akerman

Blog Post

Providers Get Unpleasant Surprise from Latest Provisions to the No Surprises Act

October 6, 2021
By Kirk S. Davis

Efforts to stop surprise medical costs are continuing to evolve. The Departments of Health and Human Services (HHS), Labor, and Treasury (collectively, the "Departments"), and the Office of Personnel Management issued an interim final rule (Interim Rule) with comment period on September 30, 2021 that implements provisions of the No Surprises Act. The majority of the provisions in the Interim Rule become effective January 1, 2022. The information in this blog is taken from the Interim Rule, unless otherwise noted.

The Interim Rule seeks to protect consumers by implementing various new measures, some of which are listed below:

- It requires providers, including physicians, providers of air ambulance services, and facilities (collectively, "providers") to offer good faith estimates of expected charges for items and services to uninsured or self-pay individuals (collectively, "self-pay individuals"). HHS understands it may take time for providers "to develop systems and processes for receiving and providing the required information" from co-providers. Therefore, for good faith estimates provided to self-pay individuals from January 1, 2022 through December 31, 2022, "HHS will exercise its enforcement discretion in situations

Related People

Kirk S. Davis

Related Work

Health Insurers and Managed Care Organizations
Healthcare
Healthcare Fraud and Abuse
Hospitals and Health Systems

Related Offices

Miami
Tampa

Health Law Rx

Akerman Perspectives on the Latest Developments in Healthcare Law

Visit this Akerman blog

where a good faith estimate" is provided a self-pay individual, but does **not** include expected charges from co-providers.

- It protects self-pay individuals from being billed an amount ***substantially in excess*** of the good faith estimate they received. "Substantially in excess" is defined as an amount that is at least $400 more than the provider's total amount of expected charges listed on the good faith estimate. Patients will be able to initiate a patient-provider dispute resolution process in these situations.
- It creates an Independent Dispute Resolution (IDR) process for group health plans and health insurance issuers (collectively "plans") and non-participating providers. The IDR process allows plans and non-participating providers to determine the out-of-network rate for items and services, including certain emergency, nonemergency, and air ambulance services.

Of the above provisions, the addition of the plan and provider IDR process, described in further detail below, has caused the most concern to providers.

Federal IDR Process for Providers and Plans

A Federal IDR process, similar to arbitration, will be established to allow plans and non-participating providers to resolve disputes regarding out-of-network rates. If a claim is made for certain out-of-network items or services and the non-participating provider cannot agree on the amount to be paid, a party has 30 days to open negotiations with the other party as to the out-of-network cost. If negotiations fail during that time period, either party may initiate the IDR process. A detailed timeline is included at the end of this blog.

The parties then jointly select a certified IDR entity. The IDR entity must attest that it does not have a conflict with either party. If the parties cannot jointly select an IDR entity, the Departments will select one for them.

No later than 10 days after the IDR entity is selected, the parties must each submit to the IDR entity an offer for a payment amount for the item or service being disputed. The IDR entity uses the information submitted by the parties to determine the appropriate out-of-network amount. However, and most controversial, is that the IDR entity is required to begin with the presumption that the qualifying payment amount (QPA) is the appropriate amount. In general, the QPA is the plan's median contracted rate for the same or similar service in the specific geographic area.

Uproar from Providers

The Interim Rule has been met with immediate opposition. On the same day it was released, the American Hospital Association (AHA) issued a statement that the "rule unfairly favors insurers to the detriment of hospitals and physicians who actually care for patients. These consumer protections need to be implemented in the right way, and this misses the mark." The American College of Radiology (ACR) shares AHA's sentiment that the Interim Rule is not in line with the intent of the law. The Chair of ACR's Board of Chancellors issued the following statement: "Making a health plan's calculated 'qualifying payment amount' — which does not reflect real world payment rates — the primary factor in independent dispute resolution arbitration will cause large imaging cuts and reduce patient access to care, regardless of their insurer."

Providers are concerned the Interim Rule will drive up the cost of healthcare instead of reducing it as the law intended. The American College of Emergency Physicians (ACEP) issued the following statement: "ACEP is deeply concerned that by requiring arbiters to greatly prioritize the artificially low [QPA] set by insurance companies, rather than giving equal weight to a mix of other factors, the new rule as written undermines the entire process."

Are More Surprises to Come?

There likely will be continued pushback against the Interim Rule in the days and months to come. The Interim Rule is expected to be published on the Federal Register on October 7, 2021. If it is published on that date, comments to the rule may be made until December 6, 2021.

It will be interesting to see whether the Departments make any changes based on the backlash from providers. In the meantime, to be compliant, providers and plans must put in place the necessary measures by the current effective date – January 1, 2022.

Important Open Negotiation and Independent Dispute Resolution Deadlines:

Independent Dispute Resolution Action	**Timeline**
Initiate 30-business-day open negotiation period	30 business days, starting on the day of initial payment or notice of denial of payment
Initiate independent dispute resolution process following failed open negotiation	4 business days, starting the business day after the open negotiation period ends
Mutual agreement on certified independent dispute resolution entity selection	3 business days after the independent dispute resolution initiation date
Departments select certified independent dispute resolution entity in the case of no conflict-free selection by parties	6 business days after the independent dispute resolution initiation date
Submit payment offers and additional information to certified independent dispute resolution entity	10 business days after the date of certified independent dispute resolution entity selection
Payment determination made	30 business days after the date of certified independent dispute resolution entity selection
Payment submitted to the applicable party	30 business days after the payment determination