SURPRISE BILLING REGULATIONS: IMPACT ON OUT-OF-NETWORK PROVIDERS

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U.S. Litigation and Dispute Resolution Alert

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On 1 July 2021, the United Stated Office of Personnel Management, and the Departments of the Treasury, Labor, and Health and Human Services (collectively, the Departments) issued an Interim Final Rule[1] (the IFR) implementing the No Surprises Act,[2] enacted to ban surprise medical bills effective 1 January 2022. For out-of-network providers, the IFR bars health care providers who are not contracted to health plans from billing patients more than would be paid for in-network services in emergencies and in other specified nonemergency situations. Intended to provide patients protection against unanticipated medical expenses, the IFR will remove the predominant methodology used by health plans to pay out-of-network providers under the Affordable Care Act (ACA).[3] For out-of-network providers, the IFR creates administrative complexity and can result in reduced reimbursement.

Key takeaways include:

- The IFR eliminates of the Greatest of Three Rule (defined below) predominantly used to calculate out-of-network reimbursement rates.
- The Greatest of Three Rule will generally be replaced with methodologies established by state law, other than for states with an All-Payer Model.
- Where state law does not apply, the parties must enter into a federal independent dispute resolution (IDR) process that incorporates the “baseball-style” arbitration process set forth by the No Surprises Act.[4]
- The IFR eliminates the predictability and flexibility for providers that the existing ACA methodology provided.

BACKGROUND

Prior to the No Surprises Act, the ACA enacted provisions requiring that any group health plan or health insurer that provides or covers emergency services hold harmless patients who see out-of-network providers as if these patients saw in-network providers. The regulations interpreting these provisions required group health plans and insurers to reimburse providers at the greatest of three enumerated amounts (the Greatest of Three Rule): (1) the rate generally reimbursed by the plan of insurance for out-of-network providers (i.e., the usual, customary, and reasonable amount), (2) the median in-network rate, or (3) the amount that would be paid under Medicare for the emergency service, taking into account the in-network copayment and coinsurance obligations. For over a decade, this methodology set a floor for out-of-network provider reimbursement, and providers have looked to this framework in anticipating payment amounts.

NO SURPRISES ACT

The No Surprises Act will effectively repeal the Greatest of Three Rule framework and replace it with a new reimbursement regime for emergency services, air ambulance services furnished by nonparticipating providers, and certain nonemergency services provided by nonparticipating providers at participating health care facilities.[5] The No Surprises Act directs the Departments to establish through rulemaking the methodology that a group health plan or health insurance issuer offering group or individual health insurance coverage must use to determine the qualifying payment amount (QPA).[6] However, the amount a plan pays to such a provider is separately determined. Under the IFR, the methodology for determining out-of-network rates will be based on:

- An amount determined by an applicable All-Payer Model Agreement.
- If there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law.
- If there is no such applicable All-Payer Model Agreement or specified state law, an amount agreed upon by the plan or issuer and the provider or facility.
- If none of the above apply, an amount determined by an IDR entity, with consideration to the QPA.[7]

The Departments intend to issue regulations soon regarding IDR entities and the IDR process.[8]

Under this new regime, reimbursement will be determined based on the existence of a relevant agreement or state law and, in the absence of either, by an IDR entity. Priority is first given to any applicable All-Payer Model Agreements executed between a state and the federal government. Under the Social Security Act, states are authorized to test innovated payment and service delivery models. The IFR details its impact on the Maryland and Vermont all-payer model agreements and the Pennsylvania Rural Health Model currently in place. This portion of the IFR at publication is irrelevant outside of these states.

Second, the IFR looks to “specified state law” in determining out-of-network reimbursement. The IFR explains: “a specified state law is a state law that provides a method for determining the total amount payable under a group health plan or group or individual health insurance coverage to the extent the state law applies.” In order for a state law to determine the out-of-network rate, that law must apply to:

(1) the plan, issuer, or coverage involved, including where a state law applies because the state has allowed a plan that is not otherwise subject to applicable state law an opportunity to opt in, subject to section 514 of ERISA; (2) the nonparticipating provider or nonparticipating emergency facility involved (and in the case of state out-of-network rate laws, the nonparticipating provider of air ambulance services involved); and (3) the item or service involved.

If the state law does not meet this criteria, it may not be used to determine the out-of-network rate. For example, where a state's surprise billing laws apply only to health maintenance organizations (each, an HMO), the federal surprise billing law would govern all other types of coverage and the state law would only govern HMO coverage.

Third, in states where the law does not govern out-of-network reimbursement, out-of-network rates will be determined either through agreement between the provider or facility and plan or issuer or through an IDR process if agreement cannot be reached. The Departments have indicated that a federal IDR process under the No Surprises Act will be implemented in future rulemaking “later this year”; however, they have thus far provided little detail as to how this IDR process will operate. The IDR entity will be required to utilize the “baseball-style”

arbitration rules set by the No Surprises Act. In a “baseball-style” arbitration, each party offers a single payment amount to resolve the dispute, and the IDR entity selects one amount or the other with no ability to split the difference or arrive at any other conclusion. The IFR reiterates the requirement in the No Surprises Act for the IDR entity to consider the QPA when selecting between the offer submitted by a plan or issuer and the offer submitted by a facility or provider in order to determine the total payment for services furnished by an out-of-network provider.

NOTICE AND COMMENT

The IFR will become effective 60 days after publication in the federal register and public comments must be made in this same time period.

CONCLUSION

The uncertainty surrounding the IDR process that is yet to be announced and the consideration of the QPA in the IDR process has potentially far-reaching consequences for provider reimbursement. By removing the predominant methodology used to calculate reimbursement rates of out-of-network providers and replacing it with the federal IDR process, providers will likely see a substantial impact on rate as the effective date of the No Surprises Act draws near.

K&L Gates' health care practice routinely assists health systems, hospitals, and other providers and suppliers with legal advice and strategic considerations, including providing advice on reimbursement matters and preparing clients' public comments on proposed and final rulemakings. Contact the authors of this article or another K&L Gates lawyer for assistance with the IFR or to receive updates on Medicare reimbursement.

FOOTNOTES

[1] Requirements Related to Surprise Billing; Part I. (display copy).

[2] The No Surprises Act was signed into law as part of the Consolidated Appropriations Act of 2021 (H.R. 133; Division BB – Private Health Insurance and Public Health Provisions).

[3] IFR at 117 (“The provisions of section 2719A of the PHS Act will no longer apply with respect to plan years beginning on or after January 1, 2022.”).

[4] Gary S. Qualls, *The Federal No Surprises Act and its Arbitration Provisions*, K&L GATES HUB (Feb. 12, 2021).

[5] K&L Gates is preparing a forthcoming practice note concerning the impact on nonparticipating providers at participating health care facilities.

[6] IFR at 62. The IFR contains details regarding the manner in which the QPA is calculated. This includes defining a process to use contracted rates to establish the QPA as the median rate based on similar items and services, providers and facilities, and geographic regions.

[7] IFR at 20–21.

[8] *Id*.

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