SURPRISE!

BALANCE BILLING PROHIBITIONS COMING IN 2022

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Lawmakers in Washington and Columbus closed out 2020 by finally addressing an issue that has long vexed consumers of health care — surprise medical bills. The problem is familiar to most. Heart attack, stroke, or trauma victims are transported to an emergency room that does not participate in their health insurance carrier's network. Or patients receiving non-emergency treatment at their in-network hospital discover afterwards that, unbeknownst to them, the anesthesia team or lab service was out-of-network. Or patients at a smaller hospital need an expensive air ambulance ride for more complex care elsewhere. Later, when the bills come, patients realize that, unlike in-network treatment, their health insurance carrier's payments cover only a fraction of the "usual-and-customary" charges of the out-of-network provider, and that provider in turn "balance bills" the patients for the difference.

For years, consumer advocates have sought enactment of laws to shield patients from the effects of balance billing, which can lead to considerable debt and even bankruptcy. Despite policymakers' widespread agreement on protecting patients, the stumbling block has been determining what to do with the portion of the bill not paid by the patient, when the patient's health insurer and the provider have no "network" agreement in place for payment of charges. Should the physician or hospital accept an in-network rate anyway, and if so, what rate? Should the insurer pay the provider's full out-of-network usual-and-customary charge? Should the payment in such situations be tied to some benchmark? New federal and state laws answer these questions and also mandate new consumer protections.

The Federal "No Surprises Act"

The federal No Surprises Act proves that bipartisan lawmaking is not dead. Backed by committee leadership in both parties, the bill was tucked into the larger Consolidated Appropriations Act for 2021 (H.R. 133) and passed on December 21, 2020. Beginning January 1, 2022, patients who carry health insurance cannot be required by either their insurance plan or a health care provider to pay more than their regular in-network contribution (referred to in the law as "cost sharing") if they receive emergency care from an out-of-network provider or facility, and this cost sharing must count toward any in-network maximums under the plan. The same rule applies to out-of-network air (but not ground) ambulance transport. As to non-emergency care, patients at an in-network facility can only be balance billed by an out-of-network provider at that facility if, at least 72 hours before the scheduled treatment, the provider gives them a good faith estimate of the cost and a list of in-network providers offering the same service, and obtains the patient's knowing and voluntary consent to be balance billed. Consent is unavailable if no in-network options exist at the facility, or if the care is for unforeseen or urgent reasons, or if it is for ancillary services such as anesthesia, neonatology, and pathology. Absent this consent, the patient must be billed as if in-network.

So after patients have paid their share of the out-of-network charges, how much of the remaining balance amount must the insurer pay? The insurer must tender a payment (or denial thereof) to the provider, and if they cannot come to an agreement within 30 days on a payment amount, either side (insurer or provider) may initiate Independent Dispute Resolution (IDR). Each side submits its final offer to an HHS-approved arbitrator along with supporting evidence, which may include a provider's training and experience, geographic market share, and acuity of the patient's case, as well as a "qualifying payment amount" (more on that below). In a win for insurers, the arbitrator may not consider the provider's usual-and-customary charges (which tend to be high), but in a win for providers, the arbitrator cannot consider Medicare or Medicaid rates (which tend to be low). Using baseball arbitration rules, the arbitrator must pick one number or the other, the decision is final, and the loser not only pays the winner's costs but is barred from using IDR against the same entity regarding the same service for 90 days.

The federal law includes a host of other transparency provisions and consumer protections. For example, insurers must give their beneficiaries an "advance explanation of benefits" showing estimated costs at least 72 hours before scheduled treatment, while providers must timely bill their patients — a patient who receives a bill more than 90 days after receiving care has no obligation to pay. Importantly, the law also calls for a rulemaking to establish a "qualifying payment amount" for arbitrators to consider in IDR. For 2022, the qualifying payment amount (unless otherwise set by a state) is an insurance plan's 2019 median total maximum payment for a given service in a given geographic region, with the amount adjusted in subsequent years. The law also requires HHS to post detailed results of IDR proceedings on its website on a quarterly basis, and provides grants to states to establish "all payor databases" containing the payment history of out-of-network claims. Collectively, these provisions may operate as a back-door method of establishing industry benchmarks for out-of-network reimbursement, something providers have long resisted.

Finally, the No Surprises Act makes room for states that have passed, or will pass, their own laws addressing surprise billing. Aside from the air ambulance provisions (which preempt state law), the IDR process does not apply in states that have their own laws for

determining out-of-network payments while shielding patients from balance billing. This is of critical importance in Ohio.

Ohio H.B. 388

Not to be outdone, one day after Congress passed the No Surprises Act, Ohio's General Assembly enacted its own balance billing protections by an overwhelming majority. Also taking effect in January 2022, H.B. 388 creates new sections 3902.50 through 3902.54 of the Revised Code that in many ways mirror the federal law. Patients cannot be balance billed either for emergency services (including lab work) provided at an out-of-network emergency facility, or for unanticipated out-of-network care provided at an in-network facility. Like the federal law, H.B. 388 contains an exception for the latter category, as long as providers inform the patient that they are out-of-network, give a good faith cost estimate, and obtain the patient's consent. Unlike the federal law, Ohio's law also bars balance billing for out-of-network ground ambulance services.

Ohio's reimbursement method likewise resembles the federal model, but has a few key differences. First, the plan must tender a payment to the provider equal to the largest of (a) the plan's median in-network rate, (b) the Medicare rate, and (c) the plan's general methodology for calculating out-of-network rates, such as the usual-and-customary rate (note that the last factor was expressly excluded from consideration under the federal law). The provider can accept this default rate or opt to negotiate, but if negotiations fail after 30 days, *only the provider* can initiate dispute resolution. Ohio's arbitration process is also baseball-style, but requires the billed amount to exceed $750, although up to 15 similar claims can be batched to reach this threshold. The arbitrator must consider the in-network rates of both the health plan at issue and of other health plans for similar services, any in-network rates negotiated between the parties per a contractual relationship within the past six years, and "relevant" materials from a previous arbitration involving the parties. The losing and winning parties split the arbitrator's fees on a 70/30 basis.

Key Considerations

With less than a year to go before these dual laws take effect, health care payors and providers in Ohio would do well to consider the five following takeaways as they make their preparations:

1. *Know which law applies.* Generally speaking, the Ohio law will apply with respect to payment terms and dispute resolution among insurers and providers. The notable exception is air ambulance service, over which federal law will control. That being said, any gaps in the state law will be filled by the federal law, which is more comprehensive in nature and contains many more consumer protections and reporting requirements.
2. *Watch the rulemaking.* The No Surprises Act requires two separate rulemaking processes by three different departments (HHS, Treasury, and Labor) on July 1 and October 1, 2021. These proposed regulations will address the methods for calculating a "qualifying payment amount," the audit measures for ensuring compliance by payors and providers, and the details of the IDR process, among other issues. Similarly, H.B. 388 calls for the Ohio Department of Insurance to issue implementing rules, including rules defining "provider," "facility," "emergency facility," and "ambulance." With less than a year to go until these laws take effect, the rulemaking process will have to move fast.
3. *Negotiated resolution is encouraged.* Both laws have many incentives for payors and providers to resolve their disputes. Baseball arbitration is an all-or-nothing gambit. The loser pays most (or all) of the arbitration costs. And much of the information used in IDR cases will become public. Congress and the General Assembly have signaled they want industry to work this out on their own.
4. *Be mindful of prior dealings.* For disputes going to IDR, arbitrators may consider past contractual rates between the parties, contractual rates between that provider and other payors, and submissions and decisions in other hearings. Also it remains to be seen whether Ohio opts to create an all payor database, which would bring additional payment data into the mix.
5. *Non-compliance will be costly.* Insurance plans or providers who balance bill patients in violation of the federal No Surprises Act are subject to $10,000 in civil monetary penalties. Additionally, for violations of H.B. 388, Ohio will subject providers to professional discipline and payors to charges of unfair or deceptive insurance practices.

Conclusion

As 2022 grows closer, the long-awaited goal of protecting patients from unforeseen balance billing appears to be nearing completion. For insurance plans and health care providers seeking to comply with the new federal and state mandates, however, the challenges have only begun.

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