plans will not be deemed out of compliance with these requirements if a plan applies network cost-sharing to an OON provider when the member received inaccurate information.

ID Cards

With plan years starting January 1, 2022, health plans must include deductible and out-of-pocket maximums on insurance identification (ID) cards, as well as a phone number and website address for members seeking assistance. Prior to the NSA, insurance ID cards typically included a participant's and dependents' names, ID numbers, copayments, and possibly the name of the plan's provider network. The Departments intend to issue rules in the future on implementing the ID cards, particularly for more complex plan designs. In the meantime, the Departments indicate that health plans are expected to implement the ID card requirements using a good faith, reasonable interpretation of the law.

No Surprises Act Impact on Plans

The economic impact analysis of the interim final rules on surprise medical bills indicates that providers and payers will incur significant one-time and ongoing administrative costs to comply with the NSA requirements. Detailed analysis on the impact of the surprise medical bill protections on premiums is expected to be included in future rules.

The Congressional Budget Office (CBO) has estimated that the NSA will, on average, result in smaller payments initially to OON providers and would slow the growth of payments to providers over time. This would reduce premiums between 0.5 and 1.0 percent in most years. However, current pricing in markets across the country differ dramatically so the "effects in any given market could be quite different."

The actual impact to GHIP plan costs will be impacted by the factors detailed below.

The Decrease in Member's Out-of-Pocket Costs

The decrease in member's out-of-pocket costs since cost-sharing will be determined based on network benefit levels. This is expected to be minimal since the in-network cost sharing is already required under the GHIP.

The Change in Total Plan Payments to Non-Network Providers

The change in total plan payments to non-network providers that are based on the formulas specified in rules. This could be significant if plans are currently paying above the median contracted rate to OON providers. CBO expects that over time, both network and OON provider payments will converge around the median in-network rates under the NSA.

The Shift of Services From Non-Network to Network Providers

The shift of services from non-network to network providers either because more members use network providers or because some OON providers contract with health

plans to avoid the administrative effort of the notice/consent requirements. In states that already have balance billing protections, OON provider use went down significantly.

Post-Stabilization Services
The extent to which post-stabilization services received from non-network providers are covered as in-network benefits. Currently GHIP does not include post-stabilization services in the requirements to cover OON providers at the network benefit level so covering such services at the network benefit level could increase plan costs.

Increased Administrative Costs
The increased administrative costs to comply with the NSA provisions may put pressure on future premiums. The Board typically limits the administrative costs included in plan premiums.

No Surprises Impact on Members
In 2020, non-Medicare GHIP members incurred approximately $77 million in services from non-network providers. Most of these services were emergency or urgent services and therefore were paid at in-network benefit levels under the terms of the current GHIP Certificates of Coverage. The GHIP already requires health plans to provide emergency and urgent services and non-emergency services provided at network facilities to be covered at the network benefit level. This includes protecting members from balance billing by OON providers. Therefore, the surprise medical bill provisions of the NSA are not expected to have a significant impact on members.

However, members could benefit from improved information on estimated out-of-pocket costs and the network status of a provider due to the Good Faith Estimate, Advanced EOB provisions, more accurate provider directories, and ID cards. Advanced EOBs are not currently common with medical services but would be similar to dental pre-estimates, which are commonly used by dentists to identify coverage and out-of-pocket costs for planned dental procedures.

Adding protections for post-stabilization services provided by non-network providers after an emergency could also benefit members when they receive additional services after experiencing a health care emergency if providers effectively implement the notice and consent requirements included in the NSA.

The overall impacts to member health are expected to be limited. There may be a moderate benefit from coverage of post-stabilization care if a member would otherwise have been at risk of being moved or otherwise have care limited, but to the extent that this is possible, it is likely small enough as to not impact program costs.

Transparency
The TiC rules and the CAA include requirements to make certain costs publicly available to promote price transparency. These requirements include both member-facing, online price comparison tools as well as the availability of machine-readable files

that disclose contract pricing for network providers and historical net pricing for OON providers and prescription drugs.

Member-Facing Online Comparison Tools

Member-facing, online comparison tools allow plan users to search for specific services covered under their health plan and get the total applicable costs for those services by provider as well as estimates of the out-of-pocket costs that will apply based on current cost-sharing accumulators (current payments towards a deductible and out-of-pocket limit). Such tools are already available with many insurers and self-insured health plans across the country but are not currently commonly available in Wisconsin. Under the CAA, health plans are required to provide such tools for all covered services starting January 1, 2022.

However, under the TiC rules, such tools would be required for 500 covered services starting with plan years beginning January 1, 2023, and expand to all services starting with plan years beginning January 1, 2024. Recognizing the different timelines for enforcement and the amount of time and effort involved with complying with these requirements, the Departments indicated they will delay enforcement of the price comparison tool requirements until plan years starting January 1, 2023.

Machine-Readable Files

In addition to the price comparison tools, the TiC rules require health plans to provide publicly available, machine-readable files on their internet sites that would disclose pricing per service per provider under each health plan for network providers, non-network providers, and prescription drugs. For network providers, this information would reflect current contract pricing. For OON providers and prescription drugs, this information would reflect historical net pricing (after rebates). This information would be updated monthly. Such files are not intended to be read by plan members, but rather read by computers so that researchers, policymakers and other third parties could use this information for research, analysis and to develop third-party price comparison tools.

However, due to the time and effort involved in complying with these provisions, the Departments have delayed enforcement of the machine-readable file requirements for network and non-network pricing until plan years starting July 1, 2022. The requirement to provide a machine-readable file for prescription drug pricing has been delayed until the Departments issue additional rules while they consider potentially duplicative and overlapping pharmacy reporting requirements in the CAA.

The Transparency provisions in the CAA also include provisions enhancing protections under the Mental Health Parity and Addiction Equity Act. The enhanced transparency provisions require plans to complete comparative analyses of their non-quantitative treatment limits (NQTLs), such as prior authorization criteria, comparing those in place for medical and mental health services. These comparative analyses must be provided to the Departments upon request. The “Mental Health Parity and Access Update” memo summarizes the Department of Employee Trust Funds (ETF) approach to implementing these provisions (Ref. GIB | 02.16.22 | 9A).

Transparency Provisions Impact on Plans
The Departments' economic impact analysis included in the final TiC rules indicate that health plans will incur significant administrative costs to comply with the transparency requirements. These costs include technical and operational costs associated with developing the machine-readable files and member-facing tools. If the Departments determine the prescription drug machine-readable file requirement is appropriate and moves forward with enforcement, Navitus is also expected to incur significant administrative costs to produce those monthly machine-readable files and to comply with other pharmacy-related reporting required by the CAA.

The transparency provisions have the potential to impact prices plans pay to contracted providers based on many of the comments provided to the Departments in response to the initial proposed TiC rule. These commenters raised concerns that disclosure of contract pricing will result in plans and providers engaging in anti-competitive behavior through consolidation, collusion, or price-fixing. However, the Departments found no evidence to support these concerns based on the experience in those states where price transparency is already required. Rather, according to the Departments, there is some evidence that such transparency requirements promote competition since individuals are more likely to seek care and providers based on value.

The 2022 GHIP Program Agreement requires plans to attest to ETF annually that they are meeting the transparency requirements of the CAA. The actual impact on GHIP plan costs will be determined by several factors.

Whether Legal Challenges are Successful
The U.S. Chamber of Commerce and the Pharmaceutical Care Management Association are challenging the Departments rules on grounds that they will be harmed by the disclosure of contracted prices and that the Departments have exceeded their authority under the Affordable Care Act by issuing the TiC rules. There has been no movement on these lawsuits since they were filed in August 2021.

Change in Provider and Health Plan Contracting Approaches
Wisconsin's provider market is one of the most concentrated and the number of provider-owned health plans in Wisconsin suggests that the experience in Wisconsin may be different than in other states.

How Members React to New Price Comparison Tools
Members in the High Deductible Health Plan (HDHP) are more likely to be price sensitive and therefore more likely to use the newly available information when choosing providers. How well the new tools are designed and promoted will also impact how much members use them.

Increased Administrative Costs

The increased administrative costs to comply with the transparency provisions may put pressure on future premiums. The Board typically limits the administrative costs included in plan premiums.

Transparency Provisions Impact on Members

The Departments believe that the increased transparency in pricing and out-of-pocket costs will result in more informed decision-making when individuals seek medical care and will be more likely to consider value when selecting providers. For GHIP, this is more likely true for members in the HDHP since these members maybe more price sensitive. However, to purchase health care services based on value, the quality of the health care provider must also be considered. Provider quality information is not a required component of the price comparison tools, so purchasing health care services based on value will be a challenge if plans do not voluntarily include such information.

In August 2021, ETF surveyed GHIP health plans on the transparency requirements and only one health plan indicated that it planned to include provider quality information on its price comparison tool. Other plans either indicated that they hadn't decided yet or indicated they did not plan to include such information.

Further, whether members use these price comparison tools will be impacted by how much ETF and the plans promote them. ETF will continue to monitor plan's implementation of the transparency requirements including GHIP members' use of such tools.

Communications

The NSA and transparency requirements included in the CAA will require significant education of members to ensure they understand the new protections and are aware of the available price comparison information to make use of them. For GHIP members, for the most part, the NSA surprise medical billing protections are duplicative of existing protections members already have under the plan. However, the NSA adds the ability to enforce protections on providers which is currently not available. In addition, other NSA requirements, such as new ID cards, Good Faith Estimates and Advanced EOBs will be new for members.

ETF recently asked health plans to share any communication materials they are using to educate members or providers on the NSA provisions. Because the NSA provisions only recently went into effect, plans report not receiving many questions as of the writing of this memo. So far, most questions received from members have been about the new information included on their insurance ID cards.

Finally, ETF has developed a webpage describing the NSA protections to members and directing them to their health plan for additional questions. ETF is currently considering whether additional communication for members or employers is appropriate.

Staff will be available at the Board meeting to answer any questions.