Buchalter
CLIENT ALERT

February 25, 2022

A Big Win for Providers: Federal Court Strikes Unfavorable Rule on Provider-Payor Disputes Under the No Surprises Act

By: Karen N. George and Andrew H. Selesnick

A Texas federal court granted the first win for providers in a long-running fight against the provider-payor dispute process implemented in favor of payors under the No Surprises Act. Under the rules, if the providers or facilities do not agree with the out-of-network payments received from health insurers, and choose to initiate arbitration under the NSA, the arbitrators are *required* to select the payment rate closest to the insurers' median in-network rate. This undeniably skews arbitration in favor of health insurers, because whatever payment they make is presumed to be correct, resulting in a windfall to the insurers and essentially rendering the arbitration process useless. On February 23, 2022, the Court in *Texas Medical Association et al. v. United States Department of Health and Human Services et al.* agreed that this arbitration process is not appropriate and runs afoul of the NSA and Congress' clear intent. The Court struck down this portion of the rule and held that in determining the adequate out-of-network reimbursement rate, arbitrators must consider a multitude of relevant factors, and not presume that the insurers' median in-network rate is automatically correct.

Background of the No Surprises Act

The NSA was enacted to address "surprise balance billing" and protect patients from receiving bills for out-of-network emergency services, and certain non-emergency out-of-network services rendered at an in-network facility. The NSA further sets out specific requirements for the payments out-of-network providers should receive from health plans or health insurers (collectively "insurers").

If there is a specified state law that bans balance billing, then the NSA does not apply (in California, for example, it would be Department of Managed Health Care covered claims). If the NSA does apply, then the insurer reimburses the provider at a rate it believes is appropriate. If the provider disputes the payment, it can initiate the independent dispute resolution ("IDR") process.

The IDR process is a "baseball-style" arbitration where the provider and insurer each submit a proposed payment amount, and the arbitrator selects one of the offers. In selecting the payment amount, the NSA instructs the arbitrator to consider several factors, including:

- The qualifying payment amounts (the insurer's median in-network rate)
- The level of training, experience, and quality and outcome measurements of the provider or facility
- The market share held by the provider, facility, or insurer in the geographic region where the service was provided
- The acuity of the individual receiving the service or the complexity of rendering such service to the individual
- The teaching status, case mix, and scope of services of the facility that rendered the service
- Demonstrations of good faith efforts (or lack thereof) by the provider or plan to enter into an in-network agreement and, if applicable, contracted rates between the provider or facility and the insurer during the previous 4 plan years

On September 30, 2021, the Departments of Health and Human Services, Labor, and Treasury, along with the Office of Personnel Management (the "Departments") issued a hotly contested interim final rule ("Rule") implementing the IDR process. Pursuant to the Rule, when selecting between the two offers from the provider and the insurer, the Rule required that the arbitrator must select the payment amount closest to the qualified payment amounts (QPA). The QPA is the insurer's median in-network rate for the service in a specific geographic area. The arbitrator was not permitted to deviate from the amount closest to the QPA, unless credible information submitted by either party *clearly* demonstrates that the value of the service is materially different from the QPA, an impossibly high burden. This windfall to the insurers was struck down.

The Lawsuit

On October 28, 2021, the Texas Medical Association ("TMA") and Dr. Adam Corley ("Plaintiffs") filed a lawsuit against the Departments in the U.S. District Court for the Eastern District of Texas challenging the Rule implemented by the Departments. Plaintiffs moved for summary judgement requesting the Court to strike down portions of the Rule addressing the IDR process for determining out-of-network rates. Specifically, Plaintiffs argued that the Rule is unlawful and directly conflicts with the NSA by imposing a rebuttal presumption that the median in-network rate set by insurers is the appropriate out-of-network rate. Plaintiffs argued that the NSA expressly requires the arbitrator to consider several factors when choosing the payment rate, and does not instruct the arbitrator to choose the rate closest to the QPA. They noted that the NSA allows the arbitrators to exercise their discretion and weigh all the relevant factors when selecting the appropriate reimbursement rate.

The Court agreed with Plaintiffs and set aside the portions of the Rule requiring the arbitrator to presume that the QPA is the appropriate out-of-network rate. The Court held that the Act requires the arbitrator to consider *all* of the specified factors when determining the reimbursement rate. The Court found that the

NSA does not instruct that any one factor should be weighed more than the others, nor does it suggest that the offer closest to the QPA should be chosen.

While the ruling can still be appealed, this is a tremendous first win (of hopefully many) for providers in restoring the power balance in provider-payor out-of-network reimbursement disputes under the NSA. For more information about the impact of this decision on your practice or facility, please contact Karen George at kgeorge@buchalter.com or Andrew Selesnick at aselesnick@buchalter.com.

Karen N. George
Attorney
(213) 891-5083
kgeorge@buchalter.com

Andrew H. Selesnick
Shareholder
(213) 891-5223
aselesnick@buchalter.com