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Surprise billing final regulations issued

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The United States Departments of Health and Human Services (HHS), Labor and Treasury, or tri-agencies, recently issued final regulations revising certain aspects of the interim final regulations they had previously released implementing the surprise billing rules set forth under the No Surprises Act (NSA), which was adopted as part of the Consolidated Appropriations Act of 2021 (CAA).

The final rules are intended to address key issues critical to implementation and operation of the independent dispute resolution (IDR) process.

The final regulations focus on the following:

(1) The factors that an IDR entity should consider when making a payment determination as part of the IDR process;

(2) The requirements for an IDR entity's written decision; and

(3) The disclosures by plans and issuers regarding the qualifying payment amount (QPA) to address "downcoding."

Background

The concept of "surprise billing" refers to balance bills for services provided by out-of-network facilities in emergency situations, for services provided when a patient is treated by an out-of-network provider at an in-network facility, and for balance bills issued by out-of-network air ambulances.

The NSA prohibited surprise billing beginning in 2022. The NSA also established a new system for the payment to out-of-network providers and entities under surprise billing scenarios.

Under the new system, providers cannot send "surprise bills" to health plan participants. In most cases, participants can only be charged cost-sharing amounts based on the median in-network rate — the QPA — for the item or service at issue. Independently, health plans must make an initial payment to the out-of-network provider or facility in an amount determined by the plan.

If the provider or facility requests additional amounts under the plan, the parties must engage in an open negotiation period. If the payment amount remains disputed following such negotiation, either party can pursue federal IDR.

Under federal IDR, the arbitrator reviews the rate amounts proposed by the plan/issuer or provider/facility and determines the final out-of-network rate. In making the final determination, the IDR entity must consider various factors, including the QPA.

Payment determination for federal IDR entities

The Interim Final Regulations (IFR) Part II included detailed provisions regarding the process for determining the out-of-network rate under the NSA, including guidance for IDR entities when evaluating the two proposed payment amounts.

Under these rules, the Part II IFR stated that the IDR entity should select the offer closest to the QPA unless the certified IDR entity found that credible additional data submitted by either party clearly shows that the QPA materially differs from the appropriate out-of-network rate.

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Instead, the final regulations remove this aspect of the rules and instruct the IDR entity to select the offer that the IDR entity determines best represents the value of the item or service at issue. The final rules also amend and clarify the guidance for IDR entities regarding the factors to be considered when making the determination.

Factor one: QPA

First, the IDR entity must consider the QPA for the applicable year for the same or similar item or service. The QPA is a quantitative figure, as opposed to the other qualitative or more subjective information submitted. Although the IDR entity is not required to default to the offer closest to the QPA, the QPA will likely represent an appropriate out-of-network rate in most cases.

Factor two: specified additional information

Second, the IDR entity must consider additional information submitted by either party that relates to five specific circumstances, which are the same circumstances listed in the statute and in the Part II IFR. However, the IDR entity should not place weight on repetitive information submitted. The additional factors include the level of training and experience of the provider or facility and the acuity of the patient.

Factor three: information requested by the IDR entity

Third, the IDR entity must consider information provided by a party in response to a request from the IDR entity. Note that the information need only be considered if it relates to the payment determination and does not include prohibited factors. Factors prohibited from being considered are consistent with the statute (e.g., usual and customary charges, billed charges and public payer rates).

Factor four: other information

Finally, the IDR entity must consider information that either party submits on its own, but only if such information relates to the payment determination and does not include prohibited factors.

When evaluating information other than the QPA, the IDR entity must analyze whether the information is credible and relates to the offer submitted by either party for the payment amount for the item or service at issue. The IDR entity should not give weight to information that is not credible and if it is unrelated to either party's offer for the payment amount.

As mentioned above, the IDR entity should not give weight to information if it is already accounted for by the QPA or other credible information already considered. In many cases, factors such as patient acuity or the complexity of furnishing the qualified IDR item or service to the participant, will already be accounted for in the QPA calculation and should not receive additional weight.

Air ambulance

When an IDR entity determines the appropriate out-of-network rate for an out-of-network air ambulance service, the rules set forth above will generally apply; however, there are additional factors specific to air ambulance services that can be considered, including ambulance vehicle type and population density at the point of pick up.

Note that the Part II IFR instructed the IDR entity to only consider additional information if such information clearly evidenced that the QPA is materially different from the appropriate out-of-network rate.

In addition, for out-of-network air ambulance services, the IDR entity should assess whether the additional information is credible and relates to the offers submitted for the item or service and should not afford weight to the information if not credible or related — much like the process for emergency services.

Likewise, the IDR entity should not afford weight to additional information if it is already accounted for in the QPA or other information already submitted.

Written decision of federal IDR entity

Under the Part II IFR, an IDR entity was required to explain its determination in a written decision submitted to the parties and the tri-agencies, in a form and manner established by the tri-agencies. But under the Part II IFR, the IDR entity was only required to explain the credible information that they considered that demonstrated that the QPA was materially different from the appropriate out-of-network rate if the IDR entity did not select the offer closed to the QPA.

Rather, the final regulations require that an IDR entity's written decision include in its explanation: the rationale for the determination, including what information the IDR entity determined demonstrated that the offer selected best represents the value of the item or service at issue; the weight afforded the QPA; and any other credible information. To the extent the IDR entity relies on information other than the QPA, it is required to explain why it determined such information was not already reflected in the QPA.

Disclosures related to the QPA and 'downcoding'

Under the Part II IFR, when the QPA is the basis for cost-sharing (which is typically the case for self-insured plans), the plans and issuers are required to share certain information regarding the QPA with a provider or facility. Plans and issuers must provide some of the information automatically with the initial payment or notice of denial of payments and some of the information upon request by the provider or facility.

The final rules add a new three-part QPA disclosure to the disclosures required to be included with each initial payment or notice of denial of payment, in those cases where a plan or issuer reviews claims and alters services codes or modifiers submitted by the provider or facility to another service code or modifier that the plan or issuer determines is more appropriate. This process is known as "downcoding" when the adjustment results in a lower reimbursement amount.

The final rules require plans and issuers to include with each initial payment or notice of denial information regarding whether the QPA is based on a downcoded service code or modifier. If so, the plan or issuer must explain why and which modifiers or codes were altered, added or removed; and the amount that would have been the QPA had the service code or modifier not been downcoded.

Initiation of open negotiation

Under the NSA, if an out-of-network provider or facility wants to seek payment in addition to the initial payment made by the plan or issuer, such provider or facility must commence a 30-day open negotiation with the plan or issuer before proceeding to IDR.

In the preamble to the final regulations, the tri-agencies state that some plans are requiring providers or facilities to use a plan- or issuer-owned web system to initiate open negotiation.

The tri-agencies clarify that under the current rules, when a party to a payment dispute elects to initiate the open negotiation period, the party must use the standard notice issued by the tri-agencies and may satisfy the requirement to provide the notice to the opposing party electronically — to the email address provided with the initial payment or denial of payment. A plan or issuer cannot refuse to accept the standard notice of initiation of open negotiation from a provider or facility because such provider or facility did not use the plan's or issuer's online portal.

However, plans and issuers may encourage use of an online portal and can seek supplemental information through a supplemental open negotiation form.

Obstacles to implementation

At the end of September 2022, a new lawsuit was filed in federal court in Texas that threatens implementation of the final rules. The Texas Medical Association (TMA), joined by other plaintiffs, has challenged certain provisions in the new rules, and the case will be in front of District Judge Jeremy Kernodle, who ruled in TMA's favor in its previous lawsuit challenging the previous IFR. The American Hospital Association and the American Medical Association have joined the case as amici supporting TMA.

It is important to consider as well that both plans and providers need to be aware of their state laws governing surprise billing and negotiation of out-of-network rates. Regardless of the IFR's legal status, state law is applicable and a potentially big piece of the puzzle in determining how to comply with all the applicable regulations.

What this means to you

The regulations became effective 60 days after their publication in the Federal Register, which occurred October 25, 2022. The final regulations are applicable with respect to items or services provided or furnished on or after October 25, 2022, for plan years beginning on or after January 1, 2022.

Regarding the increased disclosures by plans and issuers for downcoded items and services, HHS, Labor, and Treasury recognized that such notices are often provided through automated systems that may require additional time to update. Plans and issuers may use reasonable methods to provide the additional disclosure with an initial payment or notice of denial of payment while the automated systems and procedures are updated.

The provisions of the Part I and Part II IFRs that were not revised by the final regulations remain in effect and were first applicable for plan years beginning on or after January 1, 2022.

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