Departments Issue Final Rules to Clarify Dispute Resolution and Transparency under No Surprises Act

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On August 19, the U.S. Departments of Health and Human Services, Labor, and the Treasury (the Departments) released final rules regarding the No Surprises Act provisions of the Consolidated Appropriations Act, 2021. The rules address the No Surprises Act's required independent dispute resolution (IDR) process and finalize prior interim final rules relating to information that group health plans and health insurance issuers must share about the qualifying payment amount (QPA) – the median of a plan or insurer's in-network rates for the item or service in the relevant geographic region – used to determine disputed out-of-network covered expenses.

Federal IDR Process Clarified

Interim final rules issued in October 2021 required that certified IDR entities select the offer closest to the QPA, unless the certified IDR entity determined that any additional credible information submitted by the parties demonstrated that the QPA was materially different from the appropriate out-of-network rate. A federal District Court later vacated this requirement in multiple 2022 rulings. The final rules remove the provisions that the District Court vacated.

The final rules specify that certified IDR entities should select the offer that best represents the value of the item or service under dispute after considering the QPA and all permissible information submitted by the parties. So, certified IDR entities must consider the QPA and then must consider all additional permissible information submitted by each party to determine which offer best reflects the appropriate out-of-network rate. The additional information may not include information prohibited by the statute.

Certified IDR entities should evaluate whether the information relates to the payment amount offer submitted by either party and whether it is credible. The certified IDR entity also should determine if the information double counts any information already factored into the QPA or included in other information submitted by the parties. Certified IDR entities then should select the offer that best represents the value of the item or service under dispute.

New Key Term: Downcoding

In July 2021 interim final rules, the Departments required plans and issuers to disclose the QPA for each item or service to providers (including air ambulance providers) and facilities with each initial claim payment or notice of denial of payment in any case where the QPA sets the relevant cost-sharing amount. Additionally, when a plan or issuer changes a provider or facility's service code used for billing purposes to one of lesser value – which would reduce the payment to the provider or facility – the plan or issuer must now provide additional information for this "downcode" process.

The final rules define "downcode" as a plan or issuer altering the applicable service code to another service code or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed code or modifier is associated with a lower QPA than the service code or modifier billed by the provider, facility, or provider of air ambulance services. If a QPA is based on a downcoded service code or modifier, the plan or issuer must provide the following with its initial payment or notice of denial of payment:

- A statement that the service code or modifier billed by the provider, facility, or provider of air ambulance services was downcoded
- An explanation of why the claim was downcoded, including a description of which service codes or modifiers were altered, added, or removed, if any
- The amount that would have been the QPA had the service code or modifier not been downcoded

The Departments declare that the new downcoding information is essential to the negotiation process and will ensure that providers can develop an appropriate offer during IDR. The additional detail could, for example, lead a certified IDR entity to understand that the QPA for a downcoded service is not appropriate and select an appropriate offer between the parties.

IDR Entity Written Determinations

Finally, October 2021 interim final rules required certified IDR entities to explain their payment determinations and underlying rationale in writing submitted to the parties and the Departments. The final rules require that the written decision explain the information used and relied on by the certified IDR that demonstrated the selected offer is the out-of-network rate that best represents the value of

the item or service. This includes the weight given to the QPA and any additional credible information. If the certified IDR entity relies on additional information when selecting an offer, it must explain why the certified IDR entity felt the information was not already reflected in the QPA.

Transparency Rules

The No Surprises Act requires plans and issuers to post a notice about the Act's patient protections and balance billing requirements on their websites. Plans and insurers must also disclose this information on explanations of benefits for covered items or services. The FAQs confirm group health plan sponsors without their own public health plan website can satisfy this requirement if a third-party administrator (TPA) or insurer agrees in writing to post the information on its website.

The FAQs clarify that a group health plan sponsor can satisfy the requirement to post machine-readable files (MRFs) if its service provider agrees in writing to post the information on its website on behalf of the plan. If a plan maintains a public website, it must still post a link back to the provider's website.

Plans and insurers must make price comparison information and cost-sharing estimates available through an internet-based self-service tool for 500 specific items and services as of January 1, 2023, and all covered items and services as of January 1, 2024. The Departments have stated they will update the list of items and service codes for the already-identified 500 items and services quarterly and provide reasonable time for plans and insurers to update their tools to reflect the current codes.

Air Ambulance Service Coverage

The FAQs reiterate that the No Surprises Act does not mandate that plans and insurers covering only emergency air ambulance services also cover air ambulance services for non-emergencies like transporting a patient between two facilities. If a plan or insurer covers benefits for air ambulance services, the plan or insurer must cover the services when provided by an out-of-network air ambulance provider. However, this does not mean that such benefits or services that must be covered. So, if a plan excludes non-emergency air ambulance services, the No Surprises Act does not require those services to be covered.

Finally, where the No Surprises Act does apply to air ambulance services, the FAQs state that patients are protected from out-of-network bills from air ambulance companies even with a non-U.S. pickup point. The Departments pledge to provide future guidance as to which geographic region plans should use to determine the QPA in these cases. Until then plans and insurers must use a reasonable method to determine the geographic region, including by basing the geographic region on the border point of entry to the United States after patient pickup.

Reference-Based Pricing Plans

FAQs released along with the final rules confirm that the No Surprises Act applies to plans with no provider network such as a plan that uses reference-based pricing. Out-of-network providers and air ambulance companies that provide emergency care are thus barred from sending balance bills to patients in one of these plans, but the same protection would not extend for non-emergency services.

Patients receiving emergency care from an out-of-network provider should pay no more in cost-sharing than if their care had been provided by an in-network provider. A plan with no network will calculate the proper amount based on the "recognized amount" under the No Surprises Act. This amount is determined by a specified state law, an all-payer model, or the QPA. If a payer lacks sufficient information to calculate a median contracted rate because there is no network, it must calculate the QPA using an eligible database.

Behavioral Health Facilities

The FAQs provide that where a behavioral health crisis response facility is licensed to provide emergency services and is geographically separate from a hospital, the facility would qualify as an independent free-standing emergency department. Therefore, patients who get emergency services subject to the No Surprises Act in such a facility that is out-of-network should not receive a surprise bill.

Conclusion

The final rules intend to further the transparency of the way plans and carriers cover out-of-network costs. The processes addressed in the final rules are new, so it will take time to determine whether and how they achieve the intended results. Federal officials recently reviewed some 45,000 disputes and have based the current guidance in part on this data. The Departments announced that they intend to continue examining payment determinations and will adjust the process through future guidance as more data results from claims processed through IDR. We will continue to monitor the results and related guidance and will update as needed.