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Buyer Beware:
Will the No Surprises Act Eliminate Surprise Billing?

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Overview of Litigation Challenging No Surprises Act Interim Final Rule

As noted elsewhere herein, the No Surprises Act ("Act") was enacted in December 27, 2020 as part of the Consolidated Appropriations Act of 2021 to address "surprise medical bills' received by consumers and to provide protections for consumers that may access services at an out of network provider. *Pub. L. No. 116-260, div. BB tit. I, 134 Stat. 1182, 2758-2890 (2020).* The Act can be found at 42 USC §§ 300gg-111, 300gg-131, 300gg-132.[1]

The new federal independent dispute resolution process, established by the Act has since come under intense scrutiny once the Departments of Health and Human Services, Labor and Treasury promulgated its rules, in the form of Interim Final Rules ("IFR") that were published[2] on October 7, 2021 (86 Fed. Reg. 55980 (Oct. 7, 2021).

By way of general background, the IFR implements the federal Independent Dispute Reolution ("IDR") process that is available to providers, facilities, plans and issuers in the event that agreement is not reached regarding out-of-network reimbursement following a 30-day open negotiation period. The entire IDR process is set out in the IFR.

The process for arbitration is widely touted to be a "baseball style" arbitration, meaning that two parties bring their "best and final" offer, along with any supporting evidence, to the arbitrator for determination by that arbitrator of the most appropriate offer. This determination is required to be consistent with the Act, the rules and guidance established by the government. The final determination is binding all the parties.

In states that have an All-Payer Model Agreement or other specified state law, the out-of-network rate is either the amount agreed to by the insurer and the out-of-network provider, or an amount determined by the IDR process set forth in the statute and in its regulations.

While the Act contains six criteria for the arbitrator to take into consideration, upon promulgation of the IFR, those criteria are laid out in a differing manner, with one criterion arguably, having more significance than the others. It is the apparent conflict between the Act and its regulations that have caused significant consternation in the provider community; so much so that a large number of provider organizations have filed lawsuits challenging the IFR both on the substance of the IDR process itself, as well as the process in which the IFR were issued.

The Act's Dispute Resolution Criteria

The Act's IDR criteria are located in Subsection C of the Act, §300gg-111(c)(5)(A)[3] and provides as follows:

(C) Considerations in determination

(i) In general

[1] The Act amended three statutes: The Public Health Service Act ("PHSA"), which is administered by the Department of Health and Human Services), the Employee Retirement Income Security Act ("ERISA") (administered by the Department of Labor), and the Internal Revenue Code (administered by the Department of Treasury).

[2] The Interim Final Rules that contain the Independent Dispute Resolution process are in the IFR that are commonly referred to as Part II rules.

[3] This section is located in Section 2799A-1(c)(5)(A) of the Public Health Service Act.

In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR item or service shall consider-

(I) the qualifying payment amounts (QPA) (as defined in subsection (a)(3)(E)) for the applicable year for items or services that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR item or service; and

(II) subject to subparagraph (D), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B) (ii).

(ii) Additional circumstances

For purposes of clause (i)(II), the circumstances described in this clause are, with respect to a qualified IDR item or service of a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer of group or individual health insurance coverage the following:

(I) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act [42 USC §1395 aa]).

(II) The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or services was provided.

(III) The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual.

(IV) The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service.

(V) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

Id. at § 300gg-111(c)(5)(C).

The statute also prohibits the arbitrator from using the provider's usual and customary charges for an item or service, the amount the provider would have billed for the item or service in absence of the Act, or Medicare/Medicaid/CHIP or TriCare reimbursement rates.

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