Articles + Publications | October 20, 2021

Don’t Get Caught Off Guard – New Rules Established by the No Surprises Act

Labor & Employment Workforce Watch

WRITTEN BY

Edward A. Razim, III

In December 2020, Congress adopted the Consolidated Appropriations Act, 2021 (the “CCA”), which includes a special rule — the “No Surprises Act” — that is designed to protect consumers from surprise medical bills for services. Employers who sponsor group health plans are required to comply with the No Surprises Act beginning on January 1, 2022.

While the actual compliance process will be administered by the insurance company or record keeper responsible for plan design and claims administration, employers are responsible for ensuring that these changes are made to group health plans and are clearly communicated to plan participants. Therefore, employers should be aware of the types of medical bills covered by these rules. Likewise, we recommend that employers contact their providers to confirm that these new procedures will be in place by January 1, 2022.

“Surprise” medical bills are typically issued by providers or facilities that do not have an existing contractual relationship with an employer group health plan or an insurance company. The amount charged by these “out of network” providers and facilities—which isn’t subject to any contractual fee limits, cost sharing, and other restrictions—is typically well in excess of the amount a group health plan or an insurance policy will pay for those services. As a result, many out-of-network providers and facilities take various steps, including referrals to debt collectors and lawsuits, to collect the shortfall from the individuals who received the services.

The “No Surprises Act” establishes rules to address this form of “surprise” medical billing, including (1) prohibiting “balanced billing” actions to collect payment shortfalls from the patients, and (2) creating an independent dispute resolution (“IDR”) process to determine the amounts due from group health plans and insurers to out-of-network providers and facilities for non-emergency services when those parties cannot agree on the payment amount. The No Surprises Act also requires group health plans and insurers to provide an external review for any adverse determination relating to emergency services and air ambulance services. These provisions generally apply to periods beginning on or after January 1, 2022.

The following is a high level overview of the process that will be used by the Departments of Health and Human Services, Labor, and the Treasury (the “Departments”), which were charged with administering these rules, to resolve payment disputes over the amount paid by a group health plan or an insurer to an out-of-network provider or facility for out-of-network items and services (the “out-of-network rate”):

- There is an initial 30-day “open negotiation” period to determine the total out-of-network rate, including cost-sharing.

- If the dispute cannot be resolved through open negotiation, either the provider or the plan (or insurer) can initiate the IDR process. The provider and the plan can either jointly select a certified IDR entity to resolve the dispute or, if they cannot agree upon a certified IDR entity or the selected entity has a conflict of interest, the Departments will select the IDR entity.
- Each party will submit an offer for payment, with supporting documentation, to the certified IDR entity, which will issue a binding determination by selecting one of the parties' offers as the out-of-network rate. Both parties have to pay an administrative fee ($50 each for 2022), and the non-prevailing party is responsible for the certified IDR entity's remaining fees for using the process based on a ranged of listed fees.
- The current rules, which may be changed in the future in final regulations, presume that the median contracted rate used by the group health plan or the insurer for the same or similar service in the specific geographic area (referred to as the Qualifying Payment Amount or "QPA") is the appropriate out-of-network rate. The certified IDR entity must select the offer closest to the QPA unless it makes a determination that the information submitted clearly demonstrates that the value of the item or service is materially different from the QPA. When making this determination, the certified IDR entity may not consider usual and customary charges, the amount that would have been billed if the surprise billing rules had not applied, or any public payor payment or reimbursement rates.

From a plan sponsor's perspective, this process is likely to be confusing and may increase overall plan cost. It should, however, help shield participants from claims by out-of-network providers and facilities, which will benefit participants overall.

We anticipate that the rules will be modified, perhaps significantly, during the next several months as the Departments refine their published guidance, and we will continue to monitor these developments. Importantly, sponsors of group health plans should remain in contact with their providers regarding these changes, and consult with competent counsel with any questions regarding how these rules may affect the administration of their plans.

RELATED INDUSTRIES + PRACTICES

- Labor + Employment