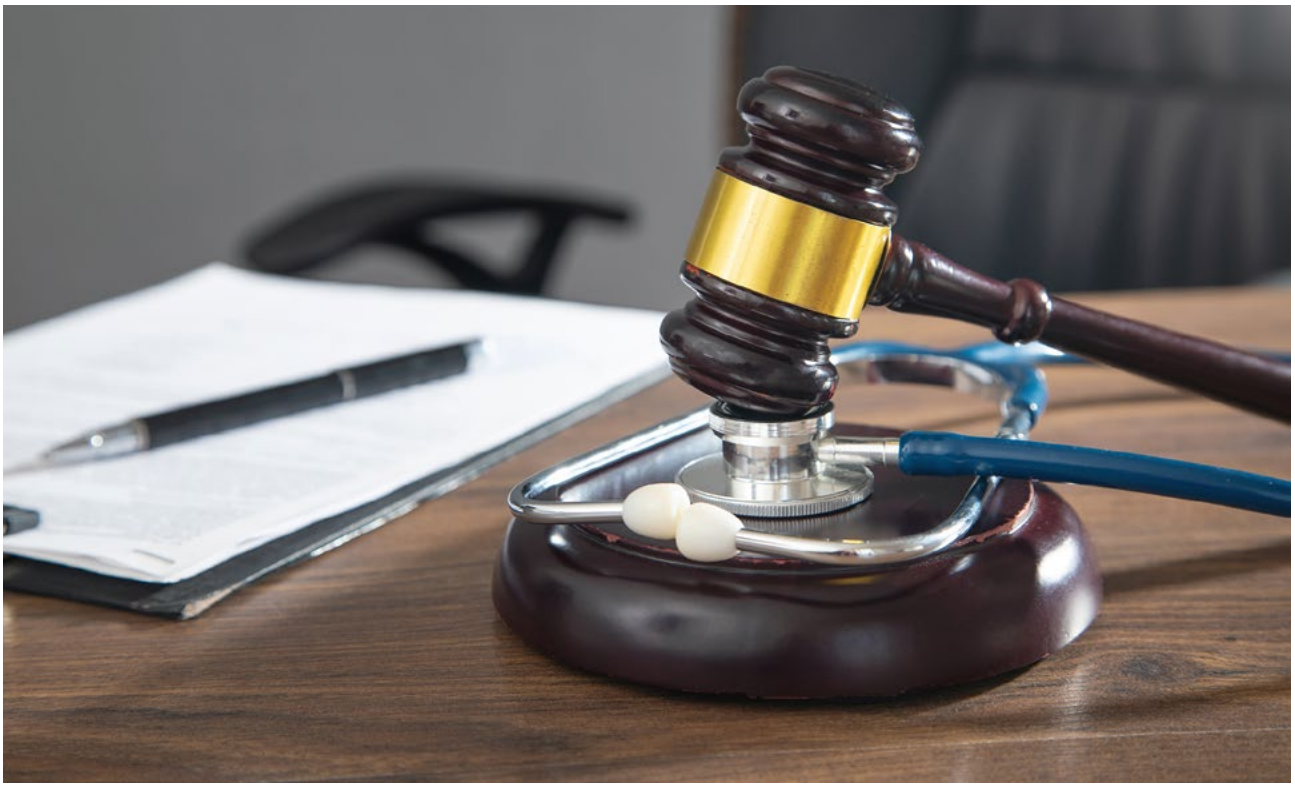

ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES: PRACTICAL Q&A

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 Laurie Kirkwood 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, Amy, and Laurie are senior members in 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.

JUST THE FAQS (ON NSA) AND NOTHING BUT THE FAQS

On August 19, 2022, the U.S. departments of Health and Human Services, Labor and Treasury (the "Departments") issued FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55 ("the FAQs Part 55"), which addressed several issues, including those related to the surprise billing provisions in the No Surprises Act ("NSA"), adopted as part of the Consolidated Appropriations Act, 2021 ("CAA").

The NSA provides protections against surprise medical bills for certain out-of-network services—emergency services, certain non-emergency services at certain types of network facilities, and air ambulance services.

These protections took effect for items or services received as of January 1, 2022. In the interim final rules issued in July 2021 to implement the NSA ("IFR Part I"), the Departments limit cost-sharing for participants who receive these out-of-network services to the in-network rates based on the "recognized amount."

Generally, the recognized amount for self-insured group health plans is going to be the median in-network rate for the item or service, unless the billed charge is less (or unless the self-insured plan opts in to state law).

NSA requirements are more easily applied to plans with in-network and out-of-network coverages, but reference-based pricing plans have no networks by design and closed-network plans have no out-of-network coverage. In this article we focus primarily on the FAQs Part 55 guidance involving application of the NSA to self-insured reference-based pricing plans and plans with no out-of-network coverage.

REFERENCE-BASED PRICING PLANS

Reference-based pricing plans do not have contracted or negotiated rates with providers. Instead, the plan typically reimburses providers based on a set price for each covered health care service, and the provider can bill the patient for the balance.

For NSA covered services, participant cost sharing (e.g. deductibles and co-insurance) is calculated using in-network rates based on the qualifying payment amount ("QPA"). QPA is then calculated based on the median contracted in-network rate for the service.

Reference-based pricing plans raise two primary issues for emergency and air ambulance services: there is no in-network cost sharing that would be applied in lieu of out-of-network cost-sharing and there are no median contracted in-network rates. Nonetheless, the agencies conclude that the NSA provisions, including the prohibition against surprise billing and balance billing for emergency services and air ambulance services, still apply to these types of plan designs.

Q1 and Q2 from FAQs Part 55 make it clear that, for emergency and air ambulance services, the surprise billing prohibitions of the NSA do not depend on whether the health plan has a network of providers.

The provisions in the NSA that limit cost sharing for out-of-network emergency services apply if a plan covers any benefits for emergency services. An out-of-network provider is any provider that does not have a contractual relationship directly or indirectly with the group health plan.

Likewise, an out-of-network emergency facility means an emergency facility that does not have a contractual relationship directly or indirectly with the group health plan. For "pure" reference-based pricing plans, all providers of emergency services, and any emergency facility, or any air ambulance services will be out-of-network, and the NSA prohibitions will apply to covered services received from those providers.

In contrast, the NSA provisions that limit cost sharing for non-emergency services apply only to services provided by an out-of-network provider at certain types of in-network health care facilities, such as network hospitals and ambulatory surgical centers.

In order for this prohibition to be triggered, the plan would need to have a contractual relationship, directly or indirectly, with the health care facility. Because reference-based pricing plans have no network facilities, the provisions of NSA that limit cost sharing and prohibit balance billing for these types of services from out-of-network providers at network facilities would not apply.

CALCULATING THE QPA WITHOUT A NETWORK

Group health plans without networks will still have to calculate cost sharing for out-of-network services subject to the NSA. In general, self-insured plans with networks calculate cost sharing for these out-of-network services as if the total amount that would have been charged for the services by a network emergency facility or network provider were equal to the "recognized amount".

As already noted, the recognized amount for self-insured group health plans generally is going to be QPA, the median in-network rate, (for the item or service, unless the billed charge is less. (For insured plans and self-insured plans that opt into state law, an All-Payer Model Agreement or specific state law may apply) For plans without networks, there is no median in-network rate.

Q3 of FAQs Part 55 confirms that a plan without a network would lack sufficient information to calculate a median contracted rate, and consequently would have to calculate the QPA using an eligible database.

Using underlying fee schedules or derived amounts is permitted, but only for plans that have contractual agreements when payments under those agreements are not on a fee-for-service basis. Plans without contractual agreements cannot calculate the QPA based on underlying fee schedules or derived amounts and are instead required to use an eligible database to calculate the QPA.

The Departments provide an example in Q3 involving a reference-based pricing plan that pays for covered services based on a fee schedule. The plan imposes no cost sharing once the deductible is met, and no All-Payer Model or specified state law applies to the plan.

In the example, a participant, after satisfying the annual deductible, is taken to a hospital emergency room for emergency services, and the facility bills the plan $1,200 for CPT code 99282. Under the plan's terms prior to the NSA, the plan would pay a reference-based amount of $800 for CPT code 99282 and the facility presumably could bill the participant for the remaining $400. However, under the NSA, the emergency facility is prohibited from billing the participant for an amount that exceeds their cost-sharing requirement.

The Departments explain in the example that under the NSA, the participant's cost-sharing requirement must be calculated as if the total amount that would have been charged for the services by the emergency facility was equal to the recognized amount for the services.

The plan must calculate the recognized amount using the QPA (because neither an All-Payer Model Agreement nor a specified state law applies in this example). Because the plan does not have a network from which to calculate median contracted rates, the QPA is calculated using an eligible database.

Using an eligible database, the plan determines the applicable QPA for CPT code 99282 is $900. Because the participant's deductible has been satisfied and the plan does not impose other cost-sharing requirements for emergency services, the participant owes no cost sharing and cannot be billed or held liable for the $400 difference between the amount billed by the facility ($1,200) and the plan's reference-based amount ($800).

Presumably under this example cost-sharing (e.g. the deductible and any co-insurance) would be based on the plan's normal cost sharing but using QPA instead of the reference based price.

CALCULATING THE OUT-OF-NETWORK RATE TO BE PAID TO THE PROVIDER FOR PLANS WITHOUT A NETWORK

For emergency and air ambulance services, Q4 of FAQs Part 55 addresses the calculation of the out-of-network rate for plans with no networks but provides no new information and reiterates the rule from the Interim Final Regulations Part II, issued in September 2021.

Under that rule, the out-of-network rate is the amount the out-of-network provider, emergency facility, or provider of air ambulance services and the plan agree upon as the amount of payment (assuming no All-Payer Model or specified state law applies).

This agreement can take place when the provider or facility accepts initial payment sent by the plan, or through negotiations with respect to such item or service. However, if the parties enter into the Federal independent dispute resolution (IDR) process and do not agree upon a payment amount before the IDR entity makes a determination, then the amount determined by the IDR entity is the out-of-network rate.

As a result, a plan that utilizes a reference-based pricing structure and does not have a network of providers may be required to make a total payment that is different from the plan's reference-based amount for items and services that are subject to the NSA.

MAXIMUM OUT-OF-POCKET REQUIREMENTS FOR REFERENCE-BASED PRICING

According to previous Affordable Care Act ("ACA") guidance, a reference-based pricing plan would not be treated as failing to comply with ACA's maximum out-of-pocket ("MOOP") requirements if the plan treated providers that accept the reference amount as the only in-network providers, on the condition that such plans use a reasonable method to ensure that it offers adequate access to quality providers at the reference-based price.

The one exception under the ACA was emergency services that would always count toward MOOP, regardless of whether the provider or facility accepts the reference price.

Q5 of FAQs Part 55 notes that the NSA's new definition for "emergency services" now applies, and that new definition now includes post-stabilization services provided as part of outpatient observation or an inpatient or outpatient stay with respect to the emergency services.

These post-stabilization services can be excluded if certain conditions are met, including notice and consent, but these conditions assume the availability of a network facility and network providers. The new definition reflects that, when patients receive these post-stabilization services, they may not have an opportunity to seek a participating provider.

Accordingly, the Departments clarify that limiting or excluding out-of-pocket spending from counting toward the MOOP with respect to providers that do not accept the reference-based price would not be considered reasonable for post-stabilization services included in the definition of "emergency services."

One of the conditions for post-stabilization not to count as emergency services is that the attending/treating physician determines that the patient can travel to a participating facility within a reasonable travel distance.

Assuming a participating facility is one that accepts the reference-based price, it would seem rare that the physician could know the pricing of the other facility in order to make that determination.

Consequently, as a practical matter, cost-sharing for these post-stabilization services in reference-based pricing plans may always count toward MOOP.

CLOSED-NETWORK PLANS

In Q6, the Departments address plans which have networks but provide no out-of-network benefits. The Departments confirm that such plans are also subject to the NSA with respect to emergency services, non-emergency services from an out-of-network provider at certain types of network facilities, and air ambulance services, so long as those services are otherwise covered under the plan if they were in-network.

The items and services must be covered in accordance with all NSA requirements related to cost sharing, payment amounts, and procedural requirements related to billing disputes, including the federal IDR process.

Q6 specifically addresses plans that have network facilities but, absent the NSA, would **never** cover an out-of-network provider in that facility and conclude that the NSA requirements "may result in a plan or coverage providing benefits for out-of-network items and services subject to the surprise billing provisions, even if the plan or coverage otherwise would not provide coverage for these items or services on an out-of-network basis." ■