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Paying for Out-of-Network Emergency, Air Ambulance and Other Services: Negotiation and Independent Dispute Resolution

In our prior article, we introduced the No Surprises Act, one of the most prominent benefits-related measures included in the Consolidated Appropriations Act, 2021 (CAA). There we discussed the general requirements for coverage of out-of-network emergency services, air ambulances and nonemergency services performed by out-of-network providers at a network facility. This article, part of our ongoing series covering the group health plan changes in the CAA, outlines the second step of this process – how to resolve differences between the provider's billed charge and the plan's payment amount. To that end, the No Surprises Act establishes a process by which health care providers and facilities on one hand and group health plans and insurers on the other, either negotiate or use an independent dispute resolution (IDR) process to work out the cost of the out-of-network care without balance billing the patient.

The Payment Process

When a group health plan receives a bill for out-of-network emergency services, nonemergency services by out-of-network providers at network facilities, or out-of-network air ambulance, the plan must pay an initial amount or provide a notice of denial of payment within 30 days. In total, the plan must pay the "Out-of-Network Rate," less the amount the person pays in cost-sharing. The Out-of-Network Rate is determined in one of three ways: state law (to the extent it applies under ERISA), a state's All-Payer Model Agreement, or in a state with no applicable law or All-Payer Model Agreement, negotiations or an IDR process between the provider or facility (collectively referred to as "providers" for this article) and the plan.

If the plan denies the service or the parties do not agree that the initial payment equals the Out-of-Network Rate, the provider and plan have 30 days to negotiate the Out-of-Network Rate, beginning on the day the provider receives the initial payment or a notice of denial. What is not clear is whether a provider can use this process to challenge a plan's denial of payment for reasons other than amount of billed charge. For instance, if a plan denies the claim in full due to lack of medical necessity or plan exclusion, can the provider still seek negotiation and IDR of a

POSTED:

Feb 16, 2021

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payment amount? Presumably, those sorts of denials would still be exclusively reviewed through the plan's appeal procedures and the negotiation/IDR process would be reserved for situations where the only remaining disagreement is the amount the plan will pay for the covered service. Language in the CAA supports this reading, but future guidance will hopefully confirm.

If no agreement is reached within 30 days, either party has four days to initiate an IDR process. The plan and the provider will jointly select the IDR entity within three business days after the IDR process is initiated. If the parties fail to agree on an IDR entity, the Departments of Labor, Health and Human Services and the Treasury (collectively, the Departments) will assign one. Within 10 days after the IDR entity is selected, the provider and the plan each must submit an offer for a payment amount, as well as any information requested by the IDR entity or otherwise related to an offer.

The IDR entity will consider the median of the plan's contracted rates, as calculated under the No Surprises Act, information provided in response to a request or related to an offer, and certain additional criteria, such as the level of training, experience, and quality of a provider and any demonstrated good faith efforts between the provider and the plan to enter into network agreements. The IDR entity is specifically prohibited from considering usual and customary charges, the amount that the provider would have billed in the absence of the No Surprises Act's ban on balance billing, or the payment or reimbursement rate by Medicare, Tricare or other public payor. It is uncertain how this will impact the industry, as the IDR entity appears to be prohibited from considering any of the usual means by which both the plans and the providers set their reimbursement rates.

The entire IDR process may last up to 30 days. The parties may continue to negotiate during the IDR process and, if they come to an agreement, the IDR process will terminate. Otherwise, the IDR entity's decision is binding and not subject to review. Once the Out-of-Network Rate is determined, whether by negotiations or by the IDR entity, the plan must pay the provider directly within 30 days.

Fees

The party whose offer the IDR entity rejects will pay the IDR entity's fees. If, however, the parties settle before the IDR entity makes its decision, the parties will split the fees equally as a default. Each party must also pay a fee to the

federal government for any year in which they participate in the IDR process.

Limits on Use of IDR Process

The party that initiates the IDR process may not submit, during the 90-day period following the IDR decision, a subsequent IDR request involving the same opposite party. However, any requests for IDR that a party would have made during that 90-day period can be submitted within 30 days after the end of the 90-day period. This seems to be a sort of anti-abuse provision to prevent the parties from continually turning to the IDR process to decide payment for the same type of claims.

Recognizing, however, that this 90-day delay could lead to a backlog of disputed claims, the No Surprises Act allows for batching of multiple claims into a single IDR process for efficiency. Batching is allowed when the same parties are involved, the disputed items and services are related to the treatment of a similar condition, and the items and services were furnished during a 30 day period, or other period allowed by the Departments. It is not clear how conditions will be deemed similar enough to be combined into a single IDR process.

If a provider satisfies the No Surprises Act's notice and consent requirements for a patient, the provider cannot also use the IDR process to obtain payment from the person's plan or insurer.

Effective Date

The Departments will jointly establish the IDR process by December 27, 2021. The requirement to negotiate/use the IDR process takes effect for plan years beginning on or after January 1, 2022.

The CAA includes the most comprehensive reforms for group health plans and insurers since 2010. The next alert in this series will focus on the requirements for advance explanations of benefits and online tools to provide cost estimates. While Congress hopes these rules will ultimately make health care more affordable for everyone, they will require substantial work from plans and insurers before 2022.