No Surprise Act

Summary of Act and Interim Final Rules

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The Interim Final Rule

- On September 30, 2021, the Departments of Health and Human Services, Labor, and the Treasury (collectively, the "Departments") jointly released an interim final rule (IFR) regarding the No Surprises Act.
- This IFR focused on, among other topics:
  - Good Faith Estimates (for uninsured/self-pay patients); and
  - The IDR Process (between providers/facilities and plans/issuers).
- Unfortunately, the IFR not only left many questions unanswered, but apparently was written in a manner to favor the plans/carriers to the detriment of out-of-network (OON) providers and facilities.

Summary of Rules

1. Emergency Services: Patient cannot be Balance Billed. Patient responsible for in-network cost share. IDR available.
2. Non-Emergency Services at In-Network Hospital or ASC with no consent or disclosure to Patient: Patient cannot be Balance Billed. Patient responsible for in-network cost share. IDR available.
3. Non-Emergency Services at In-Network Hospital or ASC with consent and disclosure provided to Patient: Patient can be Balance Billed except for Ancillary Services. No IDR available.
4. Ancillary Services: Patient cannot waive protection under Act. Patient cannot be Balance Billed. Patient responsible for in-network cost share. IDR is available.

Summary of Rules (Continued)

5. Ancillary Services are:

a) Emergency services
b) Anesthesia
c) Pathology
d) Radiology
e) Neonatology
f) Assistant surgeon services
g) Hospitalists
h) Intensivists
i) Diagnostic services
j) Laboratory
k) Non-emergency services where no par-provider available at in-network setting

Summary of Rules (Continued)

6. Ancillary Services providers generally need not provide notice and consent to Patients, although it may be possible that an ancillary provider would be required to provide GFE. IDR available (at least based on current guidance).

7. Qualified Payment Rate is the rate that IDR Entity presumes is correct. It is the in-network median rate.

8. Patient may knowingly waive the protections of the Act but the consent forms must be those prescribed by the HHS and include a GFE.

9. Notice and consent must generally be given to the Patient within 72 hours of the date of service in 15 most common languages.

10. Out of Network Providers must give GFE's for uninsured and self-funded patients. I am assuming this will apply to insured plans as well.

11. The Act does not apply to out of network services in an out of network setting.

Summary of Rules (Continued)

12. Complaint procedures are established. Up to $10,000 penalty per violation (for balance billing patients in violation of the Act).

13. IDR:

a) Negotiations for 30 business days of payment.
b) Request IDR within 4 business days of end of 30 day period.
c) Select IDR entity (or HHS selects if the parties cannot agree)
d) Offer to be submitted within 10 business days of selection.
e) 30 business days for IDR Entity to issue decision.
f) Payment in 30 calendar days.

Getting Around the QPA

- Initially, it must be noted that the IFR are only *interim* rules for which comment is sought. Based on the one-sided nature of the key provisions of these rules, we, at The Patriot Group, strongly encourage you to join us in fighting for a more even playing field, in line with Congressional intent.
  - In doing so, we highly recommend that you take the following steps:
    - Contact your local Senators, Congressmen, and Representatives (after all, the House Ways and Means Committee is already clearly on our side in noting that the IFR requires substantial changes).
    - Send correspondence to the Departments, disputing the validity, fairness, and general structure of the provisions set forth in the IFR.
    - Contact various professional groups and organizations of which you are a part, requesting that they, too, advocate for fairer rules and provisions.

Getting Around the QPA (continued)

- A few arguments that you can be asserted to dispute QPA
  - The QPA is not reflective of the market rate (it is solely reflective of one plan's/carrier's rate with providers interested in perceived security of in-network benefits)
    - The IFR illogically ignores its own assertions that in-network providers agree to discounted reimbursement rates.
    - The Departments state that the expectation is that QPA reliance will result in downward pressure on healthcare costs, which is not the intent of the Act, and which will drastically harm providers/facilities, especially smaller/independent providers/facilities and those providers that cannot become participating providers.
  - Other databases, like the 80th percentile of FAIR Health, could just as easily be used, as they are in New York and Texas, for example.
  - The preference for the QPA does not align with Congressional intent, or the language of the Act, and the Departments lack the authority to unilaterally change such a key provision of the statute.
  - The IFR bases its provisions on overarching rationales not applicable to many types of OON providers (*i.e.*, it is based on data regarding charges of private entity-backed hospitals, not smaller OON providers).

Getting Around the QPA (continued)

- Should the IFR stand as is, permitted factors will need to be relied upon to show why the QPA should be deemed inapplicable. Providers/facilities should begin contemplating how these factors can favor them as soon as possible.
  - Market Share held by the OON provider/facility or plan in the area
    - Practice size and specialty/type
    - Information about the plan's coverage area
    - Information about the QPA (particularly, how it does not accurately reflect the market)
  - Patient Acuity and complexity of the case
    - Level of training
    - Experience
    - Quality and outcome measures
  - Teaching statute, case mix, and scope of services
  - Demonstrations of good faith efforts (or lack thereof) to be in-network, as well as the contracted rates, if applicable, over the past 4 years
  - Why the federal IDR process is inapplicable to the dispute.

Deferral to State Law

- As is the case with many other aspects of the Act discussed in the IFR, the question as to how deferral to State Law will apply is still very much up in the air.
- Although the Act specifies that the federal government will defer to states maintaining specified state law (*i.e.*, a law that provides for a method for determining the total amount payable under a plan, coverage, or issuer), this deferral may only apply in states where there is a state law with similar protections as the No Surprise Act.
  - Due to this uncertainty, it is expected that further guidance on the deferral aspect of the Act will be provided. In any case, it is likely that a state-by-state basis preemption analysis will be necessary in order to determine whether the dispute will be deferred to state standards.

Topics Not Discussed

- Several topics touched upon in the IFR were not discussed during this presentation, including, but not limited to:
  - The Special Dispute Resolution Program (between providers/facilities and uninsured/self-pay patients);
  - Batching of claims and “cooling-off” periods related to IDR;
  - Cost, and payment logistics, of the IDR process;
  - IDRE conflict of interest prevention;
  - Audit processes regarding plans/carrier’s QPA metrics;
  - Certification and petition for de-certification of IDREs;
  - Determinations as to whether certain state laws are sufficient;
  - Extension of time periods based on extenuating circumstances; and
  - Extension of external review processes to cover No Surprises Act compliance.

Unanswered Questions (Among Others)

- Can plans/carriers and Providers access IDR for audits and recoupment efforts?
- What are the penalties for failing to timely pay IDR determined amounts?
- How does the Act and IFR harmonize with internal appeals and external review processes?
- What happens to past determinations if an audit reveals that the plan/carrier manipulated the QPA?

Key Takeaways

- At present, the IFR currently weighs against fair and reasonable reimbursement for OON providers.
- The comment period ended on 9/7/21. The final rule is effective 9/13/21.
- The Act and IFR are likely to create a considerable administrative burden for providers and facilities.
- Many questions remain unanswered regarding the guidance contained in the IFR and it is anticipated that additional or revised rule promulgation will mitigate some of this uncertainty.
  - ***The Patriot Group and The Force Law Firm will be reviewing future guidance and are here to help you navigate this uncertainty.***

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