Helping Ohioans with Healthcare Benefit Choices

OAHU

OAHU Legislative Update

PRESENTED BY:

Barb Gerken, OAHU Legislative Chair

Agenda

- Surprise Billing
  - Ohio - HB388
  - Federal – No Surprises Act
- Transparency in Coverage Final Rule

Surprise Billing - Ohio

Surprise Billing - Ohio

- Effective September 1, 2021
- Includes providers, facilities, ambulance (ground only) and clinical laboratories. Will use “provider” in the remaining bullet points but will include all stated.
- Consumer cannot be billed for the difference between the plan’s reimbursement and the provider’s charge.

Surprise Billing – Ohio Payment Methodology

- Benchmark ("fair market value") for payment, the greater of:
  - The median amount negotiated with in-network providers for the service in question in that geographic region under that health plan;
  - the price paid for the out of network service (if there is out of network coverage, what a plan pays for the out of network service); or
  - the Medicare rate.

Surprise Billing – Ohio
Negotiation

- In-lieu of a "greatest of 3" payment, the out of network provider/ER facility may negotiate reimbursement.
- If the negotiation has not successfully concluded within 30 days, or if both parties agree that they are at an impasse, the out of network provider may request arbitration.

Surprise Billing – Ohio Arbitration

- If arbitration is requested, each party must submit their final offer.
- The parties may submit, and the arbitrator may consider, evidence that relates to the factors described below:
  1. In-network rates that other health benefit plans or health plan issuers reimburse, and have reimbursed, that particular provider and other providers, and the factors that went into those rates (guaranteed patient volume, availability of provider's geographic area.
  2. Any in-network reimbursement rates previously agreed upon between the plan and the provider, if the health plan and the provider had a previous relationship in the past six years.

Surprise Billing – Ohio Arbitration

- To be eligible for arbitration, the service in question could not have been provided more than one year prior to the request.
- Bill, or combination of bills as listed in bundling below, must be greater than $750
  - A provider or emergency facility may bundle up to fifteen claims from the same health benefit plan that involve the same or similar services provided under similar circumstances.
- The non-prevailing party is to pay 70% of the arbitrator's fees and costs and the prevailing party is to pay 30%.

Surprise Billing – Ohio Arbitration

- Final arbitration decision will be binding except as to other remedies available at law.
- Superintendent of Insurance is tasked with selecting one single arbitration entity.
- Arbitration entity must submit annual reporting on:
  - the number of arbitrations conducted;
  - the provider type;
  - the specialty of the provider;
  - the out-of-network situation; and
  - the percentage of times the arbitrator rules in favor of the health plan versus the provider.

Surprise Billing – Ohio
Balance Billing Requirements

- For services covered by the health plan, but are provided by an individual out-of-network provider, an individual cannot be balanced billed unless:
  - The provider informs the individual that the provider is not in the covered person's health benefit plan.
  - They provide the consumer with a good faith estimate, including a disclaimer that they are not required to get the services at that location or from the provider.
  - ***The individual consents to the services.***

Surprise Billing – Federal No Surprises Act

Surprise Billing - Federal

- Will require rulemaking from DOL and IRS – no later than 7/1/2021
  - The methodology for group health plan/issuer to determine the qualifying payment amount;
  - Information plan or issuer will share with nonparticipating provider or facility when making the determination;
  - Geographic regions applied;
  - A process to receive complaints of violations.

Surprise Billing - Federal

- For services provided by a non-network provider at a network facility – insurer may not apply cost-sharing at the non-network level.
- Payment must be sent directly to the non-network provider.
- Will not apply to times or services (other than ancillary services) if the provider satisfies the notice and consent criteria.

Surprise Billing – Federal Notice Requirements

- Service must be scheduled 72 hours in advance;
- Notice that provider is not participating in the consumer's network;
- Estimated amount of billed charges;
- A list of participating providers at the facility who are able to furnish such items and services;
- Any prior authorization/care management requirements; and
- Clearly states that consent to receive items or service is optional and consumer has the ability to seek care from a participating provider or at a participating facility.

Surprise Billing – Federal Negotiation/Arbitration

- Open Negotiations – lasts 30 days after the non-network provider or facility receives notice of claim payment from health plan or issuer.
- Independent Dispute Resolution (IDR) can be started during the 2-day period beginning on the day after such open negotiation period.
  - Bundling for services by the same provider to the same insurer provided during the 30-day period following the date on which the first time or service was provided.

Surprise Billing – Federal Arbitration

- Departments have one year from enactment to establish one independent resolution process.
- Audits will be require with annual report each year, beginning in 2022.

Surprise Billing – Federal Arbitration

- If arbitration is requested, provider and/or insurer provides an offer for a payment amount.
- Considerations:
  - The qualifying payment amounts;
  - Level of training, experience and quality and outcomes measurement for the provider or facility;
  - Market share held by oon provider or facility or that of the plan or issuer in the geographic region;
  - The acuity of the individual receiving services;
  - Teaching status, case mix and scope of service of provider;
  - Demonstration of good faith efforts to enter into network agreements;
  - Contracted rates during the previous 4 plan years.
  - CANNOT consider billed charges

Surprise Billing – Federal Arbitration

- IDR Resolution is binding and not subject to judicial review;
- Provider cannot bring additional charges of the same item or service for 90 days following previous determination;
- Loser pays all arbitration fees, parties split costs if negotiation reach a settlement prior to arbiter decision.

Surprise Billing – Federal Arbitration

- Entity files for arbitration request
- Within 3 business days – allow for provider or health plan/issuer certify that available arbiter has no conflict of interest
- Within 10 days after date of selection of arbiter, each party submits their offer and information to make determination
- Within 30 days – final determination
- Within 30 day after determination – payment must be sent

Surprise Billing – Federal Arbitration

- Arbitration notice – required

Description of item or service	Location where item or service will be delivered
The amount of the offer submitted by the health plan/issuer and by the non-participating provider/facility expresses as a percentage of the qualifying payment amount	Which offer was selected by the arbiter
The category and practice specialty of each provider or facility involved in care	The identity of the health plan/issuer/provider or facility issuing the notice
Length of time for arbitration	Compensation paid to the arbiter

- Administrative fees required on an annual basis for anyone participating in the IDR process

Surprise Billing – Federal
Air Ambulance

- Provider cannot balance bill
- Member cost sharing for non-network providers will be the same as if the air ambulance provider was in network
- Cost-sharing will apply to network accumulators
- Open negotiation for 30 days beginning on the day the provider receives a response from the plan/issuer
- Same IDR process with additional considerations:
  - Ambulance vehicle type including the clinic capability level of such vehicle
  - Population density of the pick up location (such as urban, suburban, rural, or frontier)

Surprise Billing – Federal Enforcement

- Ohio Department of Insurance will be responsible for enforcement.
- $10,000 per violation for provider balance billing

Surprise Billing – Federal Transparency

- Any plan documents/id cards must have deductible amounts and out-of-pocket limits for plan (both in and out of network) beginning on or after January 1, 2022.
- Advanced explanation of benefits – timing:
  - 1 business day after the date on which the plan or coverage receives notification or request from provider
  - 3 business days after receipt if scheduled 10 days prior to time or service is to be furnished

Surprise Billing – Federal Transparency

- Advanced explanation of benefits must include:

Network status of provider or facility	Contracted rate for in-network service
For non-network providers – description of how to obtain information on network providers	Good faith estimate included in the notification from the provider or facility
Good faith estimate of the amount the plan or coverage is responsible for paying	Good faith estimate of any cost-sharing
Good faith estimate of current out of pocket limits.	Any applicable medical management techniques (prior auth, step therapy)
Disclaimer that the information provided is only an estimate	

Surprise Billing – Federal Miscellaneous

- Provider Directories – process for insurers and providers to ensure correct directory information
  - Cost-sharing for services provided based on reliance on incorrect provider network information
  - Shall not impose cost-sharing greater than what would apply in-network
  - Deductibles and out-of-pocket maximums should be applied to in-network accumulators.

Surprise Billing – Federal
Provider and Facility Requirements

- Shall provide to an individual a list of all services rendered along with the name of each practitioner for each service upon discharge or end of visit or by postal service no later than 15 calendar days after the discharge or date of visit;
- Shall submit to the group health plan/issuer the bill for services no later than 30 calendar days after discharge or date of visit;
- Send a bill for cost-sharing amounts to the individual no later than 30 calendar days after transmission of the information; and
- No patient may be required to pay a bill for health care services any earlier than 45 days after the postmark date of a bill for such services.

Surprise Billing

Surprise Billing Legislation Comparison

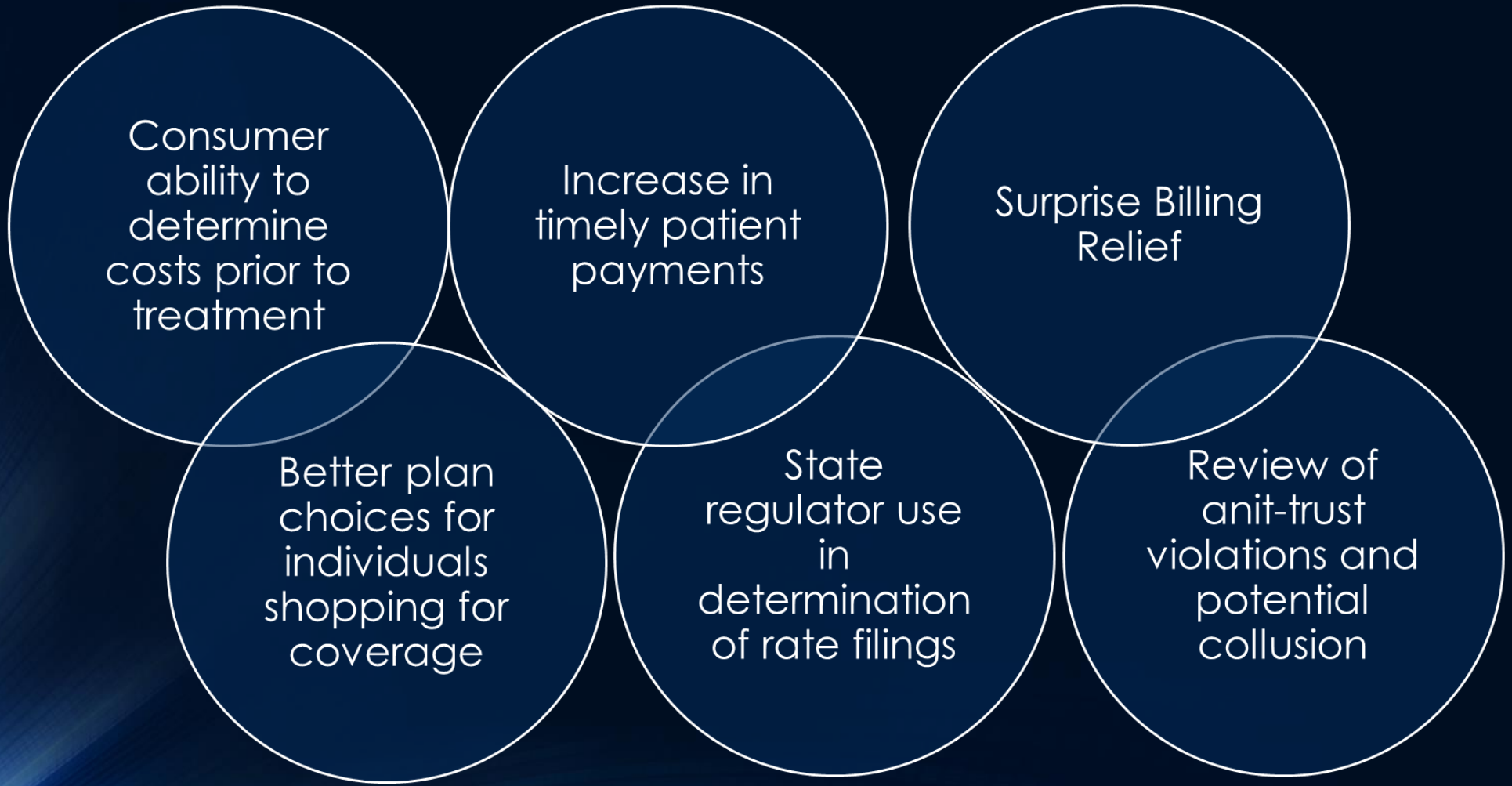
	Federal HR 133	Ohio HB 388 Holmes
Status	Via Omnibus Coronavirus Relief Act 12/14/20	Signed by Gov. DeWine 1/8/21
Coverage	• Emergency services, provided at an OON hospital (including freestanding ERs) until stabilized • Emergency services for OON Air ambulance & providers • OON covered services at in-network facility (including referrals for diagnostic services) • Patient may sign waiver (generally w/72 hours notice), but specific providers prohibited (emergency medicine, anesthesiology, pathology, radiology, neonatology assistant surgeons, hospitalists, and intensivists)	• Emergency services, provided at an OON emergency facility until stabilized • Emergency services for OON Ground ambulance & providers • OON covered services at in-network facility (including clinical laboratory) • Patient may sign waiver if provider informs them of OON status, estimate of costs, expected reimbursement & patient's expected liability
Application	• Individual and group health • Self-insured group health plans • Grandfathered plans • Federal Employee Plans • Nonfederal governmental health plans can elect to opt in *Preserves a state's ability to determine its own payment standard for state-regulated issuers of group and individual insurance. Therefore, in Ohio, federal law will cover those plans not regulated by the state.*	"Health plan issuer" means an entity subject to the Ohio Insurance Laws and rules, or subject to the jurisdiction of the Department of Insurance, contracts to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, … includes health insuring corporations, sickness and accident insurers, public employee benefit plans, self-funded multiple employer welfare arrangements, and third-party administrators, including pharmacy benefit managers.
Effective Date	1/1/2022	9 months following its effective date – 10/8/21?
Key provisions - **Protects patients**	Processed as if in-network & balanced billing prohibited; penalty of up to $10, 000 per violation	Processed as if in-network & balanced billing prohibited

Transparency in Coverage

Transparency in Coverage Timeline

- Final rules issues by HHS, DOL and IRS on October 29, 2020.
- Provisions would be implemented over a four-year period

Transparency in Coverage Intended Outcomes



Transparency in Coverage Application

- Applies to all group health plans and health insurance issuers in the group and individual market.
- Does not apply to:
  - Grandfathered plans
  - HRA/HSA
  - Excepted benefits
  - Health care sharing ministries
  - Short-term, limited duration insurance (STLDI)

Transparency in Coverage Application

- Fully insured plans may enter into contract with issuer or vendor for administration and compliance.
- Self-insured plans may enter into contract with issuer or vendor for administration but will remain liable for compliance.
  - Indemnification language may be added
- MEWAs
  - For those that are employee welfare benefit plans – MEWA assumes and retains responsibility
  - For those that are not itself a plan – each employer providing benefits is separately responsible for compliance.

Transparency in Coverage Data Files

- Three files required from issuers and group health plans in 2022:

- Requirements:
  - Files updated monthly;
  - Free of charge;
  - May not require establishment of user account, password or other credentials
  - Must include a place of service code and a provider TIN

Transparency in Coverage
In-Network Rate File

- Includes:
  - Name and identifier for each coverage option
    - Employer tax id
    - Health Insurance Oversight System (HIOS) ID
  - Billing codes used by a plan or issuer "for purposes of billing, adjudicating, and paying claims for a covered item or service"
    - CPT code, Healthcare Common Procedure Coding System (HCPCS) code, DRG, National Drug Code (NDC), ICD-10
    - Each code must include a plain language description

Transparency in Coverage
In-Network Rate File

- Includes:
  - In-Network Applicable Rate
    - negotiated rates;
    - amounts in underlying fee schedules
    - derived amounts

Transparency in Coverage Allowed Amount File

- Unique amounts a plan or issuer allowed, as well as associated billed charges, for covered items or services furnished by out-of-network providers during a specified time period.
- That period is defined as the 90-day time period that begins 180 days prior to the publication date of the Allowed Amount File
  - For example, a file published on June 30, 2021, should include data for a 90-day period beginning on January 1, 2021

Transparency in Coverage
Allowed Amount File

- Must be reflected as a dollar amount;
- Reference based pricing without a network would record all as historical payments regardless of methodology.
- Plans and issuers would not be required to provide out-of-network allowed amount data in relation to a particular provider and a particular item or service when compliance would require a plan or issuer to report out-of-network allowed amounts to a particular provider in connection with fewer than 20 different claims for payment

Transparency in Coverage
Prescription Drug File

- Negotiated rates and historical net process connected to prescription drugs.
- Prescription Drug Negotiated Rate - the amount a group health plan or health insurance issuer has contractually agreed to pay an in-network provider, including an in-network pharmacy or other prescription drug dispenser, for covered items and services, whether directly or indirectly, including through a TPA or PBM

Transparency in Coverage
Prescription Drug File

- Prescription Drug Historical Net Price Disclosure - retrospective average amount a plan or issuer paid for a prescription drug, inclusive of any reasonably allocated rebates, discounts, chargebacks, fees, and any additional price concessions received by the plan or issuer
- 90-day period beginning 180 days before the date a particular Prescription Drug File is published

Transparency in Coverage Disclosure Elements

- Requires plans and issuers to disclose cost-sharing information upon request to a participant, beneficiary or enrollee, including an estimate of the individual's cost-sharing liability for covered items or services.
- Seven elements
- Effective January 1, 2023

Transparency in Coverage Disclosure Elements

1. Estimated cost-sharing liability
   - Amount a participant, beneficiary or enrollee is responsible for paying for a covered item or service under the terms of the plan or coverage.
   - Estimates are not required to reflect the actual or final cost a particular item or service.

Transparency in Coverage Disclosure Elements

2. Accumulated amounts
   - The participant's accrued deductible or out-of-pocket payment amount (financial responsibility), plus
   - Any accrued items or services for which the plan imposes a cumulative limitation (number of items, days, units, visits or hours used), with
   - Respect to the deductible/out-of-pocket/limit maximum,
   - At the time the request for cost-sharing information is made.

Transparency in Coverage Disclosure Elements

3. Negotiated rates
   - The in-network provider payment amount for an item or service.
     - Must be expressed as a dollar amount, i.e. cannot state 150% of Medicare rate;
     - Cannot be presented as a range;
     - Prescription drugs should be based on WAC or MAC depending on brand versus generic
   - Disclosure is still required even when it may not be relevant for calculating an individual's cost-sharing liability for a particular item or service (i.e. subject to a co-payment, deductible has been met, etc.);
   - May not be required in certain payment models (capitated arrangements or Accountable Care Organizations (ACOs)

Transparency in Coverage Disclosure Elements

4. Out-of-network allowed amounts
   - Out-of-network allowed amount a group health plan or health insurance issuer would pay for a covered item or service furnished by an out-of-network provider.
     - i.e. maximum payment of $100 and member is responsible for 30% of charges, estimate would indicate the $100 maximum amount and $30 as the cost-sharing.
     - An HMO would list the allowed amount as $0

Transparency in Coverage Disclosure Elements

5. Items and Services content list
   - For bundled services, health plans would have to disclose a list of EACH item and service subject and cost-sharing liability as a bundle.
6. A notice of prerequisites
   - when consumers request cost-sharing information, health plans must inform them if the item or service is subject to concurrent review, prior authorization, step-therapy, or other medical management (fail-first) protocols.
   - Does not include medical necessity reviews

Transparency in Coverage
Disclosure Elements

7. Disclosure notice – model notice is available but not required
   - Must include the following information in plain language:
     a. an explanation disclosing that out-of-network providers may bill consumers the difference between a provider's billed charges and the sum of plan payments and copayments/coinsurance (balance billing), if balance billing is permitted under state law;
     b. a statement that actual charges may vary from the estimate;
     c. a statement that estimated cost-sharing is not a guarantee that coverage will be provided for those items and services;

Transparency in Coverage Disclosure Elements

7. Disclosure notice – model notice is available but not required (continued)
   - Must include the following information in plain language:
     d. disclosure of whether copayment assistance and other third-party payments are included and counts toward deductibles and out-of-pocket maximums; and
     e. a statement that item or service may not be subject to cost-sharing if it is billed as preventive service.

Transparency in Coverage Delivery

- Plans and issuers must make cost-sharing information available for 500 items and services identified by the departments for plan years beginning on or after January 1, 2023, and for all items and services for plan years beginning on or after January 1, 2024.
- The list of 500 items and services is available in the final rule.
- Plans and issuers must make required information available, without a fee, in two ways:
  - through an Internet-based "self-service tool" ; and
  - in paper form by mail upon a consumer's request.

Transparency in Coverage
Internet Delivery

- No subscription or other fees;
- Must provide real-time responses that are based on cost-sharing information that is accurate at the time of the request.
- Allows for a search by billing (CPT) code or a descriptive term (rapid flu test)
- Allow users to enter a specific in-network provider along with the CPT code or descriptive term
- If plan or issuer utilizes a multi-tiered network, tool would be required to produce the relevant cost-sharing information for the covered item or service for individual providers within each tier.

Transparency in Coverage
Internet Delivery

- If estimate varies based on factors other than provider, tool would also be required to allow users to input sufficient information to disclose meaningful cost-sharing information
  - i.e. preventive versus diagnostic
- If cost-sharing liability estimate for a prescription drug depends on the quantity and dosage of the drug, the tool would be required to allow the user to input a quantity and dosage

Transparency in Coverage
Internet Delivery

- If estimate varies based on the place of service at which an in-network provider furnishes the services (i.e. outpatient facility versus in a hospital setting) tool would be required to either permit a user to select a facility, or display in the results cost-sharing liability information for every in-network facility at which the in-network provider furnishes the specified item or service.
- Allow users to search for the out-of-network allowed amount or other metric for a covered item or service provided by OON providers by inputting a billing code or description term and the information that is necessary for the plan or issuer to produce the OON allowed amount (i.e. zip code for the location of the OON provider)

Transparency in Coverage
Internet Delivery

- If multiple results, tool would be required to have functionalities that allows users to refine and reorder results (sort and filter) by geographic proximity of provider and amount of estimated cost-sharing liability.
- The Departments encourage plans and issuers to also provide a mobile application version in addition to an internet website but will not require it.

Transparency in Coverage
Paper Delivery

- Must be provided as an alternative upon request;
- Cannot require a fee;
- Plan or issuer would be required to refine and reorder results if the request returns more than one result;
- Must be provided no later than 2 business days after a request is received;
- Plan or issuer may limit any results for a paper request to 20 providers per request;
- If a participant, beneficiary or enrollee requests an alternative means of disclosure (phone or email), the plan or issuer is permitted as long as the request is delivered in the same time frame as the paper method.

Transparency in Coverage Enforcement

- States will generally be the primary enforcers of the requirements
- Good faith compliance - applies if acting in good faith and with reasonable diligence…
- A plan makes an error or omission in a disclosure, if the plan corrects the information as soon as practicable
- A plan's internet website is temporarily inaccessible, if the plan makes the information available as soon as practicable
- A plan relies on information from another entity, unless the plan knows, or reasonably should have known, the information is incomplete or inaccurate

Transparency in Coverage
High End Projected Costs

- Per Insurer
- $5,295,680 in first year for full build
- $3,466,320 for second year to add all services
- $1,113,060 for annual upkeep

Questions

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