Published on *The National Law Review* https://www.natlawreview.com

Hotly Contested Dispute Resolution Rules in Second Federal No Surprises Act Interim Final Regulations Are Being Challenged in Court

Article By:

Anthony Argiropoulos

Thomas Kane

William Gibson

On September 30, 2021, the federal Departments of Treasury, Labor, and Health and Human Services issued "Requirements Related to Surprise Billing; Part II," the second in a series of interim final regulations (the "Second NSA Rules") implementing the No Surprises Act ("NSA"). This new federal law became effective for services on or after January 1, 2022.

Not surprisingly, the Second NSA Rules have sparked a series of federal lawsuits against these agencies (*see* here, here, and here) brought by providers, hospitals, and medical associations alleging that the Rules unlawfully create advantages to the payors that were not intended by the NSA. The Second NSA Rules focus on the independent dispute resolution ("IDR") that may be initiated by either party if there is a disagreement as to the payment amount. The IDR process will determine how much the payor must reimburse the non-participating provider or facility for out-of-network emergency or certain facility based non-emergency services (subject also to applicable state law or a state all-payer system).

As we previously discussed, the first set of NSA regulations provided, among other things, a methodology for how the payor calculates a patient's estimated cost-share amount and the qualifying payment amount ("QPA"), which was identified as one of several factors that IDR entities must consider if the provider and payor cannot agree on an out-of-network rate for that particular date of service. Now, pursuant to the IDR rules outlined in the Second NSA Rules, arbitrators are required to begin with the presumption that the market-based QPA represents fair compensation, thereby creating additional evidentiary burdens for providers to prove that a more generous payment is warranted.

Here is an overview of how the NSA claims submission process works and, if necessary, how the IDR process works:

The IDR process is a “baseball-style” arbitration, meaning that each party must submit a proposed offer of payment and the IDR entity resolves the dispute by selecting one of the parties’ proposed amounts. Significantly, the Second NSA Rules make clear that the IDR entity *must* select the offer that is closest to the QPA *unless* the opposing party has submitted “credible information” that “clearly demonstrates” that the QPA is “materially different from the appropriate” out-of-network rate for the covered item or service. Additional information that may be submitted to rebut this presumption includes: the provider’s training and experience, the complexity of the procedure or medical decision-making, the patient’s acuity, the market share of the insurer and provider, the teaching status of the facility, the scope of services, any demonstrations of good faith efforts to agree on a payment amount, and the contracted rates from within the prior four years. But the IDR entity may *not* consider such information in resolving the dispute unless the information “clearly demonstrates” that the QPA is an inappropriate rate for the item or service at issue. In addition, according to the statute and regulations, the IDR entity may *not* consider: (i) the usual and customary charges; (ii) the amount that would have been billed but for the NSA; and, (iii) payment rates under Medicare, Medicaid, TRICARE, or other federal programs.

Provider groups that had intended to rely on the “other” permissible factors listed in the federal law during IDR proceedings are now confronted with the additional burden of having to overcome this new presumption in favor of the QPA. In the various federal lawsuits challenging the presumption favoring the QPA, the plaintiffs argue that Congress intended for the arbiter to consider *several* factors, such as prior contracted rates for the medical service, the physician’s experience and training, and case complexity, among others. According to these lawsuits, the federal agencies’ failure to follow the NSA’s clear statutory mandates when promulgating these interim final rules by adding this new rebuttable presumption will drive down physician reimbursement rates and encourage payors to further narrow their networks, ultimately making it harder for patients to access necessary medical care. The lawsuits also argue that the Second NSA Rules may result in consumers paying higher premiums, which is contrary to Congress’s stated intent to protect certain consumers from ever-increasing health care costs.

Whether and how providers will be able to meet these new “credible” and “material difference” regulatory requirements, and the overall impact of these new regulatory requirements on network and rate negotiations, remain to be seen. These are important cases to watch as we are in the first month of the implementation of the NSA and they may further shape the regulatory implementation of the NSA.

National Law Review, Volumess XII, Number 21