LEGAL UPDATES

PUBLISHED: FEBRUARY 11, 2021

The "No Surprises Act:" How Does It Affect Employer-Sponsored Health Plans?

Services

Employee Benefits & Executive Compensation

Healthcare Providers

No Surprises Act

Professional

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The Consolidated Appropriations Act, 2021, signed into law at the end of 2020, includes the "No Surprises Act" which prohibits hospitals and doctors from issuing surprise medical bills for certain healthcare services. The Act includes open negotiation and independent dispute resolution (IDR) procedures for health plans and out-of-network healthcare facilities and providers to determine applicable payment rates. The Act will take effect on January 1, 2022. Below are some of the key provisions of the Act and implications for health plan sponsors.

Surprise medical billing

Under the Act, both self-insured and fully insured group health plans must hold plan participants harmless from surprise medical billings (also referred to as balance billing) with respect to out-of-network services. Emergency and non-emergency services are subject to different rules.

For emergency services:

Plan participants will no longer be required to pay more than the in-network cost-sharing amount for out-of-network emergency care services (including air ambulances).

Plans covering emergency room services in a hospital or independent free-standing emergency department may not require preauthorization determinations.

Out-of-network emergency expenses must count towards a participant's in-network deductible and out-of-pocket maximum.

The cost-sharing amount for emergency services may not be greater than a median amount based on in-network rates.

For non-emergency services:

Balance billing by out-of-network service providers for services performed at an in-network facility (e.g., out-of-network anesthesia services) will not be permitted, unless the participant is given advance written notice and consents to such out-of-network care.

Neither the plan nor the out-of-network provider may require the patient to pay more than the plan's usual cost-sharing for in-network provider services.

As in the emergency services context, out-of-network costs must count towards a participant's in-network deductible and out-of-pocket maximum.

Independent dispute resolution

The Act includes an IDR process, administrated by an independent, unbiased entity, for use by plans or insurers and out-of-network providers to settle payment disputes. The parties must participate in a 30-day open negotiation process, and if they are unable to resolve the matter at the end of the 30-day period, the dispute may be submitted by either party to the IDR entity to determine the payment amount for the service. The IDR entity must choose between the two offers made by the parties and may not award another amount. This process is designed to require each party to propose its best offer.

In making its determination, the IDR entity will consider the median in-network rate, information received from the parties, and optional factors, including but not limited to, the provider's level of training or experience; the plan's or out-of-network provider's market share in the geographic region in which the service was provided; the complexity of the services provided; and demonstrations of good faith (or lack thereof) to enter into network agreements. The IDR entity may **not** consider Medicare claims data in determining the negotiated price and may **not** consider provider usual and customary charges. The IDR entity's determination will not be subject to judicial review, meaning the provider (and presumably the patient/plan participant) will not be able to bring a claim in court.

Notably, the party that initiated the IDR process may not initiate another IDR with the same party and for the same service during the 90-day period following the determination. The cost of the IDR process must be paid by the party whose offer is not chosen by the IDR entity, which may encourage settlement of similar claims and discourage seeking IDR for superfluous cases.

All eyes are on the Departments of Labor, Treasury, and Health and Human Services as several areas of the Act remain open to regulation implementing and enforcing the Act. Implementing guidance concerning the IDR process is especially likely on factors an arbitrator may or may not consider in making a decision, e.g., would a high market share of an insurer justify higher payments or go against the party with the higher market share? Also, how will it be determined whether a provider engaged in good faith negotiations to enter into network agreements?

What this means to you

First, plan sponsors should continue to look for new guidance from the governmental agencies. In the meantime, plan sponsors should be reviewing their current process for determining non-network claims and talking with their insurer or third-party administrator about how this will change the administration of their plan with respect to non-network providers.

From a documentation perspective, we expect the Department of Labor to issue guidance on the changes needed to comply with the Department's claims procedures, as these rules will take the process out of the hands of participants and will put the onus on the plan's vendors and providers. We will continue to monitor how the new process may affect the ability of participants to bring a lawsuit against a plan.

Contact us

For more information on how changing healthcare legislation may impact your employee benefits, contact David Eckhardt, Myriem Bennani or your Husch Blackwell attorney.

CARES Act, COVID-19 & Return-to-Work Guidance

Husch Blackwell provides guidance regarding COVID-19 updates, the CARES Act, and rapidly changing state-by-state orders, including those that impact stay-at-home and return-to-work protocols. Contact these legal teams or your Husch Blackwell attorney to plan a way through and beyond the pandemic.