

# THE DEEP DIVE

Exclusive Compliance Insights from MZQ Consulting

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## CAA DEEP DIVE SERIES: SURPRISE BALANCE BILLING


One of the many components of [the Consolidated Appropriations Act of 2021](#) is the "No Surprises Act." This section of the new law does not directly address COVID-19 economic relief but instead gets at a longstanding health policy concern, the issue of "surprise" balance billing. It bans these "surprise" bills in certain circumstances and establishes a federal procedure to handle many types of disputed out-of-network medical claims.

Surprise billing occurs when individuals get medical care outside of their plan's network, and their providers and health plans cannot agree on a payment amount acceptable to the provider. In those cases, patients often get a "balance" bill for amounts charged by the provider but not paid by their health plan. While no one likes medical bills, they are particularly shocking and unwelcome when patients do not get to pick their provider, such as in a medical emergency. It's also very frustrating when a patient carefully selects an "in-network" healthcare facility but later receives a bill from a provider who, unbeknownst to the patient, does not have a contractual agreement with their health plan.

Federal and state-level lawmakers have been grappling with potential solutions to the issue of surprise balance billing for many years. [Seventeen states already have comprehensive laws addressing surprise bills, and 15 others have some billing protections in place for consumers](#), particularly for those with fully-insured or state-sponsored health insurance coverage. The new federal law creates a uniform level of protection that applies to all group and individual major medical plans nationwide, including those that offer fully-insured coverage and self-funded group health plans. The measure sets a floor of federal requirements, but it specifically does not preclude states from adopting even stricter standards for insurers and healthcare providers under their jurisdiction. The law is also clear that if a state already has a specific financial benchmark for billing disputes, that standard will apply to the affected entities in federal cases raised in their state.

### Patient Protections

When this part of the law takes effect next January, it will address surprise balancing billing related to emergency care, air ambulance services, and treatment by an out-of-network provider while at an in-network hospital. From the patient's perspective, the new law shields them from getting a balance bill in any of those three circumstances. Instead, patient payment responsibility in those cases will work as described in the following examples.



**Example 1 (Emergency Care):** Patient A goes to an out-of-network facility for treatment in a medical emergency. The facility and its providers may only charge Patient A what Patient A otherwise would have paid if the provider/facility was in-network. Any additional costs may only be billed to Patient A's health plan. These surprise billing protections continue until Patient A is medically stable and can consent to be transferred to an in-network facility.

**Example 2 (Air Ambulance Service):** Patient B experiences a heart attack while in a remote location. She is airlifted to the nearest emergency room. The air ambulance service does not have a contract in place with Patient B's health plan. Here again, the patient will only pay the in-network rate and cannot get a bill later for exorbitant extra costs from an out-of-network provider they did not select. The air ambulance service can bill Patient B's health plan for the balance.


**Example 3 (Out-of-Network Treatment at In-Network Facility):** Patient C seeks treatment at an in-network hospital (this may be for an emergency or non-emergency). While at the in-network hospital, an out-of-network provider treats Patient C. Subject to the exception outlined below, Patient C may only be billed the otherwise applicable in-network rates for their care.

Exception: A qualifying out-of-network provider may balance bill a patient for services rendered at an in-network facility if: (1) they provide non-emergency care, (2) they receive informed consent for treatment from the patient at least 72 hours before services are rendered, (3) the informed consent waiver includes a good-faith cost estimate, and (4) the patient is provided instructions for how to obtain comparable services from an in-network provider.

This exception does not apply to emergency medicine, anesthesiology, pathology, radiology, neonatology, and items and services provided by assistant surgeons, hospitalists, and intensivists. Diagnostic services, including radiology and laboratory services, are excluded too, and the law allows for expansion of the exceptions list through future regulatory action. Finally, non-participating providers working through in-network facilities may not balance bill a patient if there isn't an equivalent participating provider who could provide the same care at that facility instead.

### **The Arbitration Process for Providers and Health Plans**

Since providers are barred from balance billing patients in the circumstances outlined above, they will instead bill each patient's health plan. When the health plan receives such a bill, it can choose to accept the charges and pay the bill or engage in private negotiations to resolve the claim. The new law does not limit these private negotiations to any payment scale but does specify that the talks may last up to 30 days. Once the 30-day window closes, both parties have four days to either accept the results of the private negotiation or request independent arbitration for the claim. The federal government will develop regulations over the coming year



to define the dispute resolution process and create a list of independent entities capable of handling such arbitrations.

### **Factors Governing the Arbitrator's Decision**

The arbitration process will be “baseball style,” meaning that there will be one clear winner and one clear loser. When an arbitration starts, each side will present the amount that they feel is fair to resolve the claim. Both sides can determine this “best and final offer” any way they choose. However, the law specifies criteria that the arbitrator may use to determine which side prevails. Specifically, the arbitrator may consider:

- (1) The median in-network rates paid by the health plan;
- (2) Any prior contracted rates used by the parties over the past four years;
- (3) Provider or facility training or experience;
- (4) Quality outcomes on the part of the provider or facility;
- (5) Market share held by the provider or facility or the issuer in the applicable geographic region;
- (6) The complexity of the services provided and the patient's acuity;
- (7) Type and scope of the facility, including teaching status;
- (8) If there was a good-faith effort to join the insurer's network or lack thereof; and
- (9) Any other information submitted by the two parties involved in the case.

The arbitrator may not consider the provider's usual and customary charge, the billed charge, or the reimbursement rates paid by public payers, such as the Medicare rate. It is worth re-emphasizing that the arbitrator does not have the power to mediate a compromise solution. Instead, they must choose one side's initial offer. While the arbitrator's decision is final, the parties can voluntarily agree to settle the claim through private negotiations at any time before the conclusion of the process.

Finally, there may be instances where the same insurer or group health plan has multiple disputes with the same provider or facility in the same 30-day window involving similar facts. In those cases, they can batch together numerous claims into the same arbitration for efficiency purposes.

### **Protections to Limit Excessive Arbitration of Claims**

The law includes protections to discourage frivolous arbitration. First, the loser of the arbitration pays for all arbitration costs. If the two parties agree to a settlement before the end of the arbitration, then they split costs equally unless they agree to another arrangement as part of the settlement. Second, a "lock-out" clause in the law stipulates that whichever party initiated the arbitration cannot start another dispute resolution process with the other party about the same services for 90 days following the decision.

## Effective Date and Enforcement


The surprise billing prohibitions apply to plans or policy years starting on or after January 1, 2022. The law relies on the states to enforce the provisions related to fully-insured health insurance carriers, and the Department of Labor has enforcement authority when it comes to self-funded group health plans. As for providers, the law allows each state the option to compel compliance from all providers within their jurisdiction (this authority extends to air ambulance providers, which generally as aviation entities are subject to federal requirements). There may be times when a state fails to substantially enforce provider requirements, particularly the prohibition against balance billing patients. In such cases, the federal government is tasked with enforcement. Federal enforcement authority includes the ability to assess civil monetary penalties against providers of up to \$10,000 per violation. Federal regulators will also develop a process to address consumer complaints should someone get a surprise bill in violation of this law.

## Limits to the “No Surprises Act”

While the new law provides a great deal of protection to shield consumers from surprise medical bills, it does not cover all circumstances when a person may receive out-of-network care. For example, the surprise billing ban does not apply to regular vehicular ambulance services. The law also does not apply to situations when an individual voluntarily elects to see an out-of-network provider, such as for a specialty care office visit or if a person schedules an advance procedure with an out-of-network provider through an in-network facility. In those cases, the provider is still allowed to balance bill.

## Rules to be Developed and Questions That Loom

Over the next several months, the Biden Administration will engage in an extensive regulatory process to meet the January 1, 2022 implementation date. Some of the many tasks include developing: (1) clear criteria to govern the dispute resolution proceedings, (2) qualification standards for independent entities capable of handling dispute resolution for plans and providers, and (3) a list of available arbitrators. We also expect a great deal of guidance on enforcement and more details about how the federal dispute process will interface with existing state balance billing laws. One of the most anticipated pieces of guidance will relate to how plans identify in-network and out-of-network providers outside of the traditional PPO/HMO model. Many are eager to know precisely how this law will work in no-network plan situations, such plans using reference-based pricing. These plans are already present in the self-funded marketplace, and the number of plans with this alternative design structure is likely to increase once health plan payment transparency disclosure rules take full force.



We anticipate that federal regulators will propose regulations to address these and other issues by July of 2021 to gain timely stakeholder feedback. MZQ Consulting will continue to monitor developments as the federal surprise billing rules are initially issued and finalized. We will provide any relevant updates as additional information is released.

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