Legal Ease: Timely Updates for Your Practice

May 4, 2023

for the BONES Society of Florida

by Jacqueline Bain

SILVERMAN BAIN, LLP

ATTORNEYS

Agenda

2. *Use of Online Tracking Technologies by HIPAA Covered Entities*
3. *Florida's New Civil Remedies Law*

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Established in 2021.

Includes several new requirements for providers, facilities, and providers of air ambulance services to protect consumers from surprise medical bills.

The No Surprises Act

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Out-of-network providers and emergency facilities cannot bill or hold liable beneficiaries who received emergency services for a payment amount greater than the in-network cost-sharing requirement.

To apply:

Emergency services must be received at a hospital or an independent freestanding emergency department.

Patient must be enrolled in a group health plan or group or individual health insurance coverage.

Exception: The attending emergency physician or treating provider determines that the participant, beneficiary, or enrollee:

Can travel using non-medical or nonemergency transportation to an available in-network provider or facility located within a reasonable travel distance; and

Is in a condition to receive notice and provide informed consent; and

The out-of-network provider or emergency facility provides the patient with a timely written notice including certain information and obtains consent to waive surprise billing protections.

The No Surprises Act:

No balance billing for out-of-network emergency services

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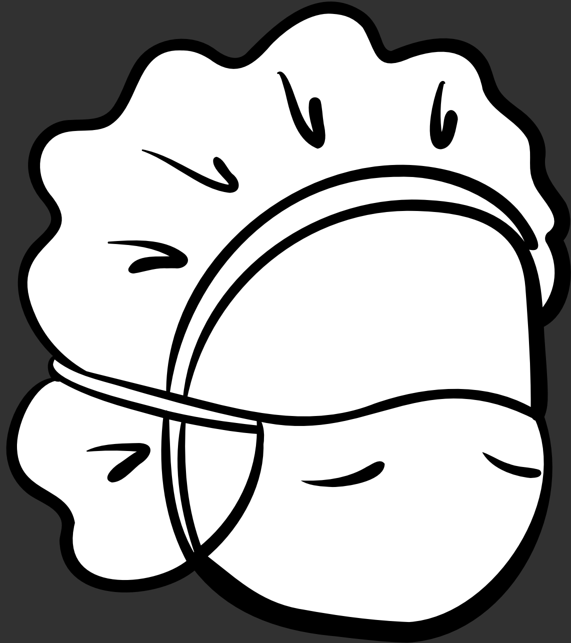

Out-of-Network providers cannot balance bill for certain non-emergency services during patient visits to in-network health care facilities without advance notice and consent.

Includes Ambulatory Surgery Centers
Does not include urgent care centers.

A provider is always prohibited from balance billing for the following items and services:
Those related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
Those provided by assistant surgeons, hospitalists, and intensivists;
Diagnostic services, including radiology and laboratory services;
Those provided by an out-of-network provider if there is no in-network provider who can provide the item or service at the facility.

The No Surprises Act:

No balance billing for certain non-emergency services provided by out-of-network providers at in-network facilities

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A provider or facility must disclose to any insurance beneficiary information regarding federal and state (if applicable) balance billing protections and how to report violations.

They must also post this information prominently at the location of the facility and on their website, and provide it to the patient prior to requesting payment from the individual or, with respect to an individual from whom the provider or facility does not request payment, prior to submitting a claim to the individual's payor.

Exception: A provider isn't required to make the disclosure to individuals if there is a written agreement where the facility agrees to make the disclosure instead of the provider.

The No Surprises Act:

Disclosure of patient protections against balance billing.

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1. When scheduling, a health care provider or facility must inquire if the patient is enrolled in an insurance plan. If so, the provider or facility must inquire whether the patient is seeking to have their claims for the item or service submitted to the individual's plan or coverage.

2. If the patient has no insurance, or doesn't intend to submit a claim, the provider or facility must provide notification to the patient of the good faith estimate of the expected charges, expected service, and diagnostic codes of scheduled services.

3. If the patient is insured and intends to have a claim submitted, the provider or facility must submit a good faith estimate to the insurer, which in turn must send an advance explanation of benefits to the patient.

The No Surprises Act:

Providing a good faith estimate in advance to an uninsured or self-pay individual.

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When an in-network contract between an insurance company and a healthcare provider ends, if the provider has a continuing care patient, it must:

• Accept payment from the insurance and patient for the course of treatment of a continuing care patient at the previously agreed-upon payment amount for up to **90 days** after the date the patient was notified of the change in the provider's network status.

• Continue to adhere to all policies, procedures, and quality standards imposed by the plan or issuer for such items or services as if the contract were still in place.

The No Surprises Act:

Continuity of care when a provider's network status changes

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The No Surprises Act:
What happens if there is a surprise bill?

1. Out-of-network provider/facility must bill payer (not patient);

2. Payer will tell provider what patient's cost-sharing responsibility is;

3. Payer must pay, followed by an open negotiation period, followed by option to go to to arbitration.

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Statute sets out what plan must pay:

- Amount determined by an applicable All-Payer Model Agreement;

- If no All-Payer Model Agreement, an amount determined by a specified state law;

- If no All-Payer Model Agreement or specified state law, an amount agreed upon by the plan and provider; or

- If none of the above, an amount determined by arbitrator.

The No Surprises Act:

What happens if there is a surprise bill? (continued)

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Standard Notices and Consent Forms:
https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf

Model Disclosure Forms:
https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf

The No Surprises Act

The Texas Medical Association has filed several lawsuits challenging the No Surprises Act.

In **March 2021**, a judge ruled that regulators did not follow the text of the act when it required the arbitrators to use the median in-network rate in settling payment conflicts between insurers and out-of-network providers.

In **January 2022**, a US District Court ruled that the final rules still unfairly advantage insurers by requiring arbitrators to give disproportional consideration to the median in-network rate when deciding between the physician and payor’s offer in a dispute.

No Surprises Act
Arbitration Litigation

The Texas Medical Association has filed several lawsuits challenging the No Surprises Act.

The TMA sued for a third time in **December 2022**, challenging the methodology for calculating payments in the arbitration process.

In **March 2023**, TMA filed a fourth lawsuit over the No Surprise Act, focusing on increased fees both parties must pay for an independent arbitration process to solve billing disputes between providers and payers.

No Surprises Act

Arbitration Litigation (continued)

- Heightened sensitivity regarding privacy of health information following COVID-19 and the Dobbs decision
- Increasing awareness of gaps in Federal Law (including HIPAA) regarding privacy of health information
- HHS and the FTC have broadly interpreted the applicability of the laws in order to bridge privacy gaps between HIPAA and other privacy laws
- Continuing efforts to develop more comprehensive federal privacy legislation
- An increasing number of states have enacted comprehensive consumer privacy legislation (which applies to health information, subject to certain exemptions) including CA, CO, CT, IA, UT, and VA

Online Tracking Technologies: Current Status and Evolution

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- Tracking technologies involve the use of a script or code (e.g., cookies, tracking pixels and codes, fingerprinting scripts, web beacons) on a website or mobile app to gather information about users as they navigate.
- Tracking technologies are used in advertising to drive targeted ads (e.g., banner and social media ads), including ads for the products and services of a business with which a user has interacted and products and services from similar businesses

Online Tracking Technologies: Definitions

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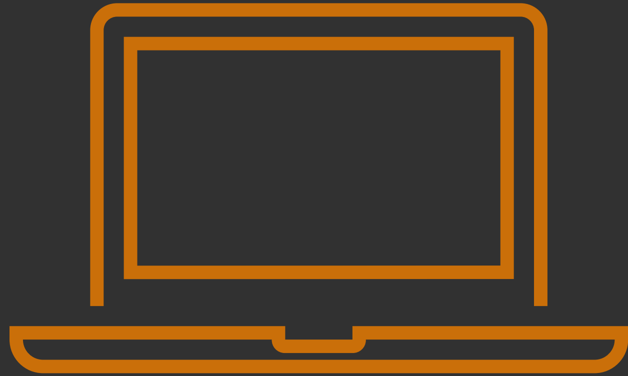
Requires vendors of personal health records (PHR) and related entities to notify consumers and in some cases the media and the FTC following a breach involving unsecured PHR identifiable health information

A PHR is an electronic record of PHR identifiable health information on an individual that can be drawn from multiple sources and that is managed, shared, and controlled by or primarily for the individual

"PHR identifiable health information" is "individually identifiable health information" and, with respect to an individual, information that is provided by an individual and that identifies the individual or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual

Does not apply to HIPAA covered entities and their business associates



Online Tracking Technologies:

FTC Personal Health Records Breach Rule

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12/01/2022 OCR Bulletin on Tracking Technologies:

All individually identifiable health information (IIHI) collected on a regulated entity's website or mobile app generally is PHI, even if the individual does not have an existing relationship with the regulated entity and even if the IIHI, such as IP address or geographic location, does not include specific treatment or billing information like dates and types of health care services.

The Bulletin represents OCR's current position on the issue of tracking technologies, but does not have the force and effect of law

Online Tracking Technologies:

HIPAA and HITECH

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Tracking technology vendors are business associates if they create, receive, maintain, or transmit PHI on behalf of a regulated entity for a covered function (e.g., health care operations) or provide certain services to or for a covered entity (or another business associate) that involve the disclosure of PHI.

De-identification of PHI by a tracking technology vendor prior to saving it does not change the vendor's status as a business associate.

Does your entity have BAAs in place with its web developer or other vendor who may house this information?

Online Tracking Technologies:

HIPAA – Vendors may be business associates

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Generally, not subject to HIPAA Rules because tracking technologies on unauthenticated webpages generally do not have access to individuals' PHI.

Exceptions:
When an individual enters credential information on a login webpage or enters registration information (e.g., name, email address), such information is PHI.

Webpages that address specific symptoms or health conditions..

Webpages where users can search for a provider or schedule an appointment, even if the page does not require a log-in to perform the search.

Online Tracking Technologies:

HIPAA – Unauthenticated Web Pages (webpages that do not require users to log in)

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OCR appears to distinguish

– a general home page for a multi-specialty provider offering information about the provider's location and services (where tracking the IP addresses visiting the site would not constitute the collection and sharing of PHI) and

– condition- or symptom-specific pages (where OCR indicates the tracking of IP addresses visiting the site would constitute the collection and sharing of PHI)

Online Tracking Technologies:
HIPAA – Generally

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Providers should:

- consult counsel for purposes of evaluating breach reporting obligations if tracking technologies may have resulted in unauthorized disclosure of PHI to third parties;
- evaluate whether any information that is collected by tracking technologies is used for marketing purposes or sold to third parties and to what extent that information is PHI requiring a HIPAA authorization for such activities;
- consider whether BAAs are required with tracking technology vendors;
- update HIPAA security risk assessments to include the use of tracking technologies involving PHI.

Online Tracking Technologies: Takeaways for Providers

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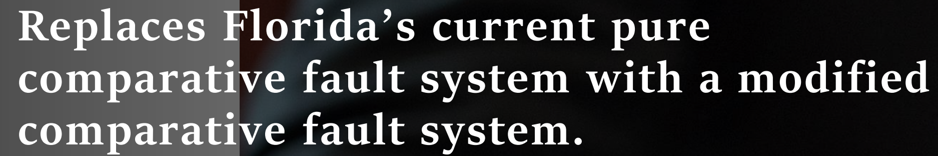

Replaces Florida's current pure comparative fault system with a modified comparative fault system.

Pure comparative fault - allows a claimant to claim damages for the 1% they are not at fault even when they are 99% at fault.

Modified comparative fault - any claimant found to be at least 51% liable for an incident cannot seek reparation from the other party.

Florida Tort Reform 2023

What the change in the law does.

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Reduces statute of limitations in negligence actions from 4 years to 2 years.

Eliminates attorney-client privilege with regard to referral and financial relationships between plaintiff's personal injury firms and treating physicians.

Introduces new evidentiary thresholds for a plaintiff in a personal injury action to prove their past and future economic damages for medical costs.

Florida Tort Reform 2023

What the change in the law does.

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Physicians who provide provide professional services to LOP/LOI patients, the plaintiff must disclose:

A copy of the letter of protection;

All billing for a plaintiff's medical expenses, which must be itemized and appropriately coded;

Whether the health care provider sold the accounts receivable to a third party, the name of the third party, and the dollar amount paid by the third party to purchase the accounts;

Whether the plaintiff had health insurance at the time of treatment and the identity of the health care coverage provider; and

Whether the claimant was referred for treatment under a letter of protection and, if so, the identity of the person who made the referral.

Florida Tort Reform 2023
Why the change in the law matters.

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Questions?

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