HAYS COMPANIES

IDR Process Regulations Issued

On October 7, 2021, the regulatory agencies published interim final regulations implementing the independent dispute resolution (IDR) process that is part of the federal surprise billing rules. The surprise billing requirements were part of the No Surprises Act (the "Act"). In a previous article, we wrote about the first set of regulations implementing these surprise billing requirements (the "Part I regulations").

As described in our previous article, the federal surprise billing requirements generally apply in three situations: (1) when a covered individual receives emergency services in an emergency department of a hospital or in an independent freestanding emergency department and either the provider or the facility is out-of-network; (2) when a covered individual receives services from an out-of-network provider during a visit to an in-network facility; and (3) when a covered individual receives air ambulance services from an out-of-network provider. The rules generally require group health plans to treat such claims as in-network claims and prohibit the provider/facility from balance billing the patient.

The Act establishes rules governing the amount a group health plan must pay the out-of-network provider/facility when the law applies to a claim. When applicable, the amount is determined by reference to an All-Payer Model Agreement or a specified State law.[1] If neither an All-Payer Model Agreement nor a specified State law applies, the payment amount is determined under the IDR process established in the Act and implemented in the new regulations (the "Part II regulations").

[1]See DOL Reg. §2590.716-3 (definition of "out-of-network rate").

IDR Process

Under the Part II regulations, if neither an All-Payer Model Agreement nor a specified State law applies, group health plans and providers will use the following IDR process to determine the amount the plan will pay for an out-of-network claim subject to the rules:

1. The plan makes an initial payment or issues a notice of denial of payment. Under the Part I regulations, the initial payment or notice of denial must typically be made or issued by a group health plan within 30 days after the bill for the services is transmitted by the provider or facility to the plan.[2]

2. During the 30-business day period beginning on the day on which the provider or facility receives the initial payment or notice of denial from the plan, the provider, facility or plan (i.e., a party) may initiate an open negotiation period for the purpose of determining the out-of-network rate.[3]
A party initiates the open negotiation period by sending a notice to the other party (referred to as the "open negotiation notice"). The open negotiation notice must include certain information specified in the Part II regulations and must be provided using a standard form developed by the regulatory agencies. The open negotiation notice may be sent in writing or electronically (e.g., email) if the party sending the notice believes, in good faith, that the electronic method is readily accessible by the other party and a paper notice is provided free of charge upon request.

Observation: In most cases, the provider/facility will initiate the open negotiation period. The plan must inform the provider/facility of the person to contact to initiate the open negotiation period in a notice that must be provided with initial payment or notice of denial.

Note: The open negotiation notice form that must be used, along with certain other required notices and forms, is currently available on this EBSA website.

3. Once the open negotiation period begins, the parties attempt to negotiate an agreement regarding the out-of-network rate. The parties have 30 business days for open negotiation beginning on the date the open negotiation notice is ***sent*** by the party initiating the period. If they reach an agreement and the out-of-network rate exceeds the initial payment plus any applicable cost-sharing paid or owed by the covered individual, the plan will pay the difference to the provider/facility. The regulations do not address the timing of any payment due from the plan to the provider/facility when an agreement is reached on the out-of-network based during the open negotiation period.

[2]See, e.g., DOL Reg. §2590.716-4(b)(3)(iv)(A).

[3] See DOL Reg. §2590.716-8(b)(1).

4. If no agreement is reached during the open negotiation period, a party may initiate the IDR process.[4] The IDR process may not be initiated until the 30-business day open negotiation period has expired. The period for initiating the IDR process begins on the 31st business day after the start of the open negotiation period and lasts four business days. A party initiates the IDR process by sending a notice to the other party. The IDR initiation notice must include certain information specified in the Part II regulations (including the party's preferred IDR entity) and must be provided using a standard form developed by the regulatory agencies. The IDR initiation notice may be sent in writing or electronically (e.g., email) if the party sending the notice believes, in good faith, that the electronic method is readily accessible by the other party and a paper notice is provided free of charge upon request.

5. The party initiating the IDR process must also notify the regulatory agencies that the IDR process has been initiated using a new Federal IDR portal. The IDR process does not begin until the notice has been provided through the IDR portal.

6. The IDR entity may be selected by agreement of the parties.[5] This occurs, for example, if the non-initiating party consents to, or fails to object to, the preferred IDR entity identified in the IDR initiation notice. The non-initiating party has three business days to object. If the non-initiating party objects, it may propose an alternative IDR entity and the initiating party then has an opportunity to accept or object to the alternative, all within three business days following the initiation of the IDR process. If no agreement is reached, the initiating party must notify the regulatory agencies of that fact on the fourth business day following the initiation of the IDR process. The regulatory agencies then select the IDR entity through a random selection method.[6]

Note: The regulations contain various requirements regarding which entities may serve as the IDR entity. Those requirements are intended to ensure the IDR entity is qualified and does not have any conflicts of interest.

7. After the IDR process has been initiated, the parties may continue to negotiate so long as the IDR entity has not made its payment determination. If an agreement is reached, the initiating party must provide notice to the regulatory agencies and the IDR entity through the Federal IDR portal. Furthermore, if the out-of-network rate exceeds the initial payment amount, the plan must pay the provider/facility within 30 business days following the date on which the agreement is reached.

[4]See DOL Reg. §2590.716-8(b)(2).
[5]See DOL Reg. §2590.716-8(c)(1).
[6]See DOL Reg. §2590.716-8(c)(1)(iv).
[7]See DOL Reg. §2590.716-8(c)(2).

8. Within 10 business days of the selection of the IDR entity, the parties must submit certain information to the IDR entity. Both parties must submit an offer of the out-of-network rate. Plans must also submit information regarding the qualifying payment amount (QPA) along with additional information about the plan.

Note: The QPA is generally the plan's median contracted rate for a particular item or service adjusted for inflation. The median contracted rate for an item or service is generally calculated by arranging in order from least to greatest the contracted rates of all group health plans of the plan sponsor in the same insurance market for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the geographic region in which the item or service is furnished and selecting the middle number. At the option of the sponsor of a self-insured plan, rates for all self-insured group health plans administered by the plan's TPA may be used instead.

9. The IDR entity must make a payment determination and notify the parties of the determination within 30 business days following the date on which the IDR entity was selected.[8] The IDR's final payment determination must be one of the offers submitted by a party. The IDR entity is required to select the offer that is closest to the QPA unless (1) it determines that creditable information submitted by a party clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate or (2) the offers are equally distant from the QPA. In either of these cases, the IDR entity must select the offer that it determines best represents the value of the item or services provided by the provider or facility.

In making its determination, the IDR entity may consider (in addition to the QPA) creditable and relevant information regarding the provider/facility's level of training, experience, and quality and outcomes measurements; the market share held by the provider, facility, and/or plan; the acuity of the covered individual or the complexity of providing care to the covered individual; the teaching status, case mix, and scope of services of the facility; demonstration of the provider/facility's and plan's good faith efforts (or lack thereof) to enter into a network agreement; and, if applicable, the contracted rates between the provider/facility and the plan during the previous four years. The IDR entity is specifically prohibited from considering the usual and customary charges, the amount that would have been billed by the provider/facility or the payment or reimbursement rate for the item or services that would be payable by a public payor.[9] These rules differ somewhat for air ambulance services.[10]

Observation: The process appears to favor group health plans by presuming the offer closest to the QPA is the out-of-network rate.

[8]See DOL Reg. §2590.716-8(c)(4).

[9]See DOL Reg. §2590.716-8(c)(4)(v).

[10]See DOL Reg. §2590.717-2.

10. The IDR entity must explain its determination in a written decision that is provided to the parties and submitted to the regulatory agencies. If the IDR entity does not select the offer closest to the QPA, the written decision must include information supporting the IDR entity's determination. The IDR entity's determination is binding on the parties unless there was fraud or evidence of intentional misrepresentation of material facts presented to the IDR entity.[11] Furthermore, the determination generally is not subject to judicial review.

Note: For 90 days following the determination, the party that initiated the IDR process is generally prohibited from initiating another IDR process involving the same party and the same (or a similar) item or service.

11. If the amount of the offer selected by the IDR entity exceeds the initial payment plus any applicable cost-sharing paid or owed by the covered individual, the plan must pay the amount due no later than 30 calendar days from the date of the IDR entity's determination. If the amount of the offer selected by the IDR entity is less than the initial payment plus any applicable cost-sharing paid or owed by the covered individual, the provider or facility must pay the difference to the plan no later than 30 calendar days from the date of the IDR entity's determination.[12]

Costs of IDR Process

The Part II regulations include rules for how the cost of the IDR process is paid.[13] Each party to the IDR process must pay a non-refundable administrative fee at the time the IDR entity is selected. This administrative fee is paid to the regulatory agencies. For 2022, the administrative fee is $50. See the Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process.

In addition, the IDR entity will collect a predetermined fee for its services. For the calendar year beginning January 1, 2022, certified IDR entities can charge a fixed fee for single determinations within the range of $200-$500 unless otherwise approved by the regulatory agencies. See the Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process.

Each party to the IDR process will pay the IDR entity's fee at the time they submit their offers to the IDR entity. The party who prevails in the IDR process (i.e., the party whose offer is selected by the IDR entity) will receive a refund of the fee it paid within 30 business days following the date on which the IDR entity makes its determination. If the parties reach an agreement after the IDR process is initiated, but prior to the IDR's determination, the IDR entity must refund 50% of each party's fee payment.

[11]See DOL Reg. §2590.716-8(c)(4)(vii).
[12]See DOL Reg. §2590.716-8(c)(4)(ix).
[13]See DOL Reg. §2590.716-8(d).

Amendment To External Review Requirements

The Part II regulations also amend the external review requirements applicable to group medical plans under the Affordable Care Act (ACA). The amendments do not change the external review requirements and procedures but rather only expand the scope of the requirements. In particular, under the amended regulations, any adverse benefit determination that involves compliance with the surprise billing rules is subject to external review.[14] Furthermore, the Part II regulations provide that grandfathered health plans, which generally are exempt from the ACA external review requirements, must offer external review for adverse benefit determinations involving compliance with the surprise billing rules.[15]

Action Items

In preparation for complying with the Part II regulations, which along with the requirements contained in the Part I regulations become effective for plan years beginning on or after January 1, 2022, plan sponsors should consider taking the following actions:

1. Speak with their legal counsel regarding the impact of and compliance with the Part II regulations.

2. Work with their third-party administrators (TPAs) to identify and allocate responsibility for the various steps to the IDR process between the plan sponsor and TPA.

3. Amend the plan to reflect the application of the amended external review rules to adverse benefit determinations involving compliance with the surprise billing rules.

[14]See DOL Reg. §2590.715-2719(d)(1)(i)(A).

[15]See DOL Reg. §2590.715-2719(a)(1)(ii).

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