FEDERAL AGENCIES CONTINUE TO ISSUE SURPRISE MEDICAL BILLING RULES,

FOCUS ON ARBITRATION PROCESS

Written By Karrie Hyatt

Since the first interim final rule (IFR) for the *No Surprises Act* on payment methodologies was released in July, the Departments of Health & Human Services, Labor, and Treasury, (the federal departments) have followed up with further guidance, issuing both a notice of proposed rulemaking (NPRM) focused on air ambulance provisions, and a second IFR on the arbitration process.

BACKGROUND

The *No Surprises Act* was passed by Congress last December as part of the *Consolidated Appropriations Act* of 2021 and goes into effect on January 1, 2022. The law is meant to protect consumers from the most pervasive types of surprise "balance" billing in certain out-of-network situations by limiting the amount of the bill to the cost-sharing they would have paid if the care had been from an in-network providers. The *No Surprises Act* seeks to protect patient consumers while prohibiting providers from surprise billing in situations where patients do not have the ability to choose an in-network provider.

SIIA has been actively engaged on this policy during congressional consideration, and throughout the federal rulemaking process. Since the passage of the *No Surprises Act*, SIIA has taken steps to be at the forefront advocating for its self-insured members. Prior to the release of the first IFR, SIIA issued a comment letter outlining a number of policy recommendations surrounding arbitration, arbiter qualifications, and payment factors.

The first IFR was concerned primarily with qualifying payment amounts (QPA) and *Employee Retirement Income Security Act* (ERISA) preemption of state surprise billings laws. There was a sixty-day comment period on the first IFR release, which SIIA used to urge for further clarifications, especially regarding self-insurance plans.

AIR AMBULANCES AND MORE

In September, the federal departments released a NPRM, titled "Reporting Requirements Regarding Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement." This release set-up data collection for these subjects for further research and clarification.

Protecting patients against surprise, and high cost, air ambulance charges is one of the key components of the *No Surprises Act*. When a patient requires an emergency airlift to a hospital, they don't have the opportunity to find an in-network provider.

Surprise Medical Billing Rules

The No Surprises Act bans surprise bills for out-of-network patients using air ambulances and limits the amount patients pay out-of-pocket, but there is little data on the actual costs involved. The NPRM outlines data collections requirements related to transportation and medical costs, payor data, and data on claims and claims denial. Under the NRPM, HHS and the Department of Transportation would be required to produce a comprehensive report on air ambulance services in the next year.

The NPRM would also require an insurance issuer, prior to finalizing an individual's coverage, to disclose direct and indirect agent and broker compensation associated with enrollment, as well as reporting that information to HHS. This proposed rule also affects agents and brokers selling individual market plans and says little about self-insured plans. More information is expected to come.

Under the NPRM, States are the primary enforcers of the new requirements, as it pertains to issuers, providers, facilities, and air ambulances.

At this time, ground ambulances are not included in the *No Surprises Act*, but it is predicted that the legislature will look to amend the law in the future.


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INDEPENDENT DISPUTE RESOLUTION/ARBITRATION PROCESS

As expected, the Phase II IFR, released September 30, pertained to the independent dispute resolution (IDR) and arbitration process for the *No Surprises Act*. It describes in detail the dispute resolution process between provider and insurer. It also issued guidance for individuals that do not have an insurance plan or prefer not to be billed through their insurance plan.

Prior to the release of the Phase II IFR, SIIA submitted a comment letter on July 30 outlining industry recommendations to the federal departments. The letter was informed by nearly 32 member companies involved in the SIIA Price Transparency Working Group. One key recommendation from SIIA was that the arbitration process be "predictable and consistent across-the-board." Overall, the process laid out by the federal departments meets that requirement. The SIIA letter also addressed concerns that the costs of the IDR process be minimized, and to some extent fees are limited.

SIIA's letter emphasized the first IFR's ruling about ERISA exemptions from individual state surprise billing law unless the insurer opts-in to the state's process, and stressed that a federal arbiter should not be permitted to look at decisions from or precedents set by individual state's surprise billing law. Arguing that ERISA precludes a federal arbiter from taking into consideration any decision produced through a state law.

While the first IFR addressed how the qualifying payment amount (QPA) would be determined, SIIA's follow-up letter addressed how the QPA should be used in an arbitration process. SIIA argued that the QPA should be the primary factor when determining a final payout amount and that any additional circumstances should be considered secondary to the QPA. The IFR agreed, stating that "the presumption that the QPA is the appropriate … amount." If the arbiter decides using the additional circumstances factor, they must clearly demonstrate the reasoning behind the decision.

Lastly, the letter requested that any federally designated arbiters should be thoroughly vetted, particularly concerning arbiter conflicts of interests and background expertise in the healthcare field. The CMS website has already listed requirements for federal arbiters and began accepting applications on November 1. Applying organizations are required to demonstrate expertise in arbitration and claims administration, managed care, billing and coding, and healthcare law. Organizations must be accredited by a nationally recognized arbitration organization. Entities submitting applications must also supply a conflict of interested attestation, as well as policies concerning internal controls to hold fees, HIPAA-related confidentiality processes, internal controls for reporting compliance, and procedures to ensure subcontractor compliance.

Either party in a dispute, the insurance plan or the healthcare provider, can petition the federal departments to deny the application of a potential arbiter or can request that the certification of a federal arbiter be revoked.

STEP-BY-STEP GUIDE TO THE PROCESS

The IFR lays out a detailed plan for the IDR/arbitration process which includes direct party negotiations, for entering into the arbitration process, and for choosing an arbiter. Much of the process will be conducted through a federal website portal developed for the *No Surprises Act*.

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When a provider receives an initial payment or notification of denial of payment from the insurance plan, they have 30 days to open formal negotiations with the plan. They begin the 30-day negotiation period by sending Open Negotiation Notice to the insurance plan, the date of issuance begins the 30-day period. When the open negotiation period ends without a resolution, either party can initiate the arbitration process and they have four business days to do it.

To begin the arbitration process, the initiating party needs to send a Notice of IDR Initiation to the other party, as well as submit notification to the federal website portal. Date of receipt on the portal begins the process. A recognized federal arbitration organization must be chosen within three days of that date by both parties. If the parties can't agree, an arbiter will be assigned within six days. At the time of the selection of the arbitration entity, each party must pay a $50 non-refundable fee.

Within ten business days of the selection of an arbiter, both parties must submit a set of information to the IDR entity as well as the organization's fee, which is listed on the federal website portal. The information that needs to be submitted by each party includes an "offer" for the out-of-network payment in both the dollar amount and as a percentage of the QPA, as well as a QPA for the applicable year. In addition, providers must submit information regarding the size of the practice by number of employees and whether the provider delivers specialty medical care. The insurance plan needs to submit information regarding their

coverage area, the QPA geographic area, and whether the plan is fully insured or self-insured.

The parties can continue to negotiate the payment after the IDR process has begun and if an agreement is reached then the IDR process will be discontinued. If no agreement is reached, the parties will be beholden to the arbiter's decision.

The IDR decision must be based on the QPA. It is the primary factor on which the arbiter will base their decision. The arbiter must assume that the QPA represents a reasonable, market-based payment and must consider the "offer" closest to it to be the correct amount to pay. The arbiter's role is not to determine if the QPA has been correctly calculated, but only to consider the information submitted by both parties.

The arbiter is allowed to consider additional criteria that may lead to a higher payment than the QPA. Some of the criteria that can be considered is level of training and experience of the provider; quality and outcome measurements; complexity of service; market share held by the provider in the region; and contracted rates over the prior four years. The arbiter cannot use Medicare rates as a basis for their decision, and are not allowed to consider a provider's usual or "billed" charges, or past arbitration decisions as precedent. However, the arbiter can consider a QPA based on Medicare multiples if that is used as part of the plan payment.

The IDR decision must include a written statement submitted to the website portal that includes the underlying rationale for their decision, particularly if the decision sets the payment above the QPA. After the IDR decision is made, the successful party will have their service fee refunded. The losing party will not.

SIIA released a statement on the Phase II IFR that said about the IDR process,

"This new IFR on arbitration strikes the correct balance between providers and self-insured plan sponsors, while also following the directives from Congress. The federal agencies should be commended for their work on these rules, which will protect patients and their families for years to come."

While the July 1 and September 30 IFRs addressed major issues in the *No Surprises Act*, there are still more policymaking and rules to clarify to come in the coming months and year. ■

Karrie Hyatt is a freelance writer who has been involved in the captive industry for more than ten years. More information about her work can be found at: www.karriehyatt.com.