ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES: PRACTICAL Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, Carolyn Smith, Ken Johnson, Amy Heppner, and Earl Porter provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte, Dallas and Washington, D.C. law firm. Ashley, Carolyn, Ken and Amy are senior members of the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to Mr. Hickman at john.hickman@alston.com.

GROUP HEALTH PLAN PROVISIONS OF THE CONSOLIDATED APPROPRIATIONS ACT: A DEEPER DIVE

On December 27, 2020, the Consolidated Appropriations Act, 2021 (CAA) was signed into law. In addition to funding the government and further COVID-19 relief, the CAA included significant provisions impacting health benefit coverage.

In prior articles we discussed the impact of CAA on FSA administration; the forthcoming broker/consultant fee disclosure rules; and the new comparative analysis disclosure requirement under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

This article provides an introduction to the so-called No Surprises Act (NSA) billing provisions of the CAA. These provisions dramatically change the way that certain emergency and additional (e.g., ancillary) health benefits are administered and requires changes beginning with plan years on and after January 1, 2022 that are applicable to all plan sponsors and TPAs. In subsequent articles we will drill down on the interim final regulations providing how the claims and dispute resolution (IDR) processes will work.

SERVICES COVERED BY NSA

Under the NSA, the financial obligation of plan participants and beneficiaries is limited to in-network cost-sharing (deductibles, co-payments, and co-insurance) for the following services performed by an out of network (OON) provider:

- **Emergency services provided in an emergency department of a hospital (including a hospital outpatient department) and in a freestanding emergency department.** Rules similar to the ACA requirements for emergency services also apply. Thus, if a plan covers any benefits for services in an emergency department of a hospital (including a hospital outpatient department) or emergency services in a freestanding emergency department: (1) plans cannot impose prior authorization requirements on emergency services (whether in-network or OON); (2) plans must cover emergency services even if the provider or facility is OON; (3) if the services are provided by an OON provider or facility, the plan cannot impose any requirement for prior authorization or any limitation on coverage that is more restrictive than the requirements that apply to in-network emergency services; and (4) plans must cover emergency services without regard to any other term of condition of coverage, other than an exclusion or coordination of benefits or a permitted affiliation or waiting period.
- **Ancillary services provided by an OON provider at an in-network facility.** Ancillary services include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology (whether or not provided by a physician or non-physician practitioner); items and services provided by assistant surgeons, hospitalists, and intensivists; and diagnostic services (including radiology and laboratory services). In addition, items and services provided by an OON provider are considered ancillary if there is no in-network provider that can furnish the service at the facility. Regulations may add additional items and services that are ancillary and may also provide a list of advanced diagnostic laboratory tests that are not ancillary services.
- **Non-emergency services performed by an OON provider at an in-network facility, unless the provider has complied with notice requirements and the individual consents to using the OON provider.** The exception for complying with notice and consent requirements does not apply to ancillary services or to any item or service that is furnished as a result of unforeseen, urgent medical needs that arise at the time a covered item or service is furnished.

NSA REQUIRED PAYMENT AMOUNT (THE QUALIFIED PAYMENT AMOUNT OR "QPA")

Plans must count participant cost-sharing for these OON services in the same manner as in-network cost-sharing (e.g., counting the cost-sharing against any in-network deductible or out-of-pocket amount). In applying the plan's in-network cost-sharing provisions to these OON services, the "recognized amount" is treated as the amount that would have been charged by an in-network provider.

For example, if a plan's cost-sharing rate for an in-network service is 20%, then if the service is performed by an OON provider, the cost-sharing amount would be 20% multiplied by the recognized amount.

In general, the recognized amount is one of the following three amounts: (1) the amount determined by an applicable state law (e.g., for a fully insured plan); (2) if there is no applicable state law (e.g., in the case of a self-funded plan subject to ERISA), the qualifying payment amount (or QPA) which is based on median contracted rates recognized by the plan; or (3) in the case of a state that has an all-payer model agreement in effect with the Centers for Medicare and Medicaid Services (CMS) pursuant to Section 1115A of the Social Security Act, the amount the state approves for the item or service.

Providers are prohibited from balance billing plan participants for any amount exceeding the in-network cost-sharing for these OON services. Group health plans are required to make an initial payment to the OON provider or a notice of denial of payment within 30 calendar days after receiving a bill from the provider.

The NSA specifically provides that the provisions relating to surprise medical bills do not adversely impact HSA eligibility. In other words, the requirement to pay an additional amount pursuant to the dispute resolution provisions before the HDHP deductible is satisfied will not cause an individual to be ineligible to contribute to an HSA.

INDEPENDENT DISPUTE RESOLUTION (IDR) PROCESS BETWEEN PROVIDERS AND HEALTH PLANS

A number of states already have laws that protect participants from surprise medical bills under fully insured plans. Where applicable, the NSA defers to payment amounts for surprise medical bills as determined under applicable state law where such laws provide equal or greater protection (specified state laws). If such a state law does not apply (e.g., in the case self-funded plans subject to ERISA or a law that is not a specified state law), bills will be resolved under the NSA IDR arbitration process.

Under the IDR process, plans and providers may negotiate during a 30-day cooling-off period, which starts on the date the provider receives the initial payment or notice of denial. If a settlement is not reached during this period, either party may initiate the IDR process within four days of the end of the cooling-off period. Providers may bundle payments to be considered in the IDR process.

There is no dollar threshold for claims to be submitted to arbitration, so claims of any amount may be submitted. The IDR process is "baseball style" arbitration, meaning that each party provides a payment offer and the arbitrator must choose one of the offers. The losing party pays the cost of arbitration. If the provider and plan agree to a payment amount before the IDR entity makes its decision, costs are split between the parties.

In general, the IDR arbitrator can consider any factors submitted by either party in making its decision. There are, however, certain factors the arbitrator can and cannot consider. For example, the arbitrator is to consider the qualified payment amount as well as information relating to the level of training, experience, and quality of outcomes of the provider, the market share held by the provider, the acuity of the individual receiving the service, and the teaching status, case mix, and scope of services of the OON facility where the services were performed.

Importantly, the IDR arbitrator cannot consider the provider's billed charges or reimbursement rates from public payors, including Medicare and Medicaid.

The IDR arbitrator has 30 days to make a decision. The decision is binding on the parities (except in the case of fraud or misrepresentation of facts). The decision also is not subject to judicial review, except in limited circumstances such as fraud, partiality, or corruption on the part of the arbitrator, misconduct on the part of the arbitrator, or if the arbitrator exceeded its powers.

Following the decision, the party that initiated arbitration cannot request arbitration for similar claims for a "lock-out" period of 90 days. This waiting period is intended to provide some incentive for the parties to negotiate similar claims. Claims relating to the lock-out period may, however, be submitted after the lock-out period ends.

AIR AMBULANCE SERVICES

Rules similar to the surprise billing provisions also apply to air ambulance services. There are some differences; for example, the factors the IDR reviewer are to consider are somewhat different in the case of air ambulance services.

Ground ambulance services are not subject to the surprise billing provisions. Instead, the CAA directs the Secretaries of Labor, Treasury, and HHS to establish an advisory committee on ground ambulance services and patient billing. The committee is to submit its report and recommendations to Congress within 180 days after the committee's first meeting.

ADDITIONAL PROVISIONS, INCLUDING TRANSPARENCY REQUIREMENTS

Access to external review process for surprise medical bills

The ACA external review process is extended to cover issues relating to surprise medical bills, including whether

a particular item or service is subject to new surprise billing rules. Note that the external review process does not apply to grandfathered plans, so that such plans should not be subject to this new requirement.

Continuity of care

When a provider leaves a plan's network, individuals in certain circumstances must be provided 90 days of continuing care as if the provider were still in-network. This applies if an individual is undergoing a course of treatment for a serious and complex condition; undergoing a course of institutional or inpatient care; scheduled to undergo nonelective surgery, including postoperative care; is pregnant and undergoing a course of treatment for the pregnancy; or was determined to be terminally ill.

Specifically, if an individual is covered under a group health plan with respect to an in-network health care provider or facility and such individual is a "continuing care patient" with respect to such provider or facility, the plan must provide notice to the individual, and potentially provide transitional care for up to 90 days, if:

- the contractual relationship between the plan and provider or facility is terminated;
- benefits provided under the plan with respect to the provider or facility are terminated because of a change in the terms of the participation of such provider or facility in the plan; or
- a contract between the plan and a health insurance issuer offering health insurance coverage in connection with the plan is terminated, resulting in a loss of benefits provided under the plan with respect to the provider or facility.

Although applicable for plan years beginning on or after January 1, 2022, the agencies have indicated that they will not be issuing any regulations before then. Therefore, until such a time that there is further rulemaking, plans, providers, and facilities are expected to implement the continuity of care requirements using a good faith, reasonable interpretation of the CAA.

Disclosure and transparency rules included in the NSA

A number of new disclosure and transparency provisions are imposed on group health plans. Many of the effective dates for these requirements were addressed in Agency FAQs 49. These requirements include:

Scalable Solutions for Self-Funded Employers

We're a leading third party administrator for self-funded employers of all sizes, in all industries. Driven by the unique needs of our employers and brokers, our proprietary technology systems enable us to administer cost-effective plan designs that match the needs of your organization.

Full Suite of Solutions

In addition to claims and benefits administration, we offer pharmacy benefit management, health management and wellness programs, stop-loss insurance, and print and payment solutions.

Seamless Integration

We offer a broader range of services compared with other TPAs and administer solutions that seamlessly integrate with your vendors.

See What Pinnacle Can Do For You

866.930.PCMI
Quotes@pinnacleTPA.com
www.PinnacleTPA.com

PINNACLE™
CLAIMS MANAGEMENT, INC.

- Provide an advanced explanation of benefits before scheduled care, including information such as the estimates of cost-sharing and the amount the plan will pay for the service and whether the provider is in-network or OON (Original effective date of plan years on/after January 1. 2022 but the agencies will defer enforcement until regulations to fully implement the requirements are adopted and applicable).

- Maintain price comparison tools available online and over the phone (Original effective date of plan years on/after January 1. 2022 delayed until plan years on/after July 1, 2022).

- Maintain up-to-date provider directories (Original effective date of plan years on/after January 1. 2022 retained).

- Include in-network and OON deductibles and out-of-pocket maximums on health plan member electronic or physical identification cards (Original effective date of plan years on/after January 1. 2022 retained pending future regulations, plans are expected to implement the ID card requirements using a good faith, reasonable interpretation of the law).

- Providers are subject to disclosure requirements, including a requirement for OON providers to provide a "good faith estimated amount" for all services to be provided. (Original effective date of plan years on/after January 1. 2022 but the agencies will defer enforcement until regulations to fully implement the requirements are adopted and applicable)

ENFORCEMENT

The surprise billing and related provisions applicable to group health plans are added to the Code, PHSA, and ERISA and will be subject to the same general enforcement structure as the ACA coverage mandates. States retain primary enforcement authority over fully insured plans, subject to federal enforcement by HHS if a state fails to substantially enforce a provision. HHS also has jurisdiction over self-funded governmental plans.

The DOL has enforcement authority over plans subject to ERISA. Under the Code, a $100 per day excise tax may apply in the case of noncompliance by private sector plans and church plans. Provisions applicable to providers are added to the PHSA and are subject to primary enforcement at the state level and potential federal enforcement. The DOL is specifically authorized to coordinate with states and HHS regarding violations of provider requirements for group health plans and conduct investigations as appropriate. ■

VBA
Virtual Benefits Administrator

Discover THE STORIES YOUR *data* IS *telling*

Are you listening to what your data is telling you?

Broken down into Stories, VBAnalytics helps you measure the quality and effectiveness of patient care across multiple measures.

Featuring Healthcare Compliance Measures

Plan administrators can deploy HEDIS performance data to identify opportunities for improvement, track and monitor quality of care initiatives, and compare against the recommended standards of care.

Get valuable population insights in one click.

Schedule a demo today to learn more.

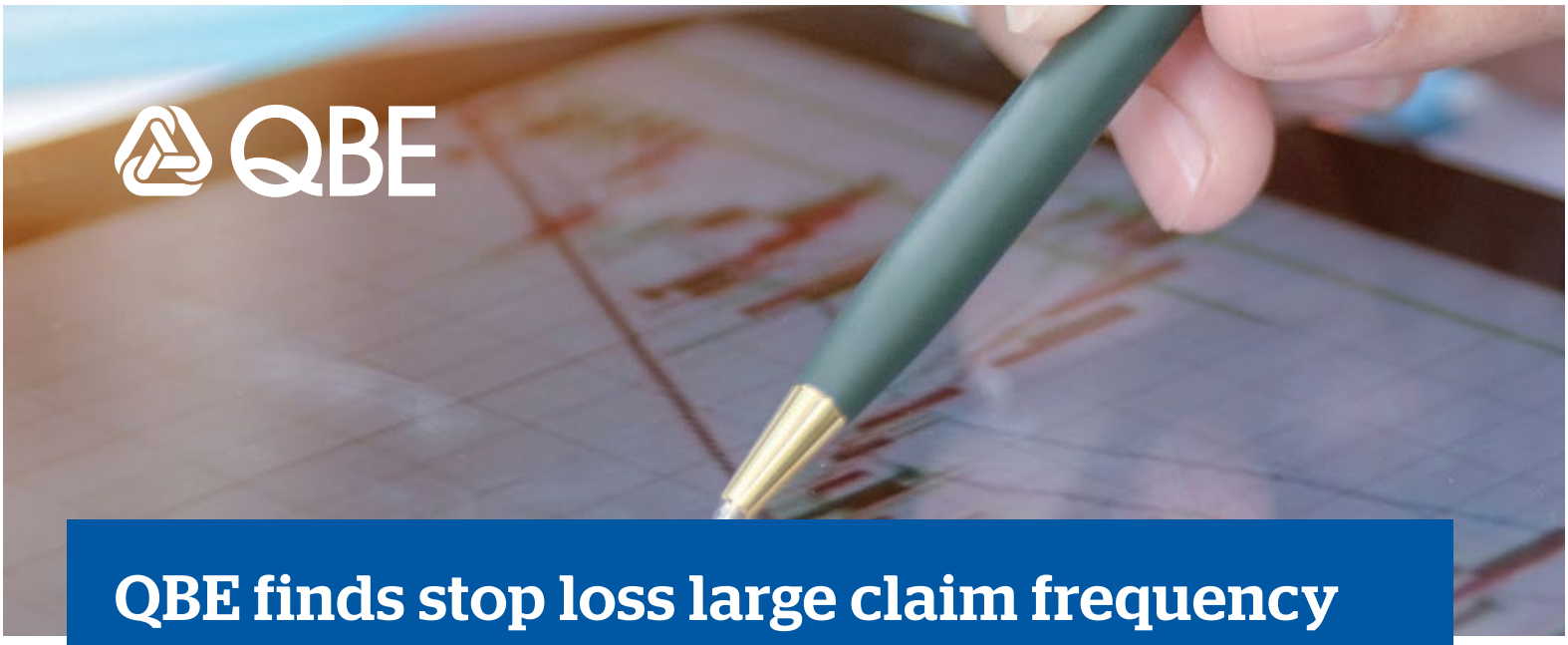
VBAnalytics

VBAnalytics combines reports and dynamic visuals to help you get the data you need, when you need it.

KEY FOCUS AREAS:

- UTILIZATION
- MEMBER RISK
- REINSURANCE
- HEALTHCARE COMPLIANCE
- MEMBERSHIP TRENDS AND SOCIAL-ECONOMIC INSIGHTS
- QUALITY OF CARE
- COVID REPORTING

vbasales@vbasoftware.com | 1.866.731.1571 | vbasoftware.com

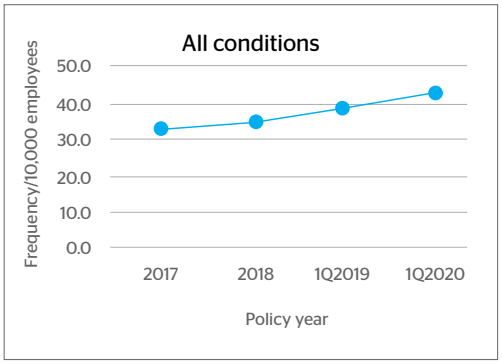


QBE finds stop loss large claim frequency increased during the pandemic

Data shows increases in claims for mental and respiratory illnesses outweighed declines in claims for neoplasms and circulatory diseases.

In QBE's 2021 Accident & Health Market Report, QBE notes an increase in the frequency of $200,000+ claims, when comparing annual policies that started in the first quarter of 2019 against those that started in the first quarter of 2020. These two time periods serve as a proxy for claims coming in before and after the onset of the COVID-19 pandemic.

The increase was driven by more claims for mental and respiratory illnesses, which were only partially offset by fewer claims for neoplasms and circulatory system diseases.



* Data as of April 30, 2021.

Neoplasms continue to be a top consideration for stop loss claims.

Although the frequency of $200,000+ claims for neoplasms declined during the pandemic, neoplasms remain a leading concern. They were by far the most common of such claims both before and during the pandemic. Meanwhile, the decline in claims frequency throughout the pandemic may be the result of missed and delayed cancer screenings, which could lead to an increase in treatment costs and complications in the future.

Medical Stop Loss

- Direct access to underwriters
- Deep technical and clinical expertise
- Focus on partner collaboration to manage risk
- Regional underwriting centers, active thought leaders in local markets

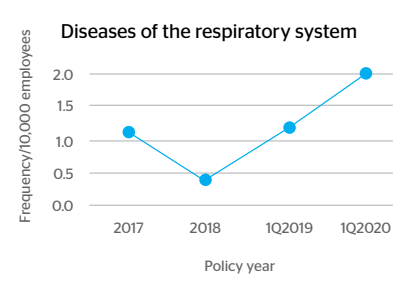
Captive Medical Stop Loss

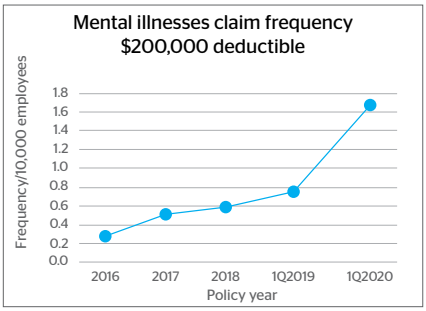
- Group and single parent captive risk assessment
- Full captive layer underwriting capability
- Clinical risk management services
- Reinsurance and insurance coverage for a variety of captive structures

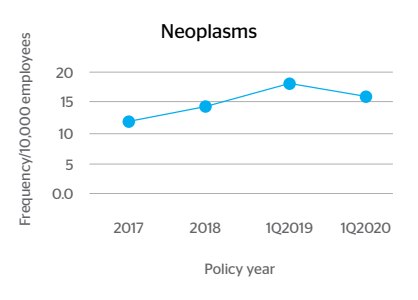
QBE is a global insurance leader

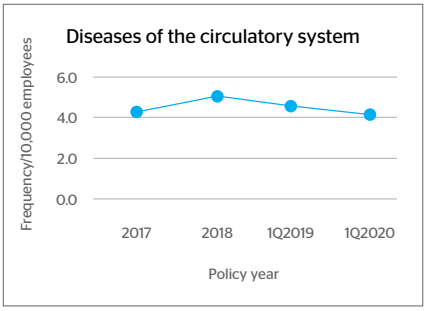
focused on helping customers solve unique risks, so they can focus on what *matters most.*

Claims frequency by primary diagnosis for members exceeding $200,000 in annual claims.









* Data as of April 30, 2021.

To learn more about QBE Accident & Health and access our full report, visit us at qbe.com/us/ah.

"The claims frequency nearly doubled for respiratory illnesses, and it more than doubled for mental illnesses," said **Tara Krauss, Head of Accident & Health** at QBE North America. "It demonstrates the broad impact of the pandemic and explains why we have seen employers seek more holistic solutions that connect mental and physical health."

For more key findings, read the full **QBE 2021 Accident & Health Report.**

Organ Transplant

- Covers first-dollar transplant expenses
- Covers 100% in-network with no co-pays or deductibles
- $1M, $2M or unlimited
- Travel and lodging expense benefits

Special Risk Accident

- Covers medical expenses for injuries that occur during policyholder-supervised and sponsored activities
- Products include:
  - Participant Accident Insurance
  - Intercollegiate Accident Insurance
  - K-12 Accident Insurance