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To: L. Thomas Rowe, Board Chairman, Housing Benefits Plan

From: Hall Benefits Law

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Re: No Surprises Act/Prohibition on Balance Billing Legal Review

Overview

The No Surprises Act (NSA), included as part of the Consolidated Appropriations Act, 2021 (the "CAA"),[1] builds upon aspects of the Affordable Care Act of 2010 (the "ACA"). The NSA includes comprehensive new patient protections against surprise medical bills.

Out-of-network (OON) surprise medical bills (also referred to as "balance billing") arise when a group health plan (GHP) participant inadvertently and unknowingly receives care from a provider (e.g., a physician) or at a facility (e.g., a hospital) that is not within the GHP's network. This may occur, for example, when the participant is taken to the closest emergency room, which is an OON facility. OON providers and facilities typically charge significantly higher rates to insurers (including self-insured GHPs) than in-network providers, which leads to significantly higher cost-sharing for GHP participants. If the plan does not agree to pay the OON provider's entire billed charges, the provider may seek to receive the "balance" by charging the GHP participant.

Under the NSA, beginning January 1, 2022, GHP participants treated by an OON provider will only be responsible for the same amount of cost-sharing[2] that they would have paid if the service had been provided by an in-network provider for:

[1] The CAA also includes a general prohibition on "gag" clauses in service provider agreements, new disclosure requirements for pharmacy benefits and other medical services, broker/consultant compensation disclosure requirements, and new disclosure requirements related to mental health parity, to name a few.
[2] For example, if the HBP requires 20 percent coinsurance for in-network emergency room visits, the HBP cannot impose a coinsurance rate of more than 20 percent for an out-of-network emergency room visit. This cost-sharing must also be counted towards a patient's in-network deductible and annual out-of-pocket maximum.

- Emergency services (including some services after the GHP participant is stabilized);
- Air ambulance services; and
- Services provided at an in-network facility but by an OON provider (unless a patient consents to being treated by the OON provider).[3]

This means that providers and facilities are now prohibited from sending balance bills to the Housing Benefits Plan (HBP) participants to collect a higher amount as it relates to the OON services set forth above.

Executive Summary/Key Action Items

Under the new balance billing prohibitions set forth in the NSA, beginning January 1, 2022, the HBP (or UnitedHealthcare) must:

- Verify that GHP participant cost-sharing for OON services covered under the NSA is no more than the qualifying payment amount (QPA);
- Provide the required notice to GHP participants that outlines the rules and requirements of the NSA; and
- Ensure that, if a GHP participant is balance billed for an OON service, the provider or facility provided notice and obtained a consent from the participant in accordance with the NSA requirements.

Billing Process for NSA-Covered Services

The following provides an example of the billing process for NSA-covered services:

A GHP participant ("Participant A") receives emergency care for an appendectomy by an OON physician (the "OON Provider") on January 15, 2022. Assume the OON Provider (i.e., the physician) bills $20,000 for the appendectomy services received by Participant A and the HBP receives the bill on March 31, 2022. Following receipt of the bill, the HBP:

1. Determines that Participant A's QPA/in-network cost share is $4,000;
2. Determines that the HBP will cover $14,000;
3. Within 30 days of receipt of the bill, the HBP makes an initial payment to the OON Provider of the HBP portion ($14,000) of the cost; and
4. The HBP sends an EOB to Participant A indicating his or her in-network cost-sharing amount ($4,000).

[3] Health care facilities include hospitals, hospital outpatient departments, critical access hospitals, and ambulatory surgical centers.

The OON Provider can dispute the HBP portion ($14,000) (i.e., if the OON Provider believes it is entitled to some or all of the $2,000 differential between the amount billed and the amount paid by the Plan and participant). If the OON Provider and HBP cannot resolve the dispute within 30 days (or April 30), the OON Provider can engage an independent dispute resolution entity (IDRE) to facilitate resolution of this matter (as set forth below).

Process for Determining Participant Cost Sharing

For self-insured GHPs that do not "opt-in" to a state surprise billing law, participant cost-sharing for covered OON services is based upon the lesser of the: i) amount billed or ii) QPA.

Qualifying Payment Amount

The QPA is the median of all the GHP's or insurer's (in HBP's case, UnitedHealthcare) contracted rates (the "median contracted rate"). If the GHP has a contract with the provider or facility, the rate is a single, contracted rate. If the GHP has a contract with multiple providers with separate negotiated rates with each provider, each unique, contracted rate is a single, contracted rate. In calculating the median contracted rate, a GHP must calculate the median contracted rate with respect to all GHPs administered by the same TPA.[4] The median contracted rate is calculated by arranging (from least to greatest) the contracted rates of all plans of the GHP sponsor (or its TPA) for the same or similar service from the same or similar provider or facility in the geographic region. If there are an odd number of contracts (e.g., $470, $495, $510), the median is the middle rate ($495). If there are an even number of contracted rates, the median contracted rate is the average of the middle two rates (e.g., $475, $490, $510, $515), the median contracted rate is $500 ($490 + $510/2).

For 2022, the GHP must calculate the QPA by increasing the median contracted rate for the same service under such GHP as of January 31, 2019, by the combined percentage increase in the CPI-U (U.S. city average) over the period 2019-2021. The combined percentage increase to adjust the median contacted rate for 2022 is 1.0648523983.[5]

Example:

UnitedHealthcare establishes a median contracted rate for a service in the amount of $3,480 as of January 1, 2019. The QPA for 2022 is calculated as follows:

$3,480 x 1.0648523983 = $3,705.69

[4] All risk sharing, bonus, penalty, or other incentive-based or retrospective payments should be excluded.
[5] Rev. Proc. 2022-11 (Dec. 28, 2021). For a service furnished in 2023 or later, a GHP must calculate the QPA by increasing the QPA for the service furnished in the immediately preceding year by the percentage increase as published each year by the Treasury Department and IRS.

Alternative Methods for Determining Median Contracted Rate

The Departments of Health and Human Services, Labor, and Treasury (the "Departments") issued the first interim final rule ("IFR 1") last year to provide guidance with respect to the contours of the GHP participant cost-sharing calculation for OON services and facilities covered under the NSA. The IFR 1 contemplates situations in which an in-network facility does not exist (e.g., an indemnity plan with no facility network).[6] For example, plans that utilize reference-based pricing often do not have a network with contracted rates upon which to base the QPA.

Underlying Fee Schedule Rate

Pursuant to the IFR 1, in the case of payments made by a GHP that are not on a fee-for-service basis (such as bundled or capitation payments), the GHP is expected to calculate the median contracted rate for each item or service using the underlying fee schedule rates for the relevant items or services. "Underlying fee schedule rate" means the rate for a covered item or service from a particular provider or facility that a GHP uses to determine a participant's cost-sharing liability for the item or service when that rate is different from the contracted rate.[7]

Derived Amount

If there is no underlying fee schedule rate for an item or service, the IFR 1 provides that the GHP must calculate the median contracted rate using the derived amount. The "derived amount" is the price that a GHP assigns to an item or service for the purpose of internal accounting, reconciliation with providers, or for submitting data to the CMS for the purpose of risk adjustment.

State Law

The Departments acknowledge that many states have adopted surprise billing laws that provide a method for determining the total amount that should be paid to an OON provider by a GHP. **For fully insured plans and certain self-funded plans that elect to "opt-in" to state law**,[8] the applicable state law will continue to apply with respect to the method for determining payment to resolve disputes between insurers and OON providers.

Approximately 17 states have comprehensive balance billing protection laws.[9] Payment dispute mechanisms in the 17 states with comprehensive protections (and potentially those states with partial protections, to the extent they rely upon arbitration, a specified payment amount, or a

[6] 86 Fed. Reg. at 36904.
[7] This definition is substantially similar to the definition of "underlying fee schedule rate" in the transparency in coverage regulations at 29 CFR 2590.715-2715A1(a)(2)(xxii).
[8] The following states permit self-funded plans to "opt in" to the state's surprise billing laws: Virginia, Nevada, Washington, New Jersey, and Maine.
[9] These states include Washington, Oregon, California, Colorado, New Mexico, Texas, Illinois, Michigan, Ohio, Georgia, Florida, Virginia, New Jersey, New York, Connecticut, New Hampshire, and Maine.

hybrid approach) would, to the extent such protections are at least as protective as the NSA requirements, remain in effect for state-regulated (i.e., fully insured) plans. The NSA also defers to states that have an "All Payer Model Agreement" (Maryland and Vermont) to determine the amount to be paid by an insurer to an OON provider or facility. Deference to specified state law only extends as far as state law applies and only to the extent that state law is at least as protective to patients as the NSA. It appears that the Departments may provide additional guidance on the interaction of state law and the NSA later this year.

Participant Notice Requirements

The GHP (or its TPA) must publicly post on its website, and include in any explanation of benefits (EOB) for OON items/services subject to the prohibition on surprise billing, a notice explaining:

- The balance billing prohibitions and requirements;
- Any applicable state requirements with respect to balance billing; and
- Information for contacting any applicable state or federal regulatory agency if the individual believes a provider/facility has violated the NSA's balance billing restrictions.

The DOL released a model notice for use by GHPs (available at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act).

Notice and Consent Exception

A GHP participant may waive the NSA's protections upon timely notice and consent. However, the notice and consent exception applies only in nonemergency situations. GHP participants cannot be asked to sign a consent waiver for emergency services (other than post-stabilization services when certain conditions are met) or air ambulance services. Even in nonemergency settings, providers cannot request a consent waiver if:

- There is no in-network provider available in the facility;
- Care is for unforeseen, urgent medical needs (whether nonemergency care or post-stabilization services); and
- The provider furnishes ancillary services that a patient typically does not select.

"Ancillary services" includes care related to emergency medicine, anesthesiology, pathology, radiology, neonatology, and diagnostic services (including laboratory services), that are provided by assistant surgeons, hospitalists, and intensivists.

Notice Contents

The notice must be tailored to each individual patient and include information about the applicable provider/facility, a good faith cost estimate of the patient's estimated charges (including a breakout of separate services), and whether prior authorization or other care management requirements may need to be satisfied. The notice must also inform the GHP participant that consent is not mandatory, and that he or she has the option to seek (or request referral for) in-network care. It must also provide a list of in-network providers at the facility. Notice and consent forms must be translated into the 15 most common languages in the facility's geographic region.[10]

With respect to the notice and consent forms:

- They must be given to the patient separately from other documents;
- They must be signed by the patient or their representative;
- A copy of the signed consent form must be given to the patient and the form must reflect the date the notice was provided and the date and time that the consent form was signed;
- Each notice must name a specific provider to be valid; and
- Written notice and consent documents must be retained for at least seven years.

Notice and consent must be given at least 72 hours in advance of a scheduled appointment. If the appointment occurs less than 72 hours after scheduling, notice and consent can be given on the same day as the appointment was made and, for same-day appointments, notice must be given at least 3 hours prior to the provision of services to which the notice and consent requirements apply.

Independent Dispute Resolution Process

The NSA establishes a process to resolve payment disputes between GHPs (or, if applicable, insurers) and OON providers that includes an open negotiation process followed by an independent dispute resolution (IDR) process if negotiations are unsuccessful. Prior to initiation of the IDR process, the parties must exhaust a 30-day open negotiation period. The OON provider or facility must initiate any IDR process within four days after the end of the open negotiation period. Within 10 days of selection of the IDRE, each party must submit to the certified IDRE their proposed payment amount for the item in dispute.

[10] The Department of Health and Human Services defines this to mean the 15 most common languages spoken in a state.

Penalties

If an OON provider sends a balance bill that violates the NSA, the Department of Health and Human Services can impose civil monetary penalties of up to $10,000 per violation on that OON provider. These penalties can be waived but only if: i) the OON provider did not knowingly violate and should not have reasonably known it violated the NSA, and ii) the OON provider withdraws the bill and reimburses the GHP or individual plus interest. While there are currently no separate penalties for GHP noncompliance, it appears that the Departments are likely to apply the penalty established through the ACA for the NSA. As a result, GHPs can expect to be fined $100/day for each affected individual in the case of noncompliance. Additional guidance with respect to NSA noncompliance penalties is expected to be released by the Departments in the coming year.