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ALERT ▪ Health Care

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Interim Final Rule Implements Controversial Surprise Billing Arbitration Provisions

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On Thursday, October 7, the Biden Administration published in the *Federal Register* its second interim final rule implementing the "No Surprises Act," which became law on December 27, 2020 as part of the FY 2021 Consolidated Appropriations Act. In general, the Act seeks to resolve the issue of "surprise billing," that is, when patients receive large medical bills after unknowingly receiving care from out-of-network providers.

Amongst other aspects of the No Surprises Act, this most recent interim final rule implements the Act's independent dispute resolution (IDR) process, a method of arbitrating disputes between insurers and providers regarding the amount to be reimbursed to the provider by the insurer for certain out-of-network health care items or services. Notably, the rule provides that, in resolving such disputes, the IDR entity must *presume* that the insurer's median in-network rate for the medical services or items at issue is the appropriate amount to be paid to the provider. Although insurer groups have generally voiced their support of the IDR process, provider groups have criticized what they have called the rule's one-sided dispute resolution process slanted in favor of the insurance industry and cautioned that the rule will ultimately reduce patient access. In addition, the release of the rule swiftly triggered a joint bipartisan statement from the House Ways and Means Committee in which the Committee accuses the Administration of conflicting with the No Surprises Act as to the evaluation of factors in the IDR process.

This Alert summarizes the IDR process set forth in the No Surprises Act and the Administration's interim final rule, and assesses the extent to which the rule establishes an IDR process that is different from what the statute requires or contemplates. This rule is scheduled to go into effect on January 1, 2022, and the deadline to file comments on this interim final rule is December 6, 2021.

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Background: Congress Provides for an IDR Process to Settle Disputed Charges

In order to resolve disputes among plans and issuers, on the one hand, and out-of-network providers and facilities, on the other, as to the amount to be paid for out-of-network items and services, the No Surprises Act calls for a federally regulated IDR process. The statute provides that, when a payment dispute arises, the parties must engage in a thirty-day "open negotiations" process, after which, if no settlement is achieved, either party may initiate the IDR process.[1] Once initiated, both parties must submit offers to an IDR entity, and the entity is required to select one of the offers presented by the parties after considering a number of factors.[2] By statute, the IDR entity is precluded from considering the provider or facility's billed charges for the items or services, the "usual and customary charges" for the items or services, or the reimbursement rate for the items or services payable by a public payor, such as Medicaid or Medicare.[3]

The first factor under the statute that the IDR entity must look to is the qualifying payment amount (QPA) for the items or services in controversy.[4] The statute generally defines the QPA as the insurer's median in-network rate for similar

[1] Consolidated Appropriations Act, 2021, Pub. L. 116-260, div. BB, tit. I. § 103(a)(2)(c)(1)-(2).
[2] *Id*. § 103(a)(2)(c)(5).
[3] *Id*. § 103(a)(2)(c)(5)(D).
[4] *Id*. § 103(a)(2)(c)(5)(C)(i)(I).

items or services in that geographic region as of 2019, adjusted annually by the Consumer Price Index for All Urban Consumers.[5]

Next, the Act instructs an IDR entity to consider various "additional circumstances"[6] including:

- "the level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service";
- "the acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual"; and
- "demonstrations of good faith efforts," or the lack thereof, by the provider and insurer to enter into network agreements.

Notably, although the statute lists the QPA as the first factor to be considered, it does not provide that the IDR entity must default to the QPA or address how the IDR entity must weigh the various factors in resolving a payment dispute. The statute expressly gives the IDR entity the power to decide the appropriate payment amount after considering the parties' positions and appropriate factors.[7]

The Administration's Interim Final Rule IDR Process

The Biden Administration's October 7 interim final rule provides additional details about the No Surprises Act's IDR process, including guidance about how an IDR entity must weigh the applicable factors when determining which of the parties' offers to select. In justifying why the agency chose to issue an interim final rule, the Administration claimed that a full public notice and comment process would be infeasible to complete in time for the Act's January 1, 2022 effective date. Significantly, the rule holds that an insurer's median in-network rate, or QPA, "represents a reasonable market-based payment for relevant items and services" and that, therefore, in resolving payment disputes between insurers and providers, the IDR entity must *presume* that the QPA is the appropriate amount to be paid.

Pursuant to the rule, an IDR entity must arrive at a resolution as follows: After considering the QPA and the additional information about the offers that the parties submit, the entity *must select the offer closest to the QPA*, unless any of the submitted information clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate. In the event that the submitted information clearly demonstrates that the QPA is not an appropriate price for the items or services at issue, or when the offers are equally distant from the QPA but in opposing directions, the IDR entity must select the offer that it determines best represents the value of the items or services, which could be either party's offer.

The Administration asserts that this prioritization of the QPA is justified on both statutory and policy grounds. First, the rule points out that the QPA is the first factor mentioned in the statute and includes "detailed rules" for its calculation, while the other factors, such as the provider's level of training and the complexity of the items or services furnished, are described as "additional" and assigned to a separate paragraph in the statute. Second, the rule states that a presumption in favor of the QPA will promote administrability and predictable outcomes because, if the parties understand that the QPA is the primary factor to be considered, they will be more likely to submit offers closer to the QPA, or even avoid the IDR process altogether by reaching a settlement prior to initiating the dispute resolution process.

To be sure, the rule does not provide that an IDR entity must completely ignore the "additional circumstances"—indeed, the Administration concedes that the presumption in favor of the QPA as the appropriate amount to be paid can be

[5] *Id.* § 102(a)(1)(a)(3)(E).
[6] *Id.* § 103(a)(2)(c)(5)(C)(ii).
[7] *Id.* § 103(a)(2)(c)(5)(A).

rebutted. Nonetheless, the rule states that information submitted to rebut the QPA presumption must "clearly demonstrate that the QPA is materially different from the appropriate out-of-network rate." By anchoring the IDR entity's evaluation to the QPA, the new rule arguably strips the IDR entity of its discretion to make the best selection as provided for in the statute, and could thus be subject to legal challenge. Given this dynamic criticized by some as creating an uneven playing field, it seems likely that over time the announced IDR process could prove to be fruitless for providers to undertake because they would be highly unlikely ultimately to receive different reimbursement amounts than what the payors offered.

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In the short time since its publication, the Administration's interim final rule has been met with mixed reaction. Insurer groups, such as America's Health Insurance Plans, have celebrated the rule, stating their belief that the rule "conform[s] to the intent of the No Surprises Act" by including a presumption that the QPA is the appropriate reimbursement level.[8] Provider groups, on the other hand, have been vocal in their displeasure with the rule. The California Medical Association, for example, called the rule "a gift to the insurance industry" that promises to "disincentivize plans from contracting with physicians, creat[e] narrow networks and patient access to care problems, and drive physicians to larger systems that will increase health care costs."[9] The American Hospital Association stated that while the No Surprises Act was "an important step forward" for patients, the Administration's rule "has moved away from Congressional intent and brought new life to harmful proposals that Congress deliberately rejected."[10]

Some members of Congress, many of whom were key framers of the No Surprises Act, have also expressed their displeasure with the rule. In particular, Congressman Richard Neal (D-MA), Chairman of the House Ways and Means Committee, issued a joint bipartisan statement with Ranking Member Kevin Brady (R-TX) in opposition to the rule. These members of Congress asserted that the rule's bias in favor of the QPA departs from Congressional intent because Congress designed the IDR process to consider a number of factors "equally," and thus "deliberately crafted the law to avoid any one factor tipping the scales." Accordingly, the statement called upon the Administration to "revisit" the rule and "consider adjustments that better align with the law Congress enacted."

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The terms of the No Surprises Act, and this latest interim final rule, take effect for plan or policy years beginning on January 1, 2022. The deadline to file comments to this interim final rule is December 6, 2021. If you have any questions, please do not hesitate to contact the authors or your usual Ropes & Gray advisor.

[8] AHIP Comments on Interim Final Rule for Implementing No Surprises Act, *available at* https://www.ahip.org/ahip-comments-on-interim-final-rule-for-implementing-no-surprises-act/.
[9] California Medical Association Statement, *available at* https://www.cmadocs.org/newsroom/news/view/ArticleId/49516/Federal-surprise-billing-rule-is-a-gift-to-the-insurance-industry.
[10] AHA Statement on Surprise Billing Interim Final Rule, *available at* https://www.aha.org/press-releases/2021-09-30-aha-statement-surprise-billing-interim-final-rule.