THE PHIA GROUP

EMPOWERING PLANS

TEXAS ASSOCIATION OF BENEFIT ADMINISTRATORS

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Compliance and Regulatory Update for Spring 2022

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Agenda

I. General Compliance Updates
- ERISA Penalties and Telehealth

II. Mental Health Parity Compliance
- NQTL Requirements
- White House Budget Proposal

III. COVID-19 Regulatory Updates & Reminders
- The Latest on Testing and Coverage
- National Emergency vs. Public Health Emergency

V. The No Surprises Act Revisited
- A Step-by-Step Walkthrough
- Case Studies
- Appeals vs. IDR Process
- Stop Loss Concerns

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General Compliance Updates

- DOL Releases Updated ERISA Civil Money Penalties

- Form 5500—Maximum penalty for failing to file increased to $2,400.00 per day that the filing is late

- ERISA Section 209(b)—Failure to furnish certain reports to plan participants. $2,400.00

- ERISA Section 502--Failure to provide information requested by the Secretary of Labor. Penalty is $171 per day not to exceed $2,713.00 per request

- ERISA Section 502—Failure by a plan sponsor of a group health plan to satisfy ERISA requirements regarding genetic information

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General Compliance Updates

- DOL Releases Updated ERISA Civil Money Penalties

- ERISA 502—Failure of the plan sponsor to provide employees of coverage opportunities under Children's Health Insurance Program

- Summary of Benefits and Coverage (SBC) — Maximum penalty for failing to provide the SBC is $1,264.00 per failure

- Violations of the Genetic Information Nondiscrimination Act (GINA), Children's Health Insurance Program, etc. - Penalties are now $127.00 per participant per day

- MEWA Filing - Penalties for failing to meet applicable filing requirements for Multiple Employer Welfare Arrangements (MEWA) are now $1,746.00 per day

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General Compliance Updates

- Congress Looks to Expand Telehealth Availability

- CAA 2022 Includes Brief Extension of HSA Telehealth Relief
  - The practical effect of the relief is that HDHPs may choose to waive the deductible for any telehealth services from April 2022 – December 2022 without causing participants to lose HSA eligibility
  - The provision is optional—HDHPs are not required to waive the deductible that would otherwise apply to non-preventive telehealth services

Note: For calendar plan year HDHPs adopting this CAA 2022 extension of the relief, there will be a three-month gap from January 2022 – March 2022 in which the standard deductible will still apply.

- House Reps. Propose the Telehealth Benefit Expansion for Workers Act

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Mental Health Parity Compliance

- Mental Health NQTL Analysis
  - As of Feb. 10, 2021, all health plans must have detailed analysis **on hand** to show that they are meeting mental health parity requirements involving non-quantitative treatment limitations (NQTLs)

- Plans May Be Asked by the DOL, HHS, or State Agencies to Provide Plan Specifics Regarding NQTLs, Including:

  - Factors Utilized
  - Evidentiary Standards & Sources
  - Comparative Analysis Demonstrating Process, Strategies & Evidentiary Standards
  - Findings & Conclusions Showing Plan Is or Is Not in Compliance

- DOL Is Required to Audit These Analyses & Report to Congress Annually

- Failure to Have Analysis On Hand Will Expose Plan to Risk of Fines & Litigation

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Mental Health Parity Compliance

- What Should Plans Do to Get in Compliance & Minimize Risk?
- Perform a NQTL Comparative Analysis, Which:
  - Reviews relevant plan documents, procedure manuals, etc.
  - Identifies any NQTLs applied to mental health benefits
  - Analyzes whether the use of NQTLs is compliant
  - Produces a report detailing the results of that analysis
  - Recommends changes to achieve compliance (if necessary)

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Mental Health Parity Compliance

- Biden's Budget Proposal Includes New Mental Health Requirements

$5.8 Trillion. Starts Oct. 1

The proposal requires all private health plans to cover mental health and substance use disorder benefits. This budget, if approved by Congress, would go much further than the MHPAEA of 2008. Also related to mental health, the White House budget includes:

- Youth mental health/suicide prevention programs
- Strengthening Suicide Prevention Lifeline
- Money for the existing shortage of behavioral health providers

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COVID-19 Compliance

- FDA Authorizes 1st Breath Test for COVID-19 Infection
  - Is it better than other available tests?
  - Do you have to cover it?

- Recap of the Testing Requirements for Plans
  - FFCRA and CARES Act require group health plans and insurers to cover the costs of COVID-19 diagnostic testing without cost-sharing, prior authorization, or other medical management requirements

- If plans do not negotiate a rate for the testing, they must pay for the testing at the cash rate posted on the provider's public website.

- Notable lawsuit - A lab posted their COVID-19 testing rates of $900 per test on their public website. They sued various health plans and third-party administrators (TPAs) alleging that the plans and TPAs violated FFCRA and the CARES Act by failing to pay the lab's posted COVID-19 test rates. Court has allowed this case to proceed. See Diagnostic Affiliates of N.E. Hou, LLC v. United Healthcare Servs., 2022 WL 214101 (S.D. Tex. 2022)

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COVID-19 Compliance

- National Emergency vs. Public Health Emergency

- Public Health Emergency
  - HHS Extends the COVID-19 Public Health Emergency Until July
  - For an additional 90 days, effective April 16
  - Cites Omicron subvariant BA.2 cases
  - This is the 9th extension
  - What impact on health plans? What happens when it ends?

- Biden extended the National Emergency on Feb. 18, which was set to expire on March 1. This most recent extension means that important deadlines continue to be tolled for one year (or, if earlier, 60 days from the end of the National Emergency)

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COVID-19 Compliance

- For Participants:
  - COBRA Qualifying Event and Disability Extension Notices
  - COBRA Election
  - COBRA Premium Payments
  - HIPAA Special Enrollment Period
  - Benefit Claims and Appeals
  - External Review
  - Perfecting a Request for External Review
- For Plan Administrators:
  - COBRA Election Notice–the 14-day deadline (44 days where the employer is the plan administrator) for a plan administrator to provide a COBRA election notice to qualified beneficiaries.

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The No Surprises Act Revisited

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Regulatory Framework

- Enacted December 27, 2020, as part of the Consolidated Appropriations Act of 2021, Public Law 116-260

- Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36872 (July 13, 2021)

  - Explains the scope of the ban of balance billing
  - Broadens definition of emergency services
  - Establishes cost sharing requirements
  - Establishes the criteria for calculating the QPA/Recognized Amount
  - Describes notice and consent
  - Explains interaction with state law

- Requirements Related to Surprise Billing; Part II, 86 FR 55980 (October 7, 2021)

  - the independent dispute resolution process for deciding rates between plans/issuers and out-of-network (OON) providers in certain situations;
  - good faith estimates for items or services for uninsured (self-pay) patients;
  - the patient/provider dispute resolution process if billed charges exceed good faith estimates; and
  - expanded rights to external review

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Overview

The No Surprises Act introduced new requirements for providers, facilities, and providers of air ambulance services to protect individuals from surprise medical bills. These requirements:

- Prohibit providers and facilities from directly billing individuals for the difference between the amount they charge and the amount that the individual's plan or coverage will pay plus the individual's cost-sharing amounts (i.e., balance billing) in certain circumstances;

- Require providers and facilities to provide good-faith estimates of charges for care to uninsured (or self-pay) individuals upon scheduling care or on request, and for individuals with certain types of coverage, to submit good-faith estimates to the individual's plan or issuer;

- Create a patient-provider dispute resolution process for uninsured (or self-pay) individuals to contest charges that are "substantially in excess" of the good faith estimate;

- Require certain providers and facilities to publicly disclose restrictions on balance billing; and

- Limit billed amounts in situations where a provider's network status changes mid-treatment or individuals act on inaccurate provider directory information

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Who Is Protected Under the NSA?

Beginning January 1, 2022, these No Surprises Act requirements will apply to items and services provided to most individuals enrolled in **private or commercial health coverage**, like:

- Employment-based group health plans (both self-insured and fully insured)
- Individual or group health coverage on or outside the Federal or State-based Exchanges
- Federal Employee Health Benefit (FEHB) health plans
- Non-federal governmental plans sponsored by state and local government employers
- Certain church plans within IRS jurisdiction
- Student health insurance coverage [as defined at 45 CFR 147.145]

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- Non-federal governmental plans sponsored by state and local government employers
- Certain church plans within IRS jurisdiction
- Student health insurance coverage [as defined at 45 CFR 147.145]

Some requirements also apply to providers and facilities with respect to uninsured (or self-pay) individuals, like requirements that providers and facilities provide good faith estimates for scheduled care, or upon request.

The NSA does not apply to beneficiaries or enrollees in Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. These programs have other protections against high medical bills. The protections also don't apply to short-term limited duration insurance (STLDI), excepted benefits, or retiree only plans; or account-based group health plans.

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When Does the NSA Apply?

The No Surprises Act requires health plans and issuers to apply in-network cost-sharing terms and prohibits out-of-network providers, facilities, or providers of air ambulance services from billing individuals more than these in-network cost-sharing limits in 3 main scenarios:

1. A person gets covered emergency services from an out-of-network provider or out-of network emergency facility;

2. A person gets covered non-emergency services from an out-of-network provider delivered as part of a visit to an in-network health care facility; or

3. A person gets covered air ambulance services provided by an out-of-network provider of air ambulance services.

In limited situations, the No Surprises Act allows some out-of-network providers and facilities to seek written consent from individuals to voluntarily waive their protection against balance billing for post-stabilization services or non-ancillary, non-emergency services.

- These situations are referred to throughout this presentation as notice-and-consent exceptions

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When Does the NSA Apply?

In-network: A provider, facility, or provider of air ambulance services that has a contractual relationship with a health plan or issuer for the item or service provided.

- Contractual relationships include single case agreements between a plan or issuer and an out-of-network facility that are used to address unique situations in which an individual requires services that typically occur out-of-network.

Out-of-network: A provider, provider of air ambulance services, or facility that doesn't have a contractual relationship with an individual's health plan or issuer for the item or service provided.

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When Does the NSA Apply?

Covered Benefits: Prohibitions on balance billing for air ambulance, emergency, and non-emergency services only apply to items or services that are covered benefits under the in-network terms of a privately insured individual's health plan or coverage

Plan Year: Prohibitions on balance billing apply to items or services delivered in health insurance plan or policy years starting on or after **January 1, 2022.**

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How Does the NSA Apply to Providers?

In situations where balance billing is banned and a notice-and-consent exception doesn't apply, an out-of-network provider, emergency facility, or provider of air ambulance services can't:

1. Bill an individual for an amount that exceeds in-network limits on cost-sharing; or

2. Hold an individual liable for paying an amount that exceeds in-network limits on cost sharing, and the individual can't be put in the middle of a dispute regarding the total payment amount from the plan or issuer to the provider, facility, or provider of air ambulance services

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How Does the NSA Apply to Providers?

After an out-of-network provider, facility, or provider of air ambulance services furnishes items or services to an individual, the out-of-network provider or facility receives an **initial payment** from the health plan or issuer. However, the final payment they receive from the plan may be determined by:

- An all-payer model agreement (APMA) or specified state law depending on the item or service, geographic area where the care was provided, and type of plan or issuer and provider or facility involved.

- If there is no APMA or specified state law that applies, the provider, facility, or air ambulance provider may accept the initial payment as payment in full or may enter into a 30-business-day period of open negotiations with the health plan or issuer to determine the final total amount.

- If negotiations fail, the two parties may enter an independent dispute resolution (IDR) process to determine final total payment.

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Calculating Cost Sharing

In situations where balance billing is banned under the No Surprises Act, health plans and issuers must determine the amount that out-of-network providers, facilities, or providers of air ambulance services can charge an individual by imposing cost-sharing requirements that are not higher than the in-network cost-sharing terms of an individual's plan.

Health plans and issuers calculate the dollar amount of cost-sharing applying the cost sharing terms to the "recognized amount," which is further specified in regulations.

Depending on the type of item or service and geographic area where care is provided, plan or issuer, and provider or facility, this amount can be set by an all-payer model agreement (if applicable to the plan/issuer and provider/facility), a specified state law (if applicable to the plan/issuer and provider/facility), or the lesser of (1) billed charges or (2) the plan's **qualifying payment amount** (QPA) for the item or service.

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Calculating Cost Sharing

The **QPA** is defined in regulation and is generally the plan or issuer's median contracted rate for the item or service in the geographic area where the item or service was delivered from January 31, 2019, indexed for inflation.

Amount used to calculate individual cost-sharing	
Emergency and Non-Emergency Services	The recognized amount which is: **An amount determined by an All-Payer Model Agreement** (e.g., Maryland's All Payer Model) *If no All-Payer Model Agreement exists:* **Amount determined by specified state law** *If no All-Payer Model Agreement or specified state law exists, the lesser of:* **a) the amount billed by the provider/facility or** **b) the qualifying payment amount for the item or service**
Air Ambulance Services	The lesser of: **a) the amount billed by provider of air ambulance services or** **b) the qualifying payment amount for the item or service**

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Provider Obligations Under the NSA

To ensure compliance with the No Surprises Act, providers, facilities, and providers of air ambulance services may need to bill the plan or issuer directly for services to determine whether No Surprises Act protections apply.

Out-of-network providers must also determine whether the facility where they delivered care is an in-network health care facility for a particular individual's health plan and coverage, as well as whether the individual received items or services provided in conjunction with a visit at an in-network facility (e.g., laboratory services).

If out-of-network providers, facilities, or providers of air ambulance services bill an individual in violation of the No Surprises Act, they may be subject to civil fines or other corrective action.

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Air Ambulance Services

Generally, out-of-network air ambulance service providers are banned from balance billing an individual for covered **air ambulance services**.

Note that ground ambulance services aren't covered under this prohibition.

Out-of-network air ambulance service providers can't balance bill for the following **air ambulance services**, including medical supplies and services provided in transport:

1. Medical transport by helicopter ("rotary wing" ambulance); and
2. Medical transport by airplane ("fixed wing" ambulance).

This applies to situations where air ambulance services are covered under the in-network terms of an individual's health plan/coverage, even if there are no in-network air ambulance service providers within an individual's plan/coverage.

Air ambulance service providers may **NEVER** seek an individual's consent to waive No Surprises Act protections for these services through notice-and-consent exceptions.

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Quiz #1

Carol is a 58-year-old female with Marketplace coverage. Over 2 days, she develops worsening abdominal pain, nausea, and constipation, which prompts her to call 911 for medical assistance. She is driven by ground ambulance transport to her local in-network emergency department for exam and treatment.

How much can the ambulance provider bill Carol under the rules of the No Surprises Act?

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Answer #1

The ambulance provider isn't banned from balance billing under the No Surprises Act because it is a ground ambulance provider.

Note: Air ambulance service providers, but not ground ambulance service providers, are banned from balance billing under the No Surprises Act. As such, no restrictions are placed on the amount the ambulance provider can bill an individual under the No Surprises Act.

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Focusing on Emergency Services

Generally, **out-of-network providers** and **out-of-network emergency facilities** can't balance bill an individual who gets covered **emergency services** for an **emergency medical condition**.

The following types of providers can't send a balance bill for **covered emergency services when providing care as an out-of-network provider** at an emergency facility:

1. Physicians;

2. Other health care providers acting within their scope of practice under applicable state law (e.g., a certified nurse practitioner or physician assistant).

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Focusing on Emergency Services

The following types of facilities can't send a balance bill for covered emergency services when providing care as an **out-of-network emergency facility:**

1. Emergency departments of a hospital, defined as hospital outpatient departments that provide emergency services;

2. Hospitals, regardless of the department, when providing post-stabilization services; and

3. Independent, freestanding emergency departments, defined as health care facilities that:

– Are geographically separate and distinct and licensed separately from a hospital under applicable state law; and
– Provide any emergency services.

Note: Urgent care centers can be treated as independent, freestanding emergency departments if they meet this definition of an independent, freestanding emergency department.

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Focusing on Emergency Services

Out-of-network providers and emergency facilities are **ALWAYS** banned from balance billing for the following **emergency services:**

- An appropriate **medical screening examination** that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department, to evaluate whether an emergency medical condition exists; and

- Such **further medical examination and treatment** as may be required **to stabilize** the individual (regardless of the department of the hospital in which the further medical examination and treatment is furnished) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department.

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The Prudent Layperson Standard

Balance billing isn't allowed for emergency services when an individual gets care for an **emergency medical condition**, using a "prudent layperson" definition (cannot simply rely on diagnosis codes!):

• A person, who has average knowledge of health and medicine, experiences a medical condition (including a mental health condition or substance use disorder) that is so severe they believe:

– They need immediate medical care; and
– Failing to get immediate medical care could:

• Result in their health or the health of their unborn child being in serious jeopardy; or
• Result in serious impairment to bodily functions; or
• Lead to serious dysfunction of any bodily organ or part.

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Quiz #2

Zoe is a 26-year-old female with Marketplace coverage. She works as a teacher and has an average knowledge of health and medicine. She has severe pain, swelling and redness of her right calf, and becomes concerned that this may be dangerous. So, she travels to the local hospital emergency department that is in her health plan's network. She has a venous ultrasound. The radiologist, who is out-of-network, reads the ultrasound, which shows a deep vein thrombosis.

Zoe is started on medication and discharged from the emergency department.

Do the No Surprises Act's balance billing protections related to emergency services apply to the radiologist?

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Answer #2

Yes, it would.

Zoe sought care for a medical condition that, using reasonable layperson judgment, she thought was an emergency medical condition that needed immediate medical attention to avoid serious jeopardy, impairment, or dysfunction.

Per the No Surprises Act, out-of-network providers are banned from balance billing for emergency services provided for emergency medical conditions. Emergency services include ancillary services available to the emergency department to evaluate whether an emergency medical condition exists, such as services of a radiologist who reads an imaging study.

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Post-Stabilization Services

Under the No Surprises Act, certain **post-stabilization services** are considered emergency services, and prohibitions on balance billing generally apply.

Post-stabilization services are covered services that are provided after the individual is stabilized, as part of an outpatient observation, or an inpatient or outpatient stay related to the emergency visit (regardless of the department of the hospital).

In limited circumstances, an out-of-network provider or emergency facility can use the No Surprises Act's notice-and-consent exceptions to obtain voluntary consent from an individual to waive the balance billing protections for post-stabilization services.

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Post-Stabilization Services and Notice and Consent

A provider or emergency facility can get written consent from an individual to waive their balance billing protections under the No Surprises Act for post-stabilization services **only if all the following requirements are met:**

	Requirement	Additional Details
1.	An individual is stable enough to travel using nonmedical or nonemergency medical transport to an available in-network provider/facility located within a reasonable travel distance given the individual's medical condition.	• Determined by attending emergency physician or treating provider. • Provider determination is binding on a facility.
2.	The individual or their authorized representative is in a condition where they can receive information and provide informed consent.	• Determined by attending emergency physician or treating provider. • An authorized representative CAN'T be a provider affiliated with the facility or an employee of the facility, unless such provider or employee is a family member of the participant, beneficiary, or enrollee.
3.	The provider/facility provides written notice and obtains written consent from the individual to waive balance billing protections, in compliance with all related statutory and regulatory requirements.	• Details provided starting on slide **51**.
4.	The provider/facility complies with state laws.	• This may include state laws that further restrict balance billing for post-stabilization services.

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Emergency Services and Plan Exclusions

If you cover Emergency Services at all, the NSA indicates that you cannot apply general plan exclusions to deny claims for emergency services.

July IFR: *The Departments are also aware that some plans and issuers that generally provide coverage for emergency services have nonetheless denied benefits for such services based on other general plan exclusions. Some plans and issuers denying claims for emergency services provided to dependent women who are pregnant, based on a general plan exclusion for dependent maternity care.*

If a plan or issuer provides or covers any benefits with respect to services in an emergency department of a hospital (or under these interim final rules, in an independent freestanding emergency department), emergency services must be provided "without regard to any other term or condition of the plan or coverage (other than the exclusion or coordination of benefits . . .)." The Departments clarify that this provision does not permit plans and issuers to exclude benefits for items and services that would otherwise constitute benefits for an emergency medical condition as defined under these interim final rules. This provision does not permit plans and issuers that cover emergency services to deny benefits for a participant, beneficiary, or enrollee with an emergency medical condition that receives emergency services, based on a general plan exclusion that would apply to items and services other than emergency services.

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Quiz #3

Carlos is a 62-year-old male with employer-sponsored health coverage. He is involved in a ski accident and sustains multiple injuries. He is taken to the closest hospital, which is out-of-network. He undergoes surgery to repair multiple leg fractures. Once he is stable and out of surgery, he is counseled on the option to transfer care to another local in-network hospital for the duration of his recovery. His treating physician determines the safest form of transport, given his medical state, would be via ambulance.

Carlos knows that the hospital he is in has an excellent reputation and wishes to stay there for his recovery. The hospital provides a written notice and gets his written consent to waive his balance billing protections under the No Surprises Act. He remains inpatient for two additional days and is ultimately discharged to home.

Does the No Surprises Act's prohibition on balance billing for emergency services apply to all days of care Carlos received from this hospital?

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Answer #3

Yes.

The hospital is banned from balance billing Carlos for items and services provided prior to his being stabilized. The hospital is also banned from balance billing him for post-stabilization services provided after surgery, despite obtaining written consent from Carlos to waive his balance billing protections under the No Surprises Act. Because he could only safely be transferred via ambulance, the hospital can't seek consent from him to waive his balance billing protections under the No Surprises Act specific to post-stabilization services.

In the event that an individual requires medical transportation to travel, including transportation by either ground or air ambulance vehicle, the individual is not in a condition to receive notice or provide consent.

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Focus on Non-Emergency Services

Generally, **out-of-network providers** are banned from balance billing an individual who gets covered, non-emergency services that are **part of a visit to an in-network health care facility.**

The following types of providers are banned from balance billing when providing nonemergency services as an **out-of-network provider** at an in-network health care facility:

- Physicians;

- Other health care providers acting within their scope of practice under applicable State law (e.g., a certified nurse practitioner or physician assistant).

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Focus on Non-Emergency Services

The No Surprises Act's prohibitions on balance billing for non-emergency services only apply to covered non-emergency services that are furnished as part of a visit to one of the following **in-network health care facilities**:

- **Hospitals** (including critical access hospitals);

- **Hospital outpatient departments**; or

- **Ambulatory surgical centers**.

Reminder: To be considered **an in-network health care facility**, a facility must be:

- In-network; or
- Have a single case agreement with a health plan or issuer for a specific individual.

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Scope of Non-Emergency Services

Out-of-network providers can't balance bill for **non-emergency items and services that are part of a visit** at an in-network health care facility. This includes the following:

1. Equipment and devices;
2. Imaging services;
3. Telemedicine services;
4. Lab services;
5. Preoperative services and postoperative services

These items or services don't need to happen physically within the in-network health care facility to be treated as part of a visit (e.g., offsite laboratory services).

Reminder: The No Surprises Act's ban on balance billing for non-emergency services only apply to plan covered services. If a non-emergency service is not covered under the in-network benefits and terms of coverage under an individual's health plan, then the No Surprises Act's rules on balance billing do not apply for these services.

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Focus on Non-Emergency Services

Ancillary services, which individuals typically have little control over, are **ALWAYS** subject to balance billing prohibitions.

The No Surprises Act defines **ancillary services** as:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, provided by either a physician or non-physician practitioner;

- Items and services provided by assistant surgeons, hospitalists, and intensivists;

- Diagnostic services, including radiology and laboratory services; and

- Items and services provided by an out-of-network provider when there is no in-network provider who can provide the item or service at the in-network health care facility.

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Focus on Non-Emergency Services

Providers and facilities may **NEVER** seek an individual's consent to waive the No Surprises Act's balance billing protections for **non-emergency ancillary services** through use of notice-and-consent exceptions.

Notice-and-consent exceptions also **NEVER** apply to waive the No Surprises Act's balance billing protections related to non-emergency services when:

- Items or services are provided due to unforeseen urgent medical needs in the course of care delivery; or

- Banned by state laws

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Non-Emergency Services and Notice and Consent

A provider/facility can use the No Surprises Act's notice-and-consent exception to get consent from an individual to voluntarily waive their balance billing protections under the No Surprises Act for non-ancillary, non-emergency services furnished in an in-network facility. All requirements for providing notice and consent documents and getting proper consent must be met.

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When NSA Does Not Apply to Non-Emergency Services

The No Surprises Act does not regulate billing for non-emergency services in the following circumstances:

- When non-emergency covered items or services are provided in an **out-of-network** hospital, outpatient hospital department, ambulatory surgical center, or other facility type specified by the Secretary of Health and Human Services (HHS).

- When the items or services provided are not covered under the in-network terms of an individual's health plan or coverage, even if provided in an in-network hospital, outpatient hospital department, ambulatory surgical center, or other facility type specified by the Secretary of HHS.

Reminder: Providers may need to bill plans or issuers directly to determine whether No Surprises Act requirements apply, given the terms of an individual's health plan/coverage and a facility's participation status.

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Quiz #4

Rhonda is a 50-year-old female with employer-sponsored health insurance who discovers a lump in her breast. Her primary care provider orders a mammogram, which shows a suspicious mass. She is referred to the local in-network hospital's outpatient department for a biopsy. The biopsy is reviewed and found to be negative for malignant cells by a pathologist who happens to be out-of-network.

How much can the pathologist bill Rhonda under the rules of the No Surprises Act?

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Answer #4

Under the No Surprises Act, the pathologist is banned from billing Rhonda more than the in-network cost-sharing amounts, as determined by her health plan. The pathologist, as an ancillary service provider, is banned from obtaining consent from the individual to waive these balance billing protections.

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Notice and Consent Recap

When can out-of-network providers or facilities use notice and consent exceptions?

Emergency services, including post-stabilization services	
Use of Notice-and-Consent Exception Not Allowed	**When providing any emergency services prior to post-stabilization services, including medical exams and treatment to stabilize an individual** **When providing items or services due to unforeseen urgent medical needs in the course of care delivery** **When providing post-stabilization services if any one of the requirements listed below are not met** **Additional situations banned by state law**
Use of Notice-and-Consent Exception Allowed	**When providing post-stabilization services and all the following are true:** • An individual is stable enough to travel using nonmedical or nonemergency medical transport to an available in-network provider/facility located within a reasonable travel distance given the individual's medical condition. • The individual or their authorized representative is in a condition where they can receive information and provide informed consent. • The provider/facility provides written notice and obtains written consent from the individual to waive balance billing protections under the No Surprises Act, in compliance with all related statutory and regulatory requirements. • The provider/facility complies with applicable state laws.

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Notice and Consent Recap

When can out-of-network providers or facilities use notice and consent exceptions?

Non-emergency services	
Use of Notice and Consent Exception <u>Not</u> Allowed	**When providing ancillary services, defined as:** • Emergency medicine, anesthesiology, pathology, radiology, neonatology items or services provided by physician or non-physician practitioner; • Items or services provided by assistant surgeons, hospitalists, and intensivists; • Diagnostic services, including radiology and laboratory services; **Items or services of an out-of-network provider if there is no in-network provider who can provide the item or service at the facility.** **When providing items or services due to unforeseen urgent medical needs in the course of care delivery.** **Additional situations banned by state law.**
Use of Notice and Consent Exception <u>Allowed</u>	**When providing non-emergency services (i.e., not post-stabilization services) in an in-network facility and all the following are true**: • The items or services do not meet the definition of ancillary services; • Another in-network provider can deliver the items or services at the in-network health care facility; and • The provider gives written notice and gets written consent from the individual to waive the balance billing protections under the No Surprises Act, in compliance with all related statutory and regulatory requirements.

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Notice and Consent Requirements

When giving notice and seeking consent from individuals to waive their balance billing protections under the No Surprises Act, providers and facilities must use standard notice and consent documents developed by HHS. The standard notice and consent documents are available on CMS.gov. Providers and facilities must tailor the standard notice with individual- and provider-specific information.

Provider/Facility supplied information in notice document:

- Patient Name
- Out-of-network provider(s) or facility name
- Statement that the health care provider is an out-of-network provider, with respect to the health plan or coverage
- Good faith estimates of the amount the individual may be charged for items or services delivered by the out-of-network provider(s) or facility
- Statement that prior authorization or other care management limitations may be required
- *For post-stabilization services furnished by an out-of-network provider in an in-network emergency facility:* A list of in-network providers at the facility able to deliver needed items or services

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Notice and Consent Requirements

Requirement	Information
Timing of delivery	• If an individual schedules an appointment at least 72 hours before the date of the appointment, notice and consent documents must be given to the individual no later than 72 hours before the date of appointment. • If an individual schedules an appointment within 72 hours of the date of the appointment, notice and consent documents must be given on the day the appointment is made, but at least 3 hours before the time when items or services are to be provided.
Method of delivery	**Notice and consent documents must be delivered:** • Together. • Physically separate from other forms. They must not be attached or incorporated into other documents or hidden among other forms. • On paper or electronically, as preferred by individual. A representative of the provider/facility must be physically present or available by phone to answer questions.

There are also language accessibility requirements providers must meet.

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Notice and Consent Requirements

The following parties may provide notice and get signed consent from individuals to waive balance billing protections under the No Surprises Act:

- Out-of-network providers;

- Out-of-network emergency facilities; and

- In-network facilities on behalf of out-of-network providers.

An individual can provide consent to waive the No Surprises Act's balance billing protections for multiple providers involved in the delivery of care through a single set of notice and consent documents. If multiple providers are using a single set of notice and consent documents, the documents must:

- Identify each provider, the services or items furnished by each provider, and the good faith estimate for each provider's services or items.

- Allow the individual to waive No Surprises Act protections for each provider separately.

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Notice and Consent Requirements

• Consent does not represent a contractual agreement of the individual to any estimated charge or to be treated by that provider or facility.

• Consent documents may be signed electronically by the individual or their authorized representative.

• For the signed consent form to be valid, it must not be revoked in writing by the individual before they get the items or services related to the consent form.

• If a provider or facility doesn't comply with any one requirement related to providing notice and consent documents and getting consent, the provider or facility can't balance bill the individual. This is true even if the provider or facility gets the individual's signed consent.

• A provider or facility can refuse to treat an individual if they don't consent to waive their balance billing protections under the No Surprises Act, so long as this is allowed under state law. However, no fees can be imposed on an individual for cancelling an appointment if they don't consent to waive their No Surprises Act protections.

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Notice and Consent Requirements

Signed consent documents must include the time and date when the individual got the notice, and the time and date when the individual signed the consent document.

- Providers and facilities must retain a copy of notice and consent documents for at least 7 years after the date when the item or service is provided.

- Providers and facilities must give a copy of the signed notice and consent documents to the individual in-person or through mail or email (based on individual preference).

- Providers and facilities must timely notify a health plan or issuer about items or services delivered for which proper consent to waive balance billing prohibitions was obtained and give the plan or issuer a copy of the signed documents, preferably with the claim.

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Quiz #5

Shawn is a 35-year-old male who has insurance through the Marketplace. He is playing soccer and sustains a knee injury, which is later diagnosed as a torn ACL. He is advised by his friends to go to a specific orthopedist who has an excellent reputation. His surgery is scheduled at an in-network ambulatory surgical center a week in advance.

One day before his surgery, he gets an email with the written notice and consent documents, informing him that the orthopedist is out of-of-network and requesting that he consent to waive his balance billing protections under the No Surprises Act in order to be treated by the orthopedist. Shawn signs the consent to waive balance billing protections, as he would like to see this specific provider for his knee surgery.

Several weeks after his surgery, Shawn gets a balance bill from his orthopedist.

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Answer #5

No, the provider violated No Surprises Act requirements related to when notice and consent documents must be provided to individuals.

Since Shawn scheduled his surgery more than 72 hours in advance, written notice and consent must be provided to the individual no later than 72 hours before the date of the appointment. In this case, the provider sent notice and consent documents one day before the appointment.

Because all requirements related to using notice-and-consent exceptions were not met, the orthopedic surgeon is banned from balance billing Shawn for services provided as part of the surgery even though he signed the consent form.

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Focusing on the IDR Process

The plan must submit an initial payment to the provider within 30 days of receiving a clean claim

If the provider accepts, great. If the provider rejects, the group health plan and the OON provider have 30 days to negotiate and make a final payment. After that, if the dispute persist, the amount the health plan will have to pay the OON provider is determined through an independent dispute resolution (IDR) process

There is no threshold amount for claims to go to the IDR process through an IDR entity

The process is “baseball style,” meaning that each side will present an arbitration brief with a settlement approach

The arbitrator picks one of the parties’ offers. The losing party pays the IDR costs

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The IDR Factors

- The IDR reviewer must consider certain factors in making its decision, including the median INN rate for the service, as well as other information the parties provide (more on this in a few slides)

- They have to consider the median INN rate that we talked about earlier, as well as other information such as the difficulty of the case and the qualifications of the provider

- The IDR reviewer cannot consider UCR, billed charges, or Medicare/Medicaid rates in making its decision

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What Info Must be Submitted in IDR?

Parties must submit:

- Final offers of payment expressed both as a dollar amount and as a percentage of the qualifying payment amount (QPA);

- The QPA for the applicable year for the same/similar items or services; for providers and /facilities;

- The size of the provider practice or facility and the; for information on the: coverage area of the plan or issuer, the relevant geographic region for purposes of the QPA, and whether the coverage is fully-insured or partially or fully self-insured; (or a FEHB carrier if the item or service relates to FEHB plans);

- And any additional information the parties would like the certified IDR entity to consider, but not including information relating to the offer that was submitted by either party. The information submitted should not include information related to any on prohibited factors; and any additional information requested by the IDR entity.

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The IDR Process Timeline

IDR Action	Timeline
Initiate open negotiation period (one party)	30 business days, starting on the day of initial payment or notice of denial of payment
Initiate IDR process (either party)	4 business days, starting the business day after the open negotiation period ends
Mutually pick IDR entity *NOTE: Departments select certified independent dispute resolution entity in the case of no conflict-free selection by parties	3 business days after the independent dispute resolution initiation date
Submit payment offers and additional information to certified independent dispute resolution entity	10 business days after the date of certified independent dispute resolution entity selection
Payment determination made	30 business days after the date of certified independent dispute resolution entity selection
Payment submitted to the applicable party	30 business days after the payment determination

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The IDR Portal Goes Live

Why care about the portal?

- Rules and fact sheets explaining what the No Surprises rules cover, numerous provider resources and detailed balance billing rules
- Information on how out-of-network payment disputes between providers and health plans will be decided
- An application to become a dispute resolution entity
- A form to submit feedback on applicants
- A list of certified organizations
- Information about consumer rights and protections to end surprise bills and remove members/patients from payment disagreements between their providers, healthcare facilities and health plans

The Federal IDR Portal is located at https://www.nsa-idr.cms.gov/.

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A Challenge to the IDR Factors

Texas Medical Ass'n, et al. v. US Department of Health and Human Services, et al.

- The Issue
  - Texas Medical Association (state medical society sued DHHS arguing arbitration gives insurers an unfair advantage in establishing payment rates
  - Key provision being challenged - whether the arbiter must put an emphasis on choosing the amount closest to the Qualified Payment Amount (QPA)
- The Ruling
  - Texas Judge ruled that the emphasis on the QPA goes against the intent of the law, which does not place as much weight on the benchmark as DHHS has
  - Judge wrote that nothing in the law "instructs arbitrators to weigh any one factor or circumstance more heavily than the others"
- Takeaways?
  - This doesn't affect whether or not a patient will receive a "Surprise Bill"
  - Plans should continue to move forward with NSA compliance
  - CMS did reacted, and HHS has appealed

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Changes to the IDR Factors

CMS said in addition to the median in-network rate, providers can submit other items for the arbiter to consider:

- The level of training, experience, and quality and outcomes measurements of providers or facilities
- The regional market share held by the provider or facility
- The acuity of the patient, member or enrollee receiving the service or the complexity of the service
- The teaching status, case mix and scope of services the facility or provider offers
- Demonstration of good faith efforts, or lack of efforts, to enter into network contact agreements with one another

The guidance, dated April 12, also clarifies that arbiters are not responsible for deciding if median in-network rates are accurate.

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A Few FAQs on IDR

- Can the Parties Settle in the Middle of the IDR Process?

Yes! The Parties can still settle while the IDR process is underway. They will each have to pay half of the cost and each pays the administrative fee unless some other agreement is reached.

- How Long Does the IDR Entity Have to Reach a Decision?

Certified IDR entities must make a payment determination not later than 30 business days after being selected as the certified IDR entity for a dispute

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IDR Process vs. Appeal Process

Can You Have Both? Yes!

The Federal IDR process will involve disputes regarding payment amounts between a plan or issuer and a provider, facility, or provider of air ambulance services, not adverse benefit determination disputes between an individual enrollee and plans or issuers. Nonetheless, if the appeal process following an adverse benefit determination (including external review, if applicable) results in a finding that a plan or issuer must provide coverage for a claim, and the plan or issuer does not pay the provider, facility, or provider of air ambulance service's billed charges, the claim may be eligible for the Federal IDR process.

Claims will not be automatically routed from one process to another. Instead, the Federal IDR process must be initiated in accordance with the requirements of the Federal IDR process set forth in the interim final rule and the external review process must be initiated by the individual enrollee, participant, or beneficiary, or their authorized representative.

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Enforcement of the NSA

- Same framework as the ACA & HIPAA
- States will regulate fully-insured plans; DOL will regulate self-funded plans
- States will regulate providers (including air ambulance); if they fail, the feds will step in
- Federal gov't can impose civil fines against providers of up to $10k per violation
- Consumer complaint hotline has been established online

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Interaction with State Law

Currently, 17 states have enacted comprehensive surprise billing laws, and another 15 states have more limited protections

This law applies to both fully insured and self-funded plans. The NSA states that it does not preempt state payment standards in state surprise billing laws

The IFR clarifies that the No Surprises Act is not intended to displace states' balance billing laws and that the Departments are exploring options for providing more flexibility for state laws to apply

Existing state laws will continue to matter in two cases

1. When they go beyond what is required under the new federal law
2. The NSA specifies that the amount fully-insured plans must pay providers for surprise out-of-network services will continue to be governed by state law in states that have a surprise billing protection on the books, rather than by the arbitration procedure under the new federal law

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Note on Texas Self-Funded Plans

About 16% of the health plans in Texas are fully insured plans, according to TDI. Those plans are governed by a state balance billing law that went into effect on 1/1/2020. Texas uses arbitration in which the arbitrator is actually allowed to consider the OON provider's billed charge as a factor. And for insurance carriers, they are paying the price. The providers are winning high arbitration payouts. And of course that is being passed down in the form of higher insurance premiums for fully insured plans

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The No Surprises Act and Stop-Loss

Looking Back

- ACA was Implemented
- Amongst Other Things, Participants are Provided with Mandatory Appeals Allowance + External Appeal Before an IRO
- Self-Funded Industry Panics: "What is denied claims exceed specific deductible, denial is externally appealed to an IRO, and IRO overturns denial? Will stop-loss recognize the payment as eligible for reimbursement? What if the process extends beyond the policy's term date?"
- Stop-loss responded almost universally with a policy addendum, advising that payments required by an IRO will be reimbursed

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Looking Forward

- NSA establishes IDR process
- IDR could require plans to pay previously unpaid amounts
- Such payments could exceed the specific deductible
- The process could be extended beyond the stop-loss policy term date
- How will carriers respond?

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Common Pitfalls to Avoid

- Plans Mishandling NSA Claims as Appeals
- Plans Mishandling Appeals as NSA Claims
- Plans Not Updating Plan Language to Account for NSA Claims
- Plans Failing to Abide by NSA Procedural Deadlines

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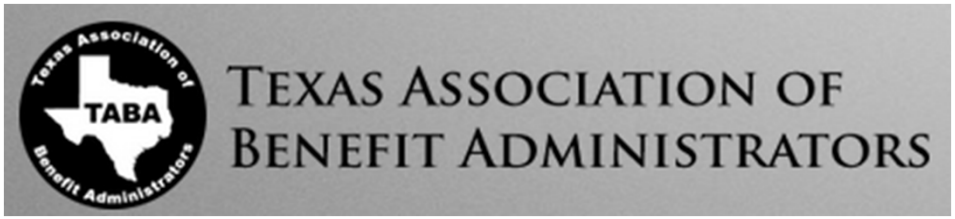
Questions?



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