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Final Rules Adopt Administrative Changes to the No Surprises Act

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On August 26, 2022, the Departments of Labor, Health and Human Services, and the Treasury (together, the "Departments") published final rules on the No Surprises Act, making changes to the administrative duties of insurance carriers, HMOs, third-party administrators, out-of-network healthcare providers, and certain other entities responsible for the Act's implementation.

The new rules, which take effect on October 25, 2022, are narrow in scope, and include the following changes:

- During processing of claims under the No Surprises Act, if "down-coding" occurs (i.e., the group medical plan alters or replaces the medical billing codes chosen by the out-of-network healthcare provider, resulting in a lower claim payment), then the final rules impose additional disclosure requirements on the plan.

- If a group medical plan and an out-of-network healthcare provider are unable to agree on the final claim payment under the No Surprises Act, and the dispute is referred to a certified independent dispute resolution entity ("IDR entity"), the final rules require the IDR entity to consider more evidence before making its decision, and to disregard any presumption in favor of the qualified payment amount ("QPA") (contrary to the position previously taken by the Departments).

Background

The No Surprises Act, which was enacted into law as part of the Consolidated Appropriations Act, 2021, generally limits out-of-network cost sharing, and prohibits balance billing, when participants in a group medical plan receive (1) emergency services from an out-of-network healthcare provider, (2) non-emergency services from an out-of-network healthcare provider at an in-network medical facility, or (3) air ambulance services.

The Departments then published interim final rules on the No Surprises Act in July 2021 and in October 2021. Certain aspects of the October 2021 interim final rules were subsequently set aside by a federal district court. Rather than appeal the court's decision, the Departments decided to alter the interim final rules, resulting in publication of the current rules.

Down-Coding

According to the final rules, "down-coding" occurs when the insurance carrier, HMO or third-party administrator for a group medical plan alters a medical billing code to another code, or alters, adds, or removes a modifier, if the changed code or modifier is associated with a lower claim payment compared to the code or modifier that was chosen by the out-of-network healthcare provider.

The final rules state that, whenever "down-coding" occurs under the No Surprises Act, the insurance carrier, HMO or third-party administrator for the group medical plan is required to furnish the following additional information to the out-of-network healthcare provider:

- A statement that the medical billing code or modifier chosen by the out-of-network healthcare provider was down-coded;
- An explanation of why the code or modifier was down-coded, including a description of which codes were altered (if any), and which modifiers were altered, added, or removed (if any); and
- The amount that would have been paid by the plan had the code or modifier not been down-coded.

Additionally, the final rules state that the Departments are responsible for monitoring the accuracy of claim payment calculations under the No Surprises Act and is committed to conducting audits for that purpose.

Determination of Claim Payments under Independent Dispute Resolution

Under the No Surprises Act, if the insurance carrier, HMO or third-party administrator for the group medical plan is unable to reach agreement with an out-of-network healthcare provider on the final claim payment (which is called the "out-of-network rate"), then either party may refer the dispute over the out-of-network rate to a certified independent dispute resolution entity. Then:

- Each party will make an offer regarding the out-of-network rate to the IDR entity, along with arguments in support of its offer.
- The IDR entity must select one of the two offers as the out-of-network rate for each item or service that is subject to the dispute.

Before the federal district court set aside portions of the interim final rules, the IDR entity began with the presumption that the QPA constituted a reasonable market-based payment for the relevant items and services. The IDR entity would

then evaluate additional information from the parties (subject to certain restrictions set forth in the interim final rules) before making its decision.

The final rules remove the presumption in favor of the group medical plan, and also remove certain restrictions on information that may be furnished by the parties in support of their offers. The final rules now specify that the IDR entity must consider all credible information submitted by the parties and determine which offer best reflects the appropriate out-of-network rate.

Examples of information that may be submitted to the IDR entity include the following:

- If the out-of-network healthcare provider is a Level 1 trauma center, the provider could furnish (a) information showing that the scope of services available at the facility was critical to the delivery of emergency services to the patient, given the patient's health condition at the time, and (b) information showing that the offer made by the group medical plan is based on emergency services from lower level facilities (i.e., not Level 1 trauma centers).

- If the out-of-network healthcare provider submits information showing that the patient's condition required the taking of a comprehensive history, a comprehensive examination, and a medical decision of high complexity, the group medical plan could respond with information showing that these factors are already included within the medical billing code chosen by the plan as the basis for its offer.

In addition, the final rules require the IDR entity to explain its payment determinations and underlying rationale in a written decision submitted to the parties and the Departments.

Employer Action

For fully insured group medical plans, the insurance carrier or HMO is responsible for complying with the final rules.

For self-funded group medical plans, the third-party administrator should be handling compliance with the final rules, although the employer or other plan sponsor is ultimately liable for any noncompliance. It will be important for the employer or other plan sponsor to monitor and confirm that the TPA is operating the plan in compliance with the final rules, especially in view of the Departments' promise to conduct audits of claim payment calculations under the No Surprises Act.