IslerDare PC

Employee Benefits Update *September 1, 2022*

No Surprises Act: Final Regulations and FAQs

On August 19, 2022, the U.S. Departments of Health and Human Services, Labor, and Treasury (the "Departments") issued the third interim final rule entitled "Requirements Related to Surprise Billing: Final Rules" (the "Final Rule") and a series of Frequently Asked Questions (FAQs), which build on earlier guidance regarding implementation of the No Surprises Act (the "Act") (see our earlier Isler Dare newsletters on the Act here). The Final Rule is narrow in scope and predominantly focuses on the controversial independent dispute resolution ("IDR") process. In particular, the Final Rule revises certain standards in the IDR process, which had previously been invalidated by the United States District Court for the Eastern District of Texas, and the FAQs address a series of the Act's requirements, including those related to surprise billing protections, open negotiation, and the IDR process. The FAQs also contain revised model notices that plans may utilize in the upcoming open enrollment season to comply with the requirement to disclose patient protections against surprise billing.

Elimination of Rebuttable Presumption Favoring Qualifying Payment Amount ("QPA")

The Final Rule eliminates the rebuttable presumption that the QPA (the median payer rate for a particular health care item or service in a particular region) is the appropriate out-of-network ("OON") rate. Under this presumption, IDR entities were instructed not to deviate from the QPA unless there was credible evidence showing that the QPA was "materially different" from the appropriate OON rate. Following the Texas federal district court ruling invalidating the Departments' earlier guidance on QPAs, the Final Rule instructs IDR entities to determine OON rates during the IDR process by selecting 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."

- **Requirement to Consider the QPA and Additional Information.** Under the Act, the QPA must be considered in every dispute under the IDR process. IDR entities must also consider "additional information", but only when submitted by the parties or requested by an IDR entity. Additional factors, when submitted or requested, may be important to the IDR entity's determination if the QPA does not fully capture the issues identified by the "additional" factors.
    - Credible, Related Information. When selecting the offer that best represents the value of the disputed health care item or service, the Final Rule emphasizes that IDR entities can only consider credible information that is related to a party's offer for that specific IDR dispute.
    - Avoidance of Double-Counting Information. When considering the additional information, the IDR entity should consider whether that additional information was already accounted for in the QPA calculation, to avoid counting the same information twice. Under the process laid out in the Final Rule, IDR entities will consider the QPA (a quantitative figure) and then evaluate whether the QPA adequately reflects the additional likely-qualitative, subjective factors to determine which offer best reflects the value of the item or service in dispute.
    - Prohibited Factors. The Final Rule retains the requirement that IDR entities ensure that additional information does not include information on any of the statutorily prohibited

factors, such as information about usual and customary charges, Medicaid reimbursement rates, and the amount that would have been billed if not for the prohibition on balance billing.

- **Payment Determinations under the IDR Process for Air Ambulance Services.** The Final Rule re-iterates that the requirement for IDR entities to consider the QPA and certain additional information also applies to determinations for air ambulance services. For air ambulance services, the additional information, if submitted by the parties or requested by the IDR entity, should relate to specific factors, including training, quality, and experience of the medical personnel that furnished the air ambulance, ambulance vehicle type, complexity of furnishing the service to the patient, population density of the point of pick-up, quality and outcomes measurements of the provider that furnished the services, and demonstrations of good faith (or lack thereof) by the disputing parties to enter into network agreements, as well as contracted rates between the parties during the previous four years (if any).

- **IDR Entities Must Provide Written Explanations for All Final Payment Determinations.** The Final Rule requires IDR entities to submit to the Department of Health and Human Services and the disputing parties a written statement detailing their reasons for a determination of an OON rate in all cases, instead of only when not choosing the QPA, as previously required.

Disclosure Requirements When "Downcoding"

The Final Rule requires group health plans and insurance providers to provide additional information to providers and facilities when "downcoding" a claim, which is defined as altering the service code or modifier to lower the QPA to an amount less than that billed by the provider or facility. In addition to the information already required with an initial payment or notice of denial of payment, the plan or insurance provider also must automatically provide a statement notifying the provider or facility that the service code or modifier billed by the provider or facility was downcoded, an explanation of why it was downcoded (including a description of which service codes and/or modifiers were altered, added or removed), and what the QPA would have been had the code or modifier not been downcoded.

The Final Rule clarifies that plans or insurance providers cannot require providers to use proprietary portals or web-based systems and may not deny receipt of a notice of initiation of an open negotiation period on that basis. The Final Rule also notes that if a provider or facility sends the standard notice of initiation of open negotiation to the email address identified by the plan or insurance provider in the notice of denial of payment or initial payment, that transmission would satisfy the requirement to provide notice to the opposing party. The FAQs outline processes related to initial payments, disclosures, and the open negotiation period, including reminding plans and insurance providers to send an initial payment or notice of denial of payment not later than 30 calendar days after an OON provider submits an invoice covered by the Act.

Balance Billing Disclosure to Participants on Public Website

The Act requires plans and issuers to make certain disclosures regarding balance billing to participants, beneficiaries, and enrollees on a public website, and the FAQs include an updated model notice. For a group health plan that does not have its own website (even if the plan sponsor does), the FAQs provide that the plan can satisfy its requirement for posting on a public website if the plan enters into a written agreement for the plan's service provider to post the required information on behalf of the plan. Nonetheless, the FAQs warn that if the service provider fails to post the required information on its public website, the plan remains liable under the Act. Employers should consider providing the updated model disclosure notices during their upcoming open enrollment season.

Additional Information

For additional information about requirements under the No Surprises Act or other transparency in health coverage rules, please contact any member of our Employee Benefits and Executive Compensation Practice Group listed below.

1945 Old Gallows Road, Suite 650
Tysons Corner, VA 22182
(703) 748-2690

1111 East Main Street, Suite 1605
Richmond, VA 23219
(804) 489-5507

Andrea I. O'Brien
aobrien@islerdare.com

Vi D. Nguyen
vnguyen@islerdare.com

Jeanne E. Floyd
jfloyd@islerdare.com

Grace H. Ristuccia
gristuccia@islerdare.com

Ashley F. Hedge
ahedge@islerdare.com