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BLOG

CAA Benefits Alert: Unpacking the Benefits Provisions in the Consolidated Appropriations Act, 2021 Surprise Billing

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In an unexpected but hard-fought win for consumers of medical care, surprise billing reform was signed into law as part of the $900 billion Consolidated Appropriations Act, 2021. The aptly-named "No Surprises Act" (the Act) is the result of a multi-year, bi-partisan effort to end surprise billing for medical plan participants and hold them harmless from balance billing by out-of-network providers, including federally regulated air ambulances. Under the Act, participants will be protected from surprise medical bills from out-of-network providers for emergency services and non-emergency services at in-network facilities (unless the participant consents to treatment by an out-of-network provider) and will only be liable for cost-sharing amounts that apply to in-network services. The Act also provides for an independent dispute resolution process to facilitate negotiation of outstanding amounts between payors and providers and contains other transparency measures discussed below. These provisions generally apply to plan years beginning on or after January 1, 2022.

Background

Medical providers and facilities that are part of a provider network have a contractual relationship with a group health plan, third party administrator (TPA), or insurer (payor) setting forth the negotiated, discounted price for covered items and services. Covered items and services received through these medical providers and facilities are commonly referred to as "in-network benefits."

Providers and facilities that are not part of a provider network (commonly referred to as "out-of-network providers" and/or "non-participating providers") lack these contractual relationships. Items and services received through these medical providers and facilities are commonly referred to as "out-of-network benefits." These out-of-network benefits also typically include participant cost-sharing amounts, but these amounts are not known by the participant up-front, because they are usually based on a percentage of the cost the plan pays the out-of-network provider and any additional amounts not paid by the plan.

Plans will typically have different participant cost-sharing amounts for in-network and out-of-network benefits. Cost-sharing amounts are either in the form of co-payments or co-insurance and for out-of-network benefits the participant will also be responsible for additional fees and expenses charged by the out-of-network provider or

facility that are not covered by the plan. In addition, most plans have separate deductibles and out-of-pocket maximums based on services and items received in-network or out-of-network.

Currently, under most health plans that offer out-of-network benefits, when a participant receives items or services from an out-of-network provider, the out-of-network provider invoices the plan its billed charges (often at higher rates than network pricing) and is reimbursed by the plan for covered expenses based on the plan's out-of-network reimbursement methodology. Such methodologies include maximum allowable amount, reference based pricing, a multiple of the Medicare reimbursement rate or usual, reasonable and customary expenses. The out-of-network provider usually seeks reimbursement for the delta not paid by the plan through other means, such as balance billing the plan participant or attempting to seek additional reimbursement from the plan through the ERISA claims process asserting its standing under an assignment of benefits/designated beneficiary theory. This billing practice has resulted in an increase in plan participant responsibility for unexpected residual medical bills and has exposed plans to an increasing amount of provider lawsuits. While many states have passed legislation aimed at curbing surprise billing, self-insured plans and federally regulated air ambulances were beyond the reach of these laws.

The No Surprises Act

The Act, which amends ERISA, the Internal Revenue Code (Code) and the Public Health Security Act (PHSA), requires both fully-insured and self-insured group health plans to hold health plan participants harmless from the impact of surprise medical bills. Under the Act, plan participants are only required to pay the in-network benefit cost-sharing amount for out-of-network benefits for emergency care services, for certain ancillary services provided by out-of-network providers at in-network facilities, and for out-of-network care provided at in-network facilities without the participant's informed consent. The Act also requires that any out-of-network expenses for the services covered under the Act accumulate towards a plan participant's in-network deductible and out-of-pocket maximum. Payment to providers would be based on a payment methodology using a median amount based on in-network rates, including for those services that are not billed on a fee-for-service basis.

The Act contains different rules for emergency and non-emergency services, but accomplishes surprise billing reform by prohibiting out-of-network providers from sending participants balance bills for more than the median in-network cost-sharing amount. With respect to emergency services, the Act requires plans to cover emergency services delivered by hospital emergency departments or certain free-standing emergency facilities without prior authorization at in-network rates. With respect to the delivery of non-emergency services, out-of-network providers are prohibited from balance billing participants unless the provider gives the participant advance written notice and the participant provides consent to receive out-of-network care.

Independent Dispute Resolution

The Act also provides for an independent dispute resolution process between payors and providers to negotiate and settle out-of-network claims through baseball style arbitration in a binding dispute resolution process known as Independent Dispute Resolution (IDR) administered by independent, unbiased entities with no affiliation to providers or payors. If the parties are unable to resolve their differences during a 30-day open negotiation, the dispute is submitted to the IDR entity. To achieve resolution, the IDR entity is required to consider the median in-network rate, relevant information brought by either party, and information requested by the reviewer, as well as factors such as the provider's training and experience, the complexity of furnishing the item or service, demonstrations of good faith efforts (or lack thereof) to enter into a network agreement, prior contracted rates during the previous four plan years, and other items. Notably, the IDR entity cannot reference Medicare claims data or provider billed charges in determining the negotiated price. There is also a tolling period in which the party that initiated the IDR may not take the same party to IDR for the same item or service for 90 days following a prior determination. In addition, the losing party must pay the cost of the entire arbitration as an incentive against seeking arbitration for superfluous cases.

Air Ambulance Reform

Under the Act, plan participants are also held harmless from surprise medical bills from federally regulated air ambulances; note that ground ambulances are not subject to the new law. Participants are only required to pay the in-network cost-sharing amount for out-of-network air ambulances (and such amounts accumulate towards the participant's in-network deductible and out-of-pocket maximum). Air ambulances are prohibited from sending participants balance bills for more than the in-network cost-sharing amount. If a 30-day negotiation period between the parties is not successful, the excess amount is negotiated by the IDR process described above looking at factors such as the training, experience, and quality of the provider, the location where the participant was picked up and the population density of that location, the air ambulance vehicle type and medical capabilities, extenuating factors such as participant acuity and the complexity of furnishing the item or service, demonstrations of good faith efforts (or lack thereof) to enter into a network agreement, prior contracted rates during the previous four plan years, or other information submitted by the parties.

In order to build a reliable reference data base, air ambulance providers are required to submit two years of cost data to the Secretaries of Health and Human Services (HHS) and Transportation (collectively, the Secretaries) and insurers are required to submit two years of claims data related to air ambulance services to the Secretary of HHS so that the Secretaries can publish a comprehensive report.

Additional Disclosure Requirements for Health Plans

The Act also contains a number of additional disclosure requirements aimed at providing plan participants with transparency as to benefit design and provider networks. Notably, the Act requires group health plans and health insurance issuers to:

- Include on the ID card issued to enrollees, the amount of the in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket maximum limitations.
- Provide an advance Explanation of Benefits (EOB) for scheduled services at least three days in advance to give participants transparency into which providers are expected to provide treatment, the expected cost, and the network status of the providers.
- Offer a price comparison tool for consumers (this is in addition to the tool required under the Transparency in Coverage rules finalized earlier this year and discussed in our alert linked here.
- Publish up-to-date directories of the plan's in-network providers, available to participants online, or within one business day of an inquiry. If a participant provides documentation that they received incorrect information from a plan or issuer about a provider's network status prior to a visit, the participant will only be responsible for the in-network cost-sharing amount.

The Act also contains a number of transparency reforms aimed at providers and allows for an external review to determine whether surprise billing protections are applicable when there is an adverse determination by a plan or issuer beginning not later than January 1, 2022.

Enforcement

The Departments of Labor, Treasury and HHS are tasked with creating a process to audit health plans to ensure they comply with the requirements to apply median in-network rates to out-of-network services. The audits would include both sample audits and targeted audits based on complaints. For fully-insured health plans (i.e., those funded through insurance), provider enforcement will be largely left to the state. Many states already have surprise billing laws on the books that are not preempted by ERISA with respect to fully-insured health plans. HHS also has the ability to impose penalties on providers of up to $10,000 per violation. For self-insured plans (i.e., those funded by an employer and/or its employees), enforcement will be governed by enforcement rules applicable to group health plans under ERISA, the Code or the PHSA, depending on the type of sponsoring entity.

Winston Takeaway: *Plan sponsors have a lot to do to prepare for these new rules, including updating their plan documents, summary plan descriptions, claim and appeal procedures (including the new advance EOB*

requirements), summary of benefits and coverage, updating provider directories and member ID cards and preparing for the new IDR process to negotiate disputed bills from out-of-network providers. Plan sponsors will also be required to work with their TPAs and insurers to ensure that they are taking steps to comply with the new rules and preparing for audits.

This article is part of our "Unpacking the Employee Benefits Provisions in the Consolidated Appropriations Act, 2021" series. Click here for other CAA-related articles. Please contact a member of the Winston & Strawn Employee Benefits and Executive Compensation Practice Group or your Winston relationship attorney for further information.

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