Surprise Medical Billing Protections Coming in 2022

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The Consolidated Appropriations Act (CAA), signed December 27, 2020, will bring significant changes to group health plans in 2022. This client alert addresses the three situations in which the "No Surprises Act" included in the CAA will end surprise medical billing.

Why do participants get surprise medical bills?

When a participant receives items or services from a nonparticipating provider, the nonparticipating provider is free to bill whatever amount it chooses for those items or services. Of course, because there is no contract, the participant's group health plan is not required to pay the nonparticipating provider's billed charge. Just like the nonparticipating provider can choose the amount it bills, the group health plan can choose the amount it pays. A group health plan's summary plan description should have a detailed explanation of the formula or schedule the plan uses for determining the amount payable to a nonparticipating provider for items and services. The amount determined under the plan's formula or schedule is often called the "allowed amount." The formula or schedule for determining allowed amounts varies by plan and can even vary by type of service. Common formulas include a multiple of Medicare rates, a median of network rates, a percentage of the billed charge, or the average of amounts charged in the geographic area.

If (as is typically the case) the allowed amount is less than the billed charge, the nonparticipating provider may send the participant a bill for the difference (known as a balance bill). The balance bill is often a surprise to the participant who may not even have known that one of the providers involved in his or her care was a nonparticipating provider. Hence, the term "surprise medical bill."

What is the difference between a participating provider and a nonparticipating provider?

The difference is presence or absence of a contractual relationship between the provider and the insurer or claims administrator of a group health plan. A participating health care provider has entered into

a network contract or other type of contract that sets reimbursement rates. A nonparticipating provider is a health care provider that is not in the network and has not otherwise contracted for set reimbursement rates.

Under what circumstances will the CAA shield participants from surprise medical bills?

Starting in the 2022 plan year, the CAA will prohibit surprise medical bills in three situations where it is particularly difficult for participants to avoid nonparticipating providers:

1. Nonparticipating emergency services;
2. Nonparticipating providers working at participating facilities; and
3. Nonparticipating air ambulances.

Starting in the 2022 plan year, when a claim is made for items or services from a nonparticipating provider in one of those three situations, the group health plan will need to:

- Base the participant's cost sharing on the "recognized amount" (generally, the median of contracted rates);
- Apply in-network cost sharing (i.e. copays, deductibles, and coinsurance);
- Count cost sharing toward in-network deductible and in-network out-of-pocket maximum;
- Adjudicate a claim within 30 days of receipt of the bill; and
- Send an initial payment based on the recognized amount (or a denial) directly to the nonparticipating provider.

Notably, these requirements will apply to both non-grandfathered and grandfathered group health plans.

Even if the nonparticipating provider is dissatisfied with the amount of the payment, it will not be permitted to balance bill the participant. The nonparticipating provider's only option will be to pursue additional payment from the group health plan through negotiations and arbitration.

How will disagreements between plans and nonparticipating providers be resolved?

If the nonparticipating provider is dissatisfied with the amount of the payment, its first step will be a demand for 30 days of negotiations. If negotiations between the nonparticipating provider and group health plan are not successful, the parties then move on to binding baseball arbitration with a certified independent dispute resolution (IDR) entity. Once the IDR entity is selected, the parties have 10 days to submit a proposed payment amount along with supporting documentation. The IDR entity then has 30 days to pick one of the two amounts. The CAA lists factors that the IDR entity may consider in deciding between the two amounts (including contracted rates and the provider's good faith efforts to join networks). However, the IDR entity is not permitted to consider Medicare or Medicaid rates or the provider's billed charge.

If the IDR entity picks an amount that exceeds the group health plan's initial payment, the group health plan must then pay the difference to the nonparticipating provider. Also, the "loser" (i.e., the party that submitted the amount that was not picked by the IDR entity) has to pay the IDR fees.

The CAA also gives a participant in a non-grandfathered plan the option to request external review of claims subject to the surprise medical billing protections. It is not clear how the arbitration and external review processes will be coordinated.

Can a nonparticipating provider ask a participant to waive surprise medical billing protections?

Participant waiver of the surprise medical billing protections is permissible in narrow circumstances. A nonparticipating provider at a participating facility will be permitted to balance bill (and the surprise medical billing protections will not apply) if and only if:

- The nonparticipating provider is not providing "ancillary services" (i.e., emergency medicine, anesthesiology, pathology, radiology, neonatology and diagnostic services) or other services where there isn't an available participating provider at the facility;
- The nonparticipating provider gives advance notice of its nonparticipating status and a good faith estimate of its charge; and
- The participant consents to be balance billed.

Now what?

The details are TBD: the tri-agencies (IRS, DOL and HHS) will be issuing regulations on multiple aspects of these CAA surprise medical billing requirements. Even so, you may want to start conversations with your group health plan's claims administrator. An employer retains legal responsibility for a self-insured group health plan's compliance but, for something like this, the employer is going to have to rely on its claims administrator to put in place legally compliant processes.