Compliance Services Alert

LOCKTON

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New surprise billing rules require much of healthcare plans and their claim payers; plan sponsors should negotiate those requirements now

Executive summary

- Federal regulators have issued the first in a series of regulatory packages addressing transparency-related requirements under last year's Consolidated Appropriations Act.
- The new rules, addressing surprise billing restrictions, prohibit out-of-network providers from balance billing patients in a variety of situations where the patients are most vulnerable, and require the patients' healthcare plan to limit cost-sharing responsibility to in-network rates and to determine the amount payable to the provider through potentially complicated calculations.
- The new rules impose significant and detailed new notice obligations on the part of group healthcare plans, with one notice going to affected enrollees and another going to the out-of-network provider.
- Regulators will issue later this year rules providing for arbitration between the plan and the out-of-network provider to resolve disputes as to the amount payable by the plan.
- Plan sponsors will want to negotiate with their insurers and third-party administrators to ensure the insurer or administrator, as the case may be, can and will comply with the new rules.

Like waves pounding a shoreline, federal regulators continue to issue benefits-related guidance packages, releasing last week the first of several successive waves of rules on the recent federal surprise billing law.

Last week's guidance addressing surprise billing requirements included in the Consolidated Appropriations Act (CAA), compliance with which is required for plan years beginning in 2022, is heavy on details more directly relevant to health insurers and third-party claims administrators (TPAs). Nevertheless, it's important for plan sponsors to understand the requirements, at least generally, because *the compliance obligation falls on their plans*. The prudent sponsor will want to negotiate contractual assurances from their insurers and TPAs that they are not only up to the surprise billing compliance challenge but, ideally, willing to indemnify the plan sponsor for failure.

Lockton comment: We are arming Lockton's account service teams with sample language they can use as a starting point for negotiations with insurers and TPAs, for the 2022 plan and contact years, on behalf of our clients. The sample language addresses not only surprise billing requirements but also mental health parity analyses and other transparency-related obligations such as new ID card rules, network accuracy requirements, cost and compensation disclosures, requirements for advance explanations of benefits rules and rules for making plan benefits and cost-sharing information available on publicly accessible websites.

Background

Last week's guidance relates to some but not all of the surprise billing-related obligations imposed on group healthcare plans under the No Surprises Act (NSA), part of the massive CAA passed by Congress in late December. The gist of the NSA is to protect healthcare plan enrollees from receiving what are often massive balance bills from out-of-network (OON) healthcare providers.

Lockton comment: A "balance bill" is an invoice to the plan enrollee for the remaining balance of charges assessed by the OON provider, after the healthcare plan has paid its portion (if any) of those charges. Because the OON provider is not limited by a network contract on what it may charge, it may levy large charges, only a small fraction of which might be paid by the plan. The provider then "balance bills" the enrollee for what the plan did not pay. These balance bills can, in some cases, impose significant financial hardship on enrollees.

Federal regulators view the new rules as one piece of the puzzle to providing surprise billing protections. A handful of states participate in an All-Payor Model Agreement, authorized under federal law, protecting consumers against surprise billings, while several other states impose balance billing restrictions on insurance companies, under state insurance law (some of those states permit self-insured ERISA plans to opt into the balance billing protection process).

Where such an All-Payor Model Agreement or state insurance law applies (a state insurance law would not apply to self-insured ERISA plans), that Agreement or state law will trump the federal law. But the vast majority of healthcare consumers and plans in the U.S. and its territories will be subject to the protections and prohibitions under last week's rules.

Overview of the new surprise billing rules

The NSA focuses on three categories of balance bills, relating to care received by patients when they are most vulnerable. The Act addresses balance bills levied by:

- OON providers for emergency care
- OON providers for many *non*-emergency services at in-network facilities (e.g., an OON anesthesiologist participating in a surgery at an in-network hospital)
- OON air ambulance services

The NSA then:

- Limits what the plan may treat as the enrollee's cost-sharing responsibility in those cases (essentially calculating the enrollee's cost share – deductibles, copayments, coinsurance and out-of-pocket maximum amounts – as though the treatment had been provided by an *in-network* provider; the cost-sharing responsibility is then applied against the enrollee's in-network deductible and out-of-pocket maximum)
- Describes what the plan is required to make as an initial payment to the OON provider, and when that payment is due
- Provides for an arbitration process to resolve disputes between the plan and the OON provider where those two parties can't agree on a final payment amount

Lockton comment: Last week's rules addressed the first two of these issues (cost sharing and initial payment). But stay tuned, as rules addressing the arbitration process are due to be issued late this year.

Additionally, regulators say between now and then they expect to issue regulations on the CAA's requirements that, beginning with the 2022 plan year, plans issue "advance explanations of benefits" in advance of scheduled healthcare services, and maintain an online price comparison tool, as well as rules on a new patient-provider dispute resolution process.

Regulators noted in last week's rules that over the next several months they also intend to issue regulations on other patient protections, most of which take effect in or just prior to 2022, such as new ID card requirements, network directory accuracy requirements, and continuity of care protections, and on healthcare plan cost reporting obligations. Those rules likely will not be issued before 2022, so regulators say plan sponsors should simply make a good faith effort to comply in the meantime.

The reach of the new surprise billing rules

The surprise billing rules apply to grandfathered and non-grandfathered healthcare plans, but do not apply to account-based plans (like health reimbursement arrangements, or HRAs), "excepted benefits" such as typical flexible spending accounts, dental, vision and appropriately structured fixed indemnity plans, or retiree-only plans.

Where care is received under a plan subject to the new rules, the rules' protections don't apply in every case or to *every* balance bill.

The rules don't apply to:

- Services and items provided by the OON provider where the patient's coverage under the plan has not yet begun (e.g., the patient is in a waiting period)
- Services and items provided by the OON provider where the plan doesn't cover the services or items, or provides only very limited coverage
- Certain "post-stabilization" services (that is, services provided to an emergency room patient after the patient's condition is stabilized)
- Non-emergency services performed by OON providers at in-network facilities *if the provider or facility provides notice to the patient and obtains voluntary consent to waive the balance billing protections*

  Lockton comment: However, facilities and OON providers may not ask for such a waiver in certain circumstances where surprise bills are likely to occur, such as where items and services are provided in relation to emergency medicine, anesthesiology, pathology, radiology and neonatology; items and services provided by assistant surgeons, hospitalists and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by an OON provider if there is no in-network provider who can furnish the item or service at the in-network facility.

The rules also don't protect enrollees who receive healthcare services in certain healthcare "facilities" – as defined in the new rules – that fall outside the rules' orbit.

Notwithstanding all those exceptions, the new rules *do* provide protection from balance billing in the vast majority of cases where a vulnerable enrollee is treated by an OON provider.

How the new surprise billing rules work

The new rules tackle both sides of the surprise billing coin. They establish a limit on cost sharing a group health plan may impose on the plan enrollee who receives OON care subject to the rules, *and* outright prohibit the OON

healthcare plan provider from chasing the plan enrollee via a balance bill, limiting the provider's remedies to negotiations with the plan and, ultimately, an arbitration hearing.

> **Lockton comment:** As noted at the top of this alert, we will not address *in detail* the many nuances relating to how plans must adjudicate OON claims under the new rules; those details and nuances we leave for another day as compliance with them will fall as a practical matter on the claim processing departments at insurance companies and TPAs.

Here's the general scheme under the new rules:

- As noted earlier, the rules focus on three categories of care: emergency services, non-emergency services rendered by an OON provider at an in-network healthcare facility, and air ambulance services; there are some minor variations to the surprise billing scheme depending on the category of care received by the enrollee.
- With respect to each of these categories, if a plan provides coverage for benefits in that category of care, it must provide coverage for care provided by an OON provider, and (generally) provide that coverage as though the care was received by an in-network provider.
- The plan determines the member's cost sharing by treating as an allowed amount all or a portion of the OON provider's charge. This allowed amount might be dictated by any applicable All-Payor Model Agreement or by an applicable state insurance law, but in most cases will be the lesser of the billed charge and something called the "qualifying payment amount," or QPA.

  > **Lockton comment:** This QPA, and how to calculate it, is the focus of most of the new rules' complexity and nuance. Very generally, it is the median of the in-network, or contracted, rates recognized by the plan on Jan. 31, 2019, for the same or similar item or service, provided within the same medical specialty and the same geographic area. That median rate is then adjusted for inflation. The plan sponsor will want to take steps to ensure its plan's claim payor (the insurer or TPA) can make these calculations and do so correctly.

- Within 30 calendar days after the plan's receipt of a clean claim (i.e., a claim with sufficient information to allow the plan to process it), the plan must send the OON provider either a denial notice or an initial payment (the plan will typically consider it as payment in full). The 30-day window is trumped by any applicable All-Payor Model Agreement or state insurance law, but those situations will be relatively rare.

  > **Lockton comment:** These transactions between the plan and the OON provider are not subject to ERISA's claims procedure rules, which dictate their own timing and notice requirements. The new rules made clear that ERISA claims procedures rules apply only where the plan enrollee is personally liable for payment to the provider. Here, once the plan determines the enrollee's cost-sharing responsibility to the OON provider, any additional obligation on the part of the plan to that provider is between the plan the provider and does not involve the enrollee.

- The OON provider, if not satisfied with the plan's initial payment or denial, may open negotiations with the plan within 30 days after receipt of that initial payment or denial. The negotiation period lasts 30 days after it is opened. If the plan and the provider can't reach agreement within that window, the provider has an additional four days to initiate arbitration under rules to be issued by federal regulators by Dec. 27 of this year.

New notice obligations … of course

What would a new healthcare plan-related regulation be without a new notice obligation? Under the new rules, any explanation of benefits provided to a healthcare plan enrollee relating to an OON claim by to which the new rules apply must include a notice, in plain language, apprising the enrollee of the OON provider's limited rights to payment from the enrollee.

Federal authorities have crafted a model notice plans may use for this purpose (this link may simply download a Microsoft Word document rather than open a new webpage).

Lockton comment: The notice must also be made publicly available and posted on a public website of the group healthcare plan or the plan's insurer.

In addition to the notice going to the plan enrollee, the new rules require that when a plan sends its initial payment or notice of denial to the OON provider, the plan include specific information about the plan's calculation of the qualifying payment amount (QPA) that serves as the basis both for the amount allowed by the plan and the enrollee's cost-sharing responsibility.

Specifically, this notice must disclose the QPA, as determined by the plan, for each item or service involved. In addition, the plan must provide a statement certifying that, based on the plan's determination, the QPA applies for purposes of the allowed amount and that each QPA shared with the provider was determined in compliance with the methodology outlined in the new rules.

In addition to that detailed information, the plan must provide a statement that if the provider wishes to initiate a 30-day open negotiation period for purposes of determining the total amount to be paid by the plan, the provider may contact the appropriate plan representative to initiate those negotiations, and that if the parties cannot reach agreement the OON provider may avail itself of the new rules' arbitration process.

Finally, upon request of the OON provider, the plan must provide detailed information related to how the QPA was calculated.

All of this information must be provided in writing, either on paper or electronically, to the OON provider when the QPA serves as the allowed amount.

Negotiating for help

Last week's rules are "interim final rules," meaning plans must comply but the federal agencies issuing the rules see them as merely *interim*; the agencies are accepting comments on the rules for several weeks, and then are sure to tweak them.

Plans, of course, must rely on their insurers and TPAs, as applicable, to implement claim processing protocols that comply with these new rules, with respect to identifying claims subject to the new rules, calculating QPAs and limiting the enrollee's cost-sharing liability based on the QPAs, providing appropriate notice to the enrollee, making an initial payment to the OON provider (or providing notice of denial) with all information required by the rules with respect to that transaction, and dealing with demands for arbitration. Plan sponsors will want to get written assurance that the insurer and/or TPA will comply with these requirements on behalf of the plan.

These matters should be negotiated with carriers and TPAs *now*, because the new rules apply to plan years beginning in or after 2022.

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