

Surprise Medical Billing – Changes to Law Will Have a Significant Impact on Group Health Plans

Labor & Employment Workforce Watch

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On December 21, 2020, Congress passed the Consolidated Appropriations Act, 2021, which included a \$900 billion COVID-19 relief and stimulus package and a new set of rules intended to address “surprise” medical billing. The No Surprises Act (the “Act”), which is part of the 2021 appropriations act, makes various changes to ERISA that are intended to ban the practice of “surprise” medical bills, which arise when a person covered by a group health plan unexpectedly receives emergency medical care from an out-of-network provider at an out-of-network facility or from an out-of-network provider at an in-network facility. In these instances, the out-of-network provider can bill the person for the difference between their charged rate and the amount an employer’s group health plan (or the insurer) agrees to pay, which is known as “balance billing.” The Act takes several steps to address this situation.

- The Act prohibits physicians and facilities from balance billing patients without the patient’s informed consent. For emergency or non-emergency services provided by out-of-network providers at either out-of-network or in-network facilities, and out-of-network air ambulance services, group health plans and insurance companies will be required to apply in-network cost-sharing. The Act also states that such services must be counted toward the patient’s in-network deductible. There is an exception, however, for “ancillary services,” which include anesthesiology, radiology, and other services.
- Group health plans and insurers will be required to issue an advanced explanation of benefits or “EOB” for scheduled services. These advanced EOBs must be provided for scheduled procedures at least three days in advance, detailing the providers scheduled, the providers’ network statuses, and expected costs to the patient.
- Participant ID cards will need to include, in clear writing, the deductible, out-of-pocket limits, and consumer assistance information. This is intended to help participants and medical providers better understand the coverage provided under a group health plan.
- The Act establishes an independent dispute resolution process that removes patients from billing disputes between plans and providers. Prior to arbitration, both parties (the provider and the plan or the insurer) must engage in a 30-day negotiation during which the parties may settle out-of-network claims. If the parties don’t come to agreement, either party can request binding arbitration. This effectively shifts the cost of any “surprise billing” to the group health plan instead of allowing it to be imposed on the participant.

These new rules will go into effect in 2022 and will impose sweeping changes to the administrative processes for both self-insured and fully-insured group health plans. Provided there isn’t a delay in implementation, the Biden Administration’s regulatory agencies will need to issue a substantial amount of regulatory guidance during the next several months and the third-party administration firms and insurance companies will have to materially change their administrative processes. Given the very tight timeframe for these changes, and the impact they will

have on plan participants and plan sponsors, we recommend that clients begin discussing these issues with their insurance agents, insurance carriers and third-party administrators during the next few months. We anticipate this will result in substantial changes to existing services agreements, summary plan descriptions and other participant communications materials.

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