Articles + Publications | November 16, 2021

The No Surprises Act Gets Litigated

WRITTEN BY

Sara B. Richman | Virginia Bell Flynn | Christopher M. Brolley | Barak A. Bassman | Leah Greenberg Katz

On October 28, the Texas Medical Association (TMA), a trade association that represents more than 55,000 physicians and medical students, filed a lawsuit in the Eastern District of Texas challenging key portions of CMS's proposed regulations implementing the No Surprises Act (Act).[1] We previously issued client alerts summarizing Part I and Part II of the proposed rules.

Specifically, TMA alleges that the regulations "were improperly issued without the requisite notice and comment[,] and … unlawfully restrict [independent dispute resolution] entities' ability to consider and exercise their discretion weighing *all* of the required factors identified by Congress when selecting the appropriate payment amount" for out-of-network services.[2]

Qualifying Payment Amount (QPA)

TMA's primary attack is on the Qualifying Payment Amount (QPA), which the regulations set as the default payment for out-of-network reimbursement rates. Introduced by the Act,[3] the QPA is the payor's median contract rate for the same or similar service in the relevant region.[4]

In the event of a dispute over out-of-network reimbursement rates, the proposed regulations require the independent dispute resolution (IDR) entity to begin with the presumption that the QPA establishes the appropriate rate, allowing for departure from the QPA only if a party presents evidence that "clearly demonstrates that the [QPA] is materially different from the appropriate out-of-network rate."[5]

TMA argues that the presumption in favor of the QPA[6] unfairly favors payors "and undermine[s] providers' ability to obtain adequate compensation for their services."[7] TMA contends that this presumption departs from the Act's requirement that out-of-network reimbursement rates be established by considering a number of factors, only one of which was the QPA, and none of which are afforded priority when determining out-of-network rates. Specifically, the Act requires the IDR to consider: 1) any information requested by the IDR entity from the parties; 2) additional information submitted by a party relating to (a) the level of training, experience, and quality and outcome measurements of the provider or facility that furnished the IDR item or service, (b) the market share held by the provider or facility in which the IDR item or service was provided, (c) the acuity of the recipient of the IDR item or service, (d) the teaching status, case mix, and scope of services of the facility that provided the IDR item or service, and (e) demonstration of good faith efforts (or lack thereof) made by the provider, facility, or plan to enter into network agreements with each other; and 3) any additional information submitted by a party that does not include information on the factors in (a)-(e).[8]

The lawsuit further claims that the QPA will often be lower than the fair market value of reimbursement amounts

paid in the marketplace because it relies on the median of contracted rates, rather than the median of actual payments made pursuant to each contract.[9] TMA argues that using median payments would more accurately approximate prevailing market rates by weighting provider contracts by volume of services rendered.[10]

TMA's lawsuit also claims that the information the payors will use to calculate the QPA is solely within their control, and that the mandatory disclosures relating to QPAs are "wholly insufficient to allow the Departments, the IDR entities, [and] … healthcare providers to ascertain whether a payor has correctly calculated the QPA."[11] Specifically, the lawsuit claims that this lack of transparency would make it difficult to ascertain "whether the claim was downcoded … , the amount of any bonuses or supplemental payments [*e.g.*, risk-sharing incentives] not included in the QPA, the number of contracts and the number of providers included in the QPA, and the types of specialties that have contracted rates in the dataset used to determine the QPA."[12]

Policy Considerations for Applying QPA

While HHS has not yet formally responded to the complaint, we can glean its likely response from CMS rulemakings, which have provided the agency's justification for creating a rebuttable presumption in favor of the QPA as the out-of-network rate. By using a clearly defined rebuttable presumption, there can be a predictable out-of-network rate structure. This anchoring provides a number of benefits. First, by increasing the predictability of IDR outcomes, the presumption may encourage parties to reach an agreement outside of the IDR process.[13] This allows parties and the government to avoid administrative costs and reduce prices that may have been inflated due to surprise billing practices prior to the Act.[14] Second, it helps limit the impact of higher out-of-network costs that would be passed on to individuals via premium increases. In other words, CMS recognizes that the presumptive use of the QPA may reduce provider payments, but argues that this is a positive for employers and consumers. And third, it promotes efficiency and predictability to the IDR process and increases the likelihood that the IDR entity will generally select the offer closest to the QPA.[15]

Troutman Pepper will continue to monitor the No Surprises Act and provide updates if more guidelines are released or more lawsuits are filed.

---

[1] *See Texas Medical Association, et al. v. United States Department of Health and Human Services, et al.*, 6:21-cv-00425 (E.D. Tex. October 28, 2021).

[2] *Id.* at ¶ 2; TMA's lawsuit also alleges that the Departments improperly denied them the opportunity to submit comments on the proposed regulations. Although the Administrative Procedure Act allows an agency to bypass the notice and comment requirements under certain narrowly defined circumstances, TMA's lawsuit contends that the proposed regulations fail to meet the standard. *See Texas Medical Association, et al*, 6:21-cv-00425, at ¶ 65.

[3] *See* 45 C.F.R. § 149.140(c) (providing the methodology for calculating qualifying payment amount).

[4] *See* 86 Fed. Reg. 55980, at 55982 (Oct. 7, 2021) (2021 Interim Final Rule Part II).

[5] *Id.* 56104

[6] *See Texas Medical Association, et al*, 6:21-cv-00425, at ¶¶ 6, 57.

[7] *Id.* at ¶ 67.

[8] 2021 Interim Final Rule Part II at 56104.

[9] *See Texas Medical Association, et al*, 6:21-cv-00425, at ¶ 68.

[10] *Id.*; *see also* 86 Fed. Reg. 36889, at 36930 (2021 Interim Final Rule Part I).

[11] *Id.* at ¶ 47.

[12] *Id.* at ¶ 71.

[13] 2021 Interim Final Rule Part II at 55996.

[14] *Id.*

[15] *Id.*

RELATED INDUSTRIES + PRACTICES

- Health Care + Life Sciences
- Health Care Insurance
- Managed Care Payor Disputes, Investigations + Regulatory Counseling