O'NEILCANNON
HOLLMAN DEJONG & LAING S.C.

HEALTH CARE LAW ADVISOR ALERT: DON'T BE CAUGHT OFF GUARD BY FEDERAL "SURPRISE BILLING" LEGISLATION

The federal No Surprises Act was signed into law in December 2020 and becomes effective on January 1, 2022. Although similar state laws exist elsewhere, Wisconsin does not currently have a "surprise billing" law. As a result, many Wisconsin health care providers will need to take steps to ensure they are complying with the requirements of this new federal law, which will impact their billing and revenue cycle practices.

The Act's primary goal is to protect patients from surprise medical bills, including unexpected charges for out-of-network services. The Act protects patients in two important ways that providers should understand.

First, for emergency services, the law prohibits out-of-network providers from balance billing for amounts beyond what the patient would have been required to pay if the services had been delivered in-network.

Second, for certain non-emergency services, the law similarly prohibits out-of-network providers from balance billing beyond the patient's in-network obligations, but with an exception that allows some providers to balance bill if they give the patient written notice at least 72 hours before services are provided and obtain the patient's consent.

The 72-hour notice must comply with specific requirements. For example, it must disclose to the patient that the provider is out-of-network, give the patient a good-faith estimate of the out-of-network charges that will be incurred, and identify alternative providers who are available to the patient. But this 72-hour notice exception does not apply for certain types of out-of-network services provided at in-network facilities, including ancillary services (such as anesthesia), diagnostic services (such as radiology and lab), or any other services that the Secretary of Health and Human Services (HHS) may identify. Providers who violate the law's balance billing prohibitions face penalties from HHS of up to $10,000 per violation.

Beyond protecting patients, the Act also provides a framework for resolving certain billing disputes between out-of-network providers and health plans. Under the new federal law, within 30 days of being billed, private health plans that cover emergency services must pay

at least a portion of an out-of-network provider's charges for covered emergency services, regardless of whether prior authorization was obtained. The same is true for out-of-network charges for covered non-emergency services rendered at in-network hospitals and facilities. The specific amounts that health plans must pay to out-of-network providers within this 30-day period will generally be determined based on the health plan's median in-network payment for the same or similar services. If the health plan's language excludes or otherwise does not cover the services being provided, then rather than make this partial payment, the health plan may issue a benefit denial within 30 days of being billed for the services.

Upon receiving the health plan's partial payment or denial letter, an out-of-network provider and health plan have 30 days to try to negotiate a resolution of any dispute. If the dispute is not resolved within this timeframe, the provider then has a tight window—four calendar days from the end of the 30-day negotiation period—to initiate an appeal using an Independent Dispute Resolution (IDR) process established under the new federal law.

The IDR process creates an independent review and expedited arbitration process. Within three days of initiating the IDR process, the parties must select a certified IDR entity to decide their dispute. Then, within 10 days of selecting the IDR entity, both the provider and the health plan must submit "final offers" to the IDR entity, together with any supporting materials that the IDR entity requires and any other information either party believes is pertinent to their dispute. The IDR entity will then select one of the two offers. The party whose offer is not selected must pay the costs of the IDR, which are expected to range from approximately $500 to $2,000 in most cases. Once an IDR entity makes its decision, the balance due must be paid within 30 days.

When deciding which "final offer" to accept, the IDR entity must consider a benchmark known as the "qualifying payment amount" (QPA) for the services at issue. As of January 1, 2022, the QPAs for various services are expected to be set at amounts that represent the median of the contracted (in-network) rates that the health plan paid for such services in the relevant market as of January 31, 2019, with an upward adjustment based on the consumer price index for urban consumers (CPIU). For 2023 and subsequent years, the QPAs for existing health plans will continue to be adjusted upward based on the CPIU. For new health plans formed after January 31, 2019, the QPAs may be calculated based on a different methodology approved by HHS, or pursuant to a database that HHS may set up in accordance with the Act.

The law mandates that an IDR entity consider the QPA when evaluating and deciding which of the competing "final offers" to approve. But there are other factors that IDR entities are also directed to consider, including the provider's training, experience and outcome measurements; the complexity of the case; the provider's teaching status; and any contracting rate history between the parties over the prior four years.

Finally, the Act requires that, effective January 1, 2022, providers must have processes in place to ensure they are regularly supplying updated provider information to health plans for use in directories that are made available to help patients identify in-network providers.

For additional information about the requirements of the federal No Surprises Act, please contact Doug Dehler by phone at (414) 276-5000 or by email at doug.dehler@wilaw.com.