Surprise, Surprise – The No Surprises Act Faces Significant Challenges

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In a publicly lauded move, Congress enacted The No Surprises Act (the "Act") to end the balance billing of patients and protect insured patients from surprise bills for emergency services by out of network providers. However, the move has been met with significant resistance from individual providers and medical associations, including the Texas Medical Association (TMA), the American Medical Association (AMA) and the American Heart Association (AHA).

Underlying Dispute and ADR Process and Material Definitions

The Act created a procedural structure under which providers submit a bill for out-of-network services to insurers, and insurers have thirty days to make an initial payment or issue a notice of denial. This new procedure largely leaves the patient outside of the payment dispute for out-of-network services. If the provider wants to dispute the insurer's determination, the provider can open a 30-day open negotiation period during which the insurer and provider attempt to resolve the dispute. At the end of the 30-day period, if the parties can't reach an agreement, they will go to IDR arbitration.

At IDR arbitration, the insurer and provider each submits a proposed payment amount and explanation. The arbitrator must resolve the dispute by selecting one of the party's proposed payment amounts, taking into account specific considerations including the qualifying payment amount, or "QPA" (the median rate the insurer would have paid to an in-network provider for the service in the geographic area), among other considerations listed at § 300gg-111(c)(5)(A) of the Act.

While the Act sets out the basic structure of the dispute and arbitration procedure, the Departments of Labor, Transportation and Health and Human Services (the "Departments") issued the second interim final rule (the "Rule") on September 30, 2021, which was intended to provide for the practical application of the arbitration process. Specifically, once the parties submit their proposed payment amounts, the Rule directs

the arbitrator to select the proposed amount that is closest to the QPA, unless the arbitrator determines the QPA is "materially different" from the out-of-network rate. Thus, the Rule creates the rebuttable presumption that the QPA is the most important consideration under the Act.

Insurers calculate and set the QPA. Thus, some view (as the Texas Supreme Court notes) that favoring the QPA over the other six factors that the IDR arbitrator is to consider provides insurers great leverage in the arbitration process. However, the crux of the plaintiff's argument is that the Rule misinterprets and conflicts with the Act by giving additional weight to the QPA, to the detriment of the providers. In *Texas Medical Association v. U.S. Department of Health and Human Services, et al*., the Texas Medical Association and the providers dealt with four distinct issues: (i) whether the plaintiffs have standing because the alleged injuries are speculative; (ii) whether the Rule conflicts with the Act by imposing a rebuttable presumption in favor of QPA; (iii) whether the Department failed to provide notice and comment required under the APA; and (iv) the proper remedy.

Description of Court's Ruling and Why

Standing

There was considerable discussion by the court regarding whether or not the plaintiffs in *Texas* had standing; however, the court found the Departments engaged in a grievous procedural injury by placing the proverbial "thumb on the scale" in favor of the QPA (and thus the insurers). The court reasoned that additional pressure on providers deprived them of the full arbitration process due under the Act and such a procedural injury confers standing. The court also found the rebuttable presumption in favor of the QPA serves to systematically reduce reimbursement to providers which, as a guarantee of financial harm, also conferred standing on the plaintiffs.

Conflict Between Rule and Act

The court next tackled whether the Department's action was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," such as to require the court to set aside the Rule. The court examined the conflict between the language of the Act and the interpretation presented by the Rule under the two-step framework established by *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc*., 467 U.S. 837 (1984). Under the *Chevron* analysis, the first step is to determine whether Congress has spoken directly on the issue, based on the language of the Act, and if so, whether it was (mis)characterized in the Rule. The court reasoned that the language of the Act itself provides the QPA and the additional circumstances "shall" be considered by the arbitrator in its determination, which *requires* the arbitrator to consider *all* of the circumstances listed in the Act rather than favoring one of the circumstances over the others. The Rule, in contrast, only allows the additional circumstances to be considered when the QPA is "materially different" from the appropriate rate. The considerable weight given to the QPA in the Rule is challenged as an attempt to impermissibly rewrite the Act to fit the Departments' agenda. Accordingly, the court held the Act established an unambiguous framework for payment disputes and the Rule conflicts with the Act by rewriting clear statutory terms.

Notice and Comment Period Requirement

The process for creating rules was established to give interested parties an opportunity to participate in the process and ensure the fairness of the rules on those parties it would govern or substantially impact. The court found that the Departments violated this rule-making process, that there was no rule-making waiver provided in the Act and there was no good cause to forego the rule-making process because of the timeline

of the Act. In fact, the court noted that the notice and comment period the Departments chose improperly to forego would have allowed all of the inconsistencies between the Act and the Rule to be brought to light and handled more efficiently. Amidst a whole host of other responses, the court determined that the Departments were not excused from the requirement to provide a notice and comment period and that the Departments' error was not harmless.

Remedy
Based on the Departments numerous failings in the Texas Supreme Court's reasoned analysis, the court ruled that vacatur and remand was the appropriate remedy, but it did not vacate the entire Rule. Instead, the court vacated only those portions of the Rule that (i) mention the "material difference" standard for the applicable rate, (ii) require the arbitrator to select the amount that is closest to the QPA and (iii) specify the QPA may only be diverged from when it is "materially different" from the appropriate out of network rate. This negates the Departments' intent to create a "rebuttable presumption" in favor of the QPA (a number the insurers have more control over) and provides an opportunity for the additional circumstances listed in the Act to be given serious consideration.

CMC / New Intended Rule

In response to this ruling by the Texas Supreme Court, the Department of Labor published the *Memorandum Regarding Continuing Surprise Billing Protections for Consumers* on February 28, 2022, acknowledging that while the Texas Supreme Court invalidated portions of the Rule concerning the arbitration procedures under the Act, the ruling did not impact the protection for consumers against surprise bills for out-of-network services. The Departments withdrew all guidance based on the invalidated parts of the Rule and committed to updating their current guidance and trainings to reflect the Texas ruling – not just in Texas, but nationally. In spite of this, the Departments made no written or formal commitment to abandon their interpretation of the Act. And while the Departments mulled over how to resolve the conflicts between the Rule and the Act, the AHA and AMA issued a challenge to the Rule and urged the U.S. District Court for the District of Columbia to follow Texas' example and vacate the unlawful portions of the Rule.

In The Wake of Texas Medical Assoc.

On August 19, 2022, the Departments issued the long-awaited third Final Rule titled "*Requirements Relating to Surprise Billing: Final Rules*" (the "Final Rule") implementing the No Surprises Act. The rules finalize many of the requirements from the July 2021 interim rule relating to information that must be shared by group health plans and health insurance providers about the QPA. Additionally, in light of Texas Medical Assoc., the Final Rule addresses what information must be considered by the IDR entity when making a payment determination.

Under the Final Rule, the parties may not presumptively rely on the QPA to determine payment – though that information is still relevant criteria. Instead, the Final Rule directs the IDR entities to use an amount that "best represents the value of the item or service, which could be either party's offer." In establishing that amount, the Final Rule requires that any information already accounted for in the QPA (*e.g.*, where accounted for in the service codes or modifiers since those already reflect patient acuity and service complexity) not be counted twice. And where the QPA does not adequately reflect the full circumstances of the service, the IDR entity must consider all additional information submitted by the parties – without a qualifier for what the IDR entity must consider as most important. The Final Rule highlights that the payment determination should be centered on an examination of the actual facts and circumstances of the dispute

and not on the QPA methodology. The Final Rule also requires all IDR entities to require a written statement justifying the determination decision for all matters, where previously they were only required to do so when selecting an amount that was not the QPA.

The Departments also have published striking statistics regarding the dispute resolution process. In the approximately five months since the IDR process was first implemented, over **46,000** disputes have been initiated, "which is substantially more than the Departments initially estimated would be submitted for a ***full year***." (Emphasis added.) In that same time period, non-initiating parties have challenged over ***21,000*** disputes for eligibility for the IDR process, ***7,000*** of which have already been found ineligible for the IDR process. The initiation of eligibility dispute has become one of the primary causes of delays in the IDR process, which the Department has attempted to address via the most recent guidance.

We expect continued challenges to the No Surprises Act as the Act goes into full swing and the complexities of the inter-connected federal and state healthcare systems are manifested. In fact, the AMA and AHA moved to dismiss their challenge to the No Surprises Act brought in the U.S. District Court of Columbia citing "*serious concerns that the August 2022 final rule departs from congressional intent just as the September 2021 interim final rule did*." We anticipate that the AHA and AMA will not be the only parties intending to make their voices heard in the courts about these continued problems.