Compliance Services

LOCKTON

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Appendix A: Details of the new surprise billing law

Under current law, out-of-network (OON) providers and facilities are permitted to bill patients the difference between the amount charged for services and what the patient's health plan pays. These "balance bill" amounts can be significant because they are based on the provider's or facility's unreduced (i.e., retail) billed charge rather than the discounted rate determined through network negotiations.

The CAA's surprise billing provisions establish for the first time a federal standard protecting from balancing billing patients insured under private plans. The new protections apply in three scenarios:

1. During an *emergency* when the patient is treated at an OON facility (including a free-standing emergency room) or by other OON providers.
2. In a *non-emergency*, where the patient is treated by an OON provider at an in-network facility without the patient's informed consent.
3. For air ambulance transport from an OON provider.

When the new law's protections apply, the plan must apply its in-network cost-sharing rules and cannot impose any requirements or restrictions (e.g., prior authorization or exclusions) that do not also apply to in-network services. The plan must credit any cost-sharing amounts toward the patient's in-network deductible and out-of-pocket maximum.

Most significantly from the patient's perspective, OON facilities and other OON providers are not permitted to balance bill patients without the patient's informed consent. Instead, they must accept as payment in full the sum of the patient's cost-sharing amount and the plan's payment as determined under the new law.

> **Lockton comment:** When patients consent to OON care at in-network facilities (e.g., a surgical patient agrees to an OON orthopedist for care at an in-network hospital) the plan is permitted to apply its normal OON cost-sharing and provider payment provisions, and the provider is permitted to balance bill the patient. This "informed consent" exception to the balance billing restriction will place a premium on providers' administrative processes to seek that consent, and on patients' ability to understand precisely what they're being asked to agree to.

To further protect patients, the new law prevents certain types of ancillary providers (e.g., anesthesiologists, radiologists, pathologists and most labs) from balance billing by prohibiting them seeking patient consent.

Calculating patient cost-sharing and plan payment for OON care

The processes for determining the patient's cost sharing and the amount the plan must pay the OON facility or other OON provider are similar, with one significant difference.

First, if the care is provided in a state that participates in an All-Payer Model Agreement with the Centers for Medicare and Medicaid Services (CMS), then the amount *the state* approved under that Agreement as adequate payment for a given service is the amount the health plan must pay, and also serves as the basis for determining the patient's cost sharing.

> **Lockton comment:** An All-Payer Model Agreement establishes a process for states to set prices for items and services that are accepted as final by providers and payers. The rates are predetermined, making them function more like in-network rates. We understand Maryland and Vermont are currently the only states that have these agreements with CMS, and the agreements do not apply to all items and services or to all payers, so the protections described below will still apply in those gaps.

Secondly, many states already have protections against balance billing, rules that establish procedures for calculating provider reimbursements and patient cost sharing, at least for insured plans and plans not subject to ERISA (ERISA preempts these state laws from applying unilaterally to self-insured ERISA plans, although in some cases self-insured ERISA plans may opt in to the state's rules). The new federal law keeps intact these state-specific rules.

Finally, absent an applicable state-specific rule, the new law sets a process for determining both the patient's cost-sharing responsibility for OON care and the plan's payment obligation.

The law establishes a general rule that *the patient's* cost-sharing amount is based on the median in-network rate paid by all plans of the plan sponsor for similar items or services provided in the prior year, plus a cost-of living adjustment (the "qualifying payment amount"). Special rules apply for new plans and for new items and services.

> **Example:** Jerry participates in a self-insured group healthcare plan subject to ERISA. The plan requires 10% coinsurance for in-network emergency care and applies no deductible. Jerry receives emergency care from an OON physician in a state without an All-Payer Model Agreement, and the physician charges $5,000 for the services. The plan determines that a typical allowable charge for such services from a similar, but in-network, physician in a similar situation would be $2,500, which thus becomes the qualifying payment amount. Accordingly, the plan determines that Jerry's co-insurance amount is $250.

The amount *the plan ultimately pays the facility or other healthcare provider* might not be the same as the qualifying payment amount. The facility or other provider (or the healthcare plan, for that matter) can insist upon a different reimbursement rate. If the parties cannot agree on a reimbursement rate within 30-days from date the provider first billed the plan, either party can demand binding arbitration. In arbitration, the parties each submit their best offer – and evidence to support that offer – to a neutral arbiter either jointly selected by the parties or appointed by the federal government, and the arbiter must choose one of the offers.

> **Lockton comment:** Importantly, the arbiter's choice of an amount different from the qualifying payment amount will not change the patient's cost sharing. In the example above, Jerry's $250 cost-

sharing responsibility would not change even if the arbiter eventually determined the plan's allowable charge should have been more than $2,500.

Penalty box

Healthcare providers that violate the surprise billing rules are subject to penalties of up to $10,000 per violation. States may impose other obligations on OON healthcare *providers* that go above and beyond the federal statutory requirements (in short, the new federal law does not preempt the ability of states to regulate how providers bill their patients). Interestingly, states are charged with enforcing the federal requirements on providers, but federal authorities will step in if states decline to enforce the rules.

Next steps for group health plan considerations

Group health plan sponsors typically rely on their insurers, third-party administrators, or other service providers to negotiate payments with OON facilities and other providers. We expect this to continue, but the timeframes will certainly be shorter (a mere 30 days) and the stakes might be higher. Not only is arbitration binding, but the party that loses pays the fees to cover the cost of arbitration.

Plan sponsors will want to coordinate with their insurers, third-party administrators, and other service providers to ensure they comply with the new rules on the plans' behalf. In particular, self-insured plan sponsors will want to discuss the process with their stop loss carrier to be certain that any arbitration award that triggers stop loss is considered a covered expense. As noted above, additional guidance is expected this summer, so much of the work to update service provider agreements and plan documents, policies and procedures will happen later in the year.

> **Lockton comment:** It is unclear what the long-term impact of the new law will be, especially for plans with little or no OON coverage, for plans that provide only skimpy benefits (e.g., "minimum essential coverage" plans), and for plans that utilize a reference-based pricing model. Although a non-partisan federal agency concluded the legislation would reduce healthcare costs, lawmakers did include several provisions requiring federal agencies to collect data about the processes dictated by the new law and how they impact plan costs and the insurance market.

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