Departments Issue Second Set of Rules on "No Surprises" Medical Billing

October 2021

The Departments of Labor, Treasury, and Health and Human Services (the Departments) released the second set of interim final regulations (IFR Part II) implementing portions of the No Surprises Act (the Act), which was enacted as part of last year's Consolidated Appropriations Act, 2021.

The Act is designed to protect patients from large "surprise" medical bills incurred from emergencies, from air ambulance services, and from services and procedures that are performed by out-of-network providers at in-network facilities.

This Aon bulletin discusses the following provisions of IFR Part II relating to employer group health plans:

- The federal Independent Dispute Resolution (IDR) process that nonparticipating providers and facilities subject to the Act and group health plans may use if there is no resolution regarding fees after an open negotiation period;
- The time frames related to the IDR process, as well as fees; and
- Applicability of the external review process for participants to issues related to the Act.

Background

The Act prohibits participants from receiving surprise balance bills in certain emergency situations and when going to an in-network facility where out-of-network providers (e.g., anaesthesiologists, radiologists, etc.) perform certain services and procedures. Among other provisions, the Act sets out:

- The cost-sharing amounts that participants can be charged in a surprise medical billing situation;
- The procedures for determining payment to providers from plans; and
- When notice and consent to balance billing are required.

The Departments published IFR Part I in July 2021 addressing:

- Prohibitions on preauthorization for emergency services;
- Rules on determining cost-sharing amounts for participants and the out-of-network amounts paid by plans; and
- Notice and consent requirements.

A summary of the provisions of IFR Part I relevant to employer group health plans can be found here in the Aon bulletin titled *Departments Issue Regulations Prohibiting Surprise Medical Bills*.

Open Negotiation Period

IFR Part II sets out the process that out-of-network providers/facilities, including air ambulance service providers, and health plans will use to determine the amount that out-of-network plans must pay. Specifically, the parties will have 30 business days to negotiate the out-of-network amount. The 30-business-day period will begin to run on the date the provider or facility receives the health plan's initial payment or notice of denial of payment. The open negotiation period may continue for up to 30 business days beginning on the day that either party first initiates the open negotiation period. The parties may discontinue the negotiation if they agree on an out-of-network amount before the last day of the 30-business-day open negotiation period. If the parties cannot agree on an out-of-network amount, they must exhaust the 30-business-day open negotiation period before initiating the federal IDR process.

Federal IDR Process

IFR Part II establishes the federal IDR process that providers/facilities and plans may use to determine the out-of-network rate for items and services subject to the Act if there is no resolution during the open negotiation period. Either party may initiate the federal IDR process, but it must be done during the four-business-day period beginning on the 31st business day after the start of the open negotiation period. The parties may select a certified IDR entity, or, if they do not select such an entity, the Departments will make the selection. The certified IDR entity cannot be a party to the dispute or an employee or agent of a party to the dispute. The IDR entity also cannot have a material familial, financial, or professional relationship with such party.

During the IDR process, each party must submit to the IDR entity an offer for a payment amount for the item or service in dispute. Also, each party must submit any other information related to the offer as requested by the IDR entity within 10 business days from when the IDR entity is selected, as well as any additional information for the IDR entity to consider.

IFR Part II directs the IDR entity to begin with the presumption that the Qualifying Payment Amount (QPA) is the appropriate out-of-network rate for the qualified item or service when making its determination. IFR Part II specifically directs the IDR entity to select the offer closest to the QPA unless the IDR entity determines that either party has submitted credible information that clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate based on the following factors:

- The level of training, experience, and quality, and outcomes measurements of the provider or facility;
- The market share held by the nonparticipating provider/facility or that of the plan in the geographic region where the item or service was provided;
- The level of complication for furnishing the item or service or the acuity of the individual receiving it;
- The teaching status, case mix, and scope of services of the facility furnishing the item or services; and

- Good faith efforts made by the provider/facility or plan to enter into network agreements and, if applicable, contracted rates between the parties during the previous four plan years.

For air ambulance services, the following factors may be considered:

- Quality and outcomes measurements of the provider;
- Acuity of the individual receiving the services or the complexity of furnishing the services to the individual;
- Training, experience, and quality of medical personnel that furnished the services;
- Ambulance vehicle type, including its clinical capability;
- Population density of the pick-up location (e.g., suburban, urban, rural, or frontier); and
- Good faith efforts made by provider/facility or plan to enter into network agreements, and if applicable, contracted rates between the parties during the previous four plan years.

The IDR entity **may not** consider the following facts:

- Usual and customary charges;
- Amount that would have been billed without the provisions of the Act; and
- Any public payer reimbursement rates (e.g., Medicare or Medicaid).

Both parties must pay an administrative fee of $50 (for 2022) plus a fixed fee established by the certified IDR entity. As noted in previous bulletins, the party whose offer is not selected is responsible for paying the certified IDR entity's fixed fee for the process. Both parties will pay the certified IDR entity both the fixed fee and the administrative fee at the time the offers are submitted, however the certified IDR entity will return the payment of its fixed fee to the prevailing party. The prevailing party is still responsible, however, for the $50 administrative fee. IFR Part II also allows parties to submit batched claims, and the fees will be assessed accordingly.

IFR Part II establishes the criteria for certifying IDR entities, setting out the specific requirements such entities must meet to become certified IDR entities. In addition, the Departments are establishing a federal IDR portal to administer the federal IDR process. The portal will be used throughout the IDR process to satisfy the requirements under the IFR Part II including providing notices, initiating the federal IDR process, submitting an application to be a certified IDR entity, submitting the certified IDR's written decision along with its underlying rationale, and satisfying reporting requirements. The federal IDR portal will be available here.

External Review

The Affordable Care Act and rules issued by the Departments in 2015 required non-grandfathered group health plans to provide for external review for certain adverse benefit determinations. IFR Part II expands the scope of that review for participants to include issues related to compliance with the

provisions of the Act. Also, IFR Part II requires grandfathered health plans, which are generally excluded from the provisions related to external review, to provide for external review of adverse benefit determinations related to claims subject to the Act. Grandfathered group health plans that currently do not have an external review process in place will need to implement that process.

Effective Date

The regulations are effective for group health plans for plan years beginning on or after January 1, 2022. The Departments are also soliciting written comments which must be received by December 6, 2021.

Resources

The text of IFR Part II is available here.

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