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Is your health insurance customer experience ready for CAA's No Surprise Act?

PRIYAMA BARUA - VP, CUSTOMER EXPERIENCE STRATEGY, MERGE
ANASTASIA FIELDS - CUSTOMER EXPERIENCE STRATEGIST, MERGE

There are sweeping changes coming to healthcare in America, and if you're paying attention, this could be your opportunity to meet regulatory requirements and surpass them to delight customers.

From Obama's ACA interoperability mandate to Trump's hospital price transparency rule and now the Consolidated Appropriations Act (CAA), it feels like a crescendo where health insurance companies are facing a pivotal moment. Thoughtful and swift action can forever change how people are impacted by the arcane and complex healthcare system that they have grudgingly gotten accustomed to.

The CAA was signed by Congress in late 2020 and while some provisions have already come into effect, several that will provide protection to members will be required to be enacted upon by 2022. This article explores one of the measures called the "No Surprise Act" and explains its provisions.

Enacting the provisions, in the world of business and experience strategy would be called a "wicked problem" — issues that are difficult because traditional problem-solving processes can't resolve them. The thing with wicked problems is that sometimes the direction taken to solve them often end up exacerbating them if the problem solving is only top down. This can be seen with President Trump's hospital price transparency rule that was well intentioned but has not had its intended effect.

Balance Billing Protections for Emergent Care

The world we live in now

If Mark had a fall while hiking and had to be airlifted to be seen at an emergency room (ER), he could be facing bills that run into tens of thousands of dollars if either he is taken to an out of network (OON) facility, or the air ambulance or a provider in the ER is not in network. The bill would run higher especially if Mark's plan is not a PPO or if Mark's plan is a self-insured plan (some states already provided protection to fully insured plans).

Post implementation of No Surprise Act

From January 2022, Mark cannot be "balance-billed" OON costs for any of the services received in this situation. The cost of care at the OON ER and all post-stabilization care would need to be covered until he can be moved to another in-network facility safely. Air ambulance transports would also be covered at in-network rates even if they were OON.

Looking out for the member

Surprise ER bills have long been a pain point for Americans. At their most vulnerable, people have been punished and brought to bankruptcy in situations where they had no choice and no way of knowing if they were being sent an OON transport. While air ambulances are covered by this provision, ground transport is not. Mark may still face an unexpected bill if the ground ambulance dispatched by 911 is not in network. Many Americans avoid emergent care in fear of facing a large bill. The next time Mark is in need of help and considers calling for an ambulance, he may not, due to the impending monetary loss. Insurance carriers have a choice to do the right thing in this scenario and extend the provision to ground transport.

Balance Billing Protections for Out-of-Network Charges at In-Network Facilities

The world we live in now

Cecilia plans to go in for a routine colonoscopy and does her research to find the right in-network facility and also ensures the doctor doing the procedure is covered by her insurance. However, if the person in the lab creating Cecilia's report is an OON provider, she could still be facing a surprise bill.

Post implementation of No Surprise Act

From January 2022, if Cecilia were to receive non-emergent care from OON providers

at an in-network facility, she must first be given other provider options that are in network and if she still chooses an OON provider, her written consent must be obtained along with providing her an estimate of the charges. This notice and consent provision doesn't apply where no in-network provider is available and specific no-exception providers she is unable to select, like a radiologist, pathologist or assistant surgeon s available and to specific "no-exception providers" like radiologists, pathologist or assistant surgeons, that Cecilia has no way of selecting.

Looking out for the member

Cecilia needs education that she has the option to not consent to being seen by an OON provider. An uninformed member may inadvertently consent to higher costs if they don't know their options. Cecilia should also have sufficient avenues for expressing grievances if there is a significant delay in care as a result of waiting for an in-network provider to become available.

Given the general population's low literacy about health insurance, there's danger of this provision being misunderstood. Would people mistakenly end up going to OON care? The only way to ensure that this wouldn't happen is to explain clearly what this provision allows for and what it doesn't allow for.

The plan sponsor/facility/provider experience

Since neither Mark nor Cecilia will be cost-sharing for the higher costs of OON health and service providers, the question of who pays comes up. First, plan sponsors, facilities and the OON provider will try to reach a resolution within 30 days, failing which an Independent Dispute Resolution (IDR) process will begin. Each entity will provide information including the medical case, the provider qualifications, attempts to join the network and payments received for similar services in the geographical area. The losing party will pay the remaining bills.

This adds tension to an already strained relationship between payers and providers. The financial burden on the entities is unknown until the results of the first few IDR processes are known, but the administrative burden alone will likely add to an inefficient system. While the provisions themselves will bring about a much better patient/member relationship, the resolution of who pays the bill can be approached differently.

For example, could providers, facilities and providers share risk so that the financial burden is split equally instead of being skewed? And could this provision ultimately lead to more aggressive expansion of networks themselves by overcoming friction points for providers joining networks?

An unintended breakdown outcome would be delayed care while patients wait for an in-network provider to become available. Could they even be denied care if providers and facilities end up bearing most of the financial burden as a result of the IDR process? Surely this is not unthinkable if the financial burden resulting from the IDR process far outweighs litigation expenses for denying care. Relationships between providers and facilities could become strained and potentially lead to an even more exacerbated shortage of qualified providers.

Advanced Explanation of Benefits

The world we live in now

Priyanka is planning the knee surgery she's been delaying and feels like she finally has everything in order for it. The only problem is that she has no idea how much her out of pocket (OOP) costs will be. Getting an accurate OOP cost from one provider is near impossible, let alone price shopping across providers.

Post implementation of No Surprise Act

From January 2022, if Priyanka is scheduled to have a surgery, the provider and facility will be required to provide a good faith estimate including billing and diagnostic codes to the plan sponsor. The plan sponsor then must provide an advanced explanation of benefits (EOB) to Priyanka within a specified time period. The advanced EOB is required to have the network status of the provider and facility, contracted rates (if applicable), expected cost sharing (OOP costs), any requirements such as prior authorizations, Priyanka's deductible and OOP max information, and lastly a disclaimer about the costs being an estimate.

Looking out for the member

EOBs have historically been badly designed, and multiple research studies have shown that people struggle to find value in them. There has not been a lot of incentive up until now to invest in a well-thought-out redesign both in terms of how they look and how they're generated. EOBs can become a clear, concise and easy-to-understand crucial piece of the new human-centered way of thinking about engaging with plan participants.

It is also vital to clearly explain that the advanced EOB is not a guarantee of final costs. With certain procedures, it is common for a physician to make an in-the-moment decision that alters the estimate due to medical necessity. A clear explanation of why costs may vary for different types of procedures will be helpful when understanding individual situations. Over time, data could be mined to understand common reasons and amounts of deviation more accurately.

This is also a great opportunity for plan sponsors to proactively provide comparable lower cost options to patients alongside the advanced EOB.

The plan sponsor/facility/provider experience

While there are a whole host of unethical reasons why providers and facilities may like to keep their costs hard to find, even well-meaning organizations find it hard to provide close to accurate real-time estimates of contracted costs. Remedying misalignment of incentives and disincentives is a first step. For example, in the hospital price transparency rule, a fine of $300 a day for not making costs of 300 common procedures public wasn't enough of a fine to make hospitals comply.

This provision introduces significant administrative costs for plan sponsors and requires close coordination between system actors on timely exchange of the right data needed. If thought through well, the process could be automated for the most part. It is predicted that this provision may encourage plan participants to move to in-network providers once they see a more complete picture on the impact on OOP costs, thereby offsetting costs to implement changes.

Price Comparison Tools

The world we live in now

In the previous example, Priyanka has been scheduled for knee surgery and can thereby get an advanced EOB to understand her OOP costs. But what if she's trying to compare prices across providers? As it currently stands, to get an estimate without an appointment, she'd need to register at the facility, have her doctor send over the orders, call the facility to ask for associated procedure billing codes (ICD codes), then call the insurance to provide the code and hopefully then receive the contracted costs. When she would ask her insurer what this means for her OOP costs, she would probably get a rundown of her deductible, coinsurance, etc., instead of a dollar amount of what she should expect to pay.

Post implementation of No Surprise Act

Beginning January 2022, plan sponsors will be required to maintain an accurate price comparison tool accessible online and by phone for in-network providers and facilities.

Looking out for the member

Designing this price comparison tool in a human-centered manner that preempts member needs and reduces cognitive load is imperative to the success of this provision. To be most useful, it takes into account the member's specific plan details to display estimated costs. For many people, cost is not the primary driver for healthcare decisions. So, accompanying these estimated costs with provider/facility reviews and ratings (even if they're generated by a third-party partnership) will be a much better customer experience.

Best-case scenario would be if this tool was built in consideration of the provider directory (see next provision) so Priyanka is not required to reconcile the information between disconnected tools.

The plan sponsor/facility/provider experience

Building this price comparison web tool and spending on overheads associated with phone inquiries are expected to add to costs for the plan sponsor. It is anticipated that these would be balanced with lower cost care pathway decisions being made by members. However, people typically only care about their OOP costs rather than the cost to the plan. In these cases, other intervention techniques can be applied to drive people toward appropriate care pathways.

The price comparison tool provision in the No Surprise Act is similar to the requirement for an online price comparison tool under the Transparency in Coverage regulations, which the Departments of Labor, Health and Human Services, and the Treasury finalized in late 2020. Those regulations require the development of an online price comparison tool for an initial 500 items and services starting with plan years beginning on or after January 1, 2023, and for remaining covered items and services for plan years beginning on or after January 1, 2024. There is a lot more detail specified in what this tool needs to have and, for this reason, the price comparison tool provision can be looked at as a stepping stone to the transparency in coverage regulation. However, it's imperative that plans start planning and building this tool as soon as possible in order to meet the January 2022 deadline.

Provider Directories

The world we live in now

Finding a provider on his insurer's website with accurate information on their network status and contact details has always been a pain for Mitch. Even if he succeeds in finding a doctor on his insurer's website, when he calls the number listed, he's not taken to the right place or is informed that the doctor has left the practice.

Post implementation of No Surprise Act

Beginning January 2022, Mitch's plan sponsor will be required to maintain an up-to-date directory of in-network providers on a public site. The information will be reviewed every 90 days and if provider information cannot be confirmed, they would be removed from the website. Plan sponsors would have two days to update the directory when informed of a change by a provider/facility. If incorrect information about network status is provided to Mitch, the provision states he has to pay in network cost sharing amounts only and the plan will bear the rest.

Looking out for the member

There is a requirement for plans to retain information for two years if a member requests information by phone, but what is the traceability if a member looks up the information by themself on the public site? The plan to remove non-responsive providers from the website also leads to a poor customer experience as they may mistakenly think their provider is no longer in network just by not being on the plan's website. Member education about their rights in this regard will be extremely important, as are easily reachable grievance routes. If plan sponsors open up such routes themselves as a first line of defense, it would be beneficial to mitigating any fallouts.

The plan sponsor/facility/provider experience

Keeping provider information current has proven to be extremely difficult for health plans. Even provider networks find it hard to keep track of changes in providers internally. This problem is further exacerbated in networks that have grown by acquisition and are functioning on fragmented systems. Well-designed third-party administrators of provider directories may be the most likely choice to fill the technical gap. To avoid costs related to providing wrong information to members, plan sponsors could instead choose to incentivize providers to keep their information updated and provide them easy-to-use interfaces to do so.

Continuity of Care

The world we live in now

Sandra recently had an operation and has been seeing a doctor for post-operative care. When calling to set up an appointment, she is informed by her doctor's office that they no longer accept her insurance and that she needs to find a new specialist or pay OON costs for her visits. But good specialists are hard to find and Sandra doesn't want to wait to continue her care, so she decides to bear the OON cost even though she can barely afford it.

Post implementation of No Surprise Act

Beginning January 2022, if a patient like Sandra is seeing a provider for continuous care needs like terminal illness, post-operative care and treatment for pregnancy, and the provider goes out of network, she would be billed in-network costs for a 90-day grace period.

Looking out for the member

It's the plan sponsor's responsibility to inform Sandra about their doctor going out of network and her right to continued care. The timeliness of this messaging will be very important to ensure Sandra is aware of her rights. This provision, however, doesn't mandate that her doctor continue providing care once they've gone out of network if the claims experience for providers is not kept consistent even after they go out of network, it's possible they decline to see the patient. This can be confusing for Sandra if her plan sponsor and doctor's office give her conflicting information.

The plan sponsor/facility/provider implication

Identification of these scenarios and timely messaging to Sandra will require significant work for plan sponsors. The additional cost burden will be borne by plan sponsors, and this is a provision that has the potential to influence premium costs for plan participants down the road.

Closing Thoughts

The CAA, and particularly the No Surprise Act, is poised to change fundamental things about the system that have caused a poor customer experience. Despite the positive nature of these changes, there are several breakdown scenarios that could occur if health plans do not understand the micro experiences that a plan participant goes through in their journey of seeking care.

Moreover, the general public is largely unaware of the CAA provisions, and unless proactive communication is sent out by the insurance carriers and employers that fund plans, they would remain unaware. An uneducated public cannot advocate for themselves.

Proactive and considerate planning by health plans can result in customer loyalty, increase satisfaction metrics, and also ease the internal process transition to a world post CAA.

How MERGE Can Support

MERGE has decades of experience solving wicked problems for health plans by understanding their customers' longitudinal journey, in consideration of the ecosystem of touchpoints that plan participants encounter. MERGE can also support creation of simple and easy-to-understand material aimed at empowering health plan participants, reducing cognitive load and lessen possibilities of misunderstanding.

Meeting CAA requirements will mean a coordinated effort between plan sponsors, medical insurance carriers, self-funded plan administrators, medical networks, individual providers and any other entity involved in the system. MERGE can facilitate focused workshops to yield impactful solutions rooted in reducing friction and building seamlessness. Our multidisciplinary teams of CX strategists, content strategists user experience designers, automated CRM and communications experts, and platform integration experts can help health plans activate all required changes for the CAA.

If you want to learn more about how MERGE can support your organization in adapting to the CAA, send an email to:

Jim Porter, EVP Managing Director
jporter@mergeworld.com

Priyama Barua, VP CX Strategy Leader
pbarua@mergeworld.com

About the Authors

Priyama Barua is the VP of Customer Experience Strategy at MERGE. Priyama has, over the course of her career, worked with many major health insurance companies in the U.S. to help them build a better customer experience. Her superpower is bringing stakeholders with competing interests together to find a better way forward by putting friction out in the open and co-creating impactful solutions.

Anastasia Fields is a Customer Experience Strategist at MERGE. Anastasia has just begun her professional career since graduating from Northeastern University in 2020, but she has already immersed herself in improving the healthcare experience. Her superpower is empathizing and understanding the needs of others, and translating that into a unified and seamless experience.