EDPMA 25 YEARS

No Surprises Act

Congressional Oversight of *No Surprises Act* Implementation

The Emergency Department Practice Management Association (EDPMA) is the nation's only professional physician trade association focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups of all ownership models and sizes, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. Together, EDPMA's members deliver (or directly support) health care for about half of the 146 million patients that visit U.S. emergency departments each year.

EDPMA asks Congress to actively oversee the implementation of the No Surprises Act to ensure achievement of legislative intent.

On December 27, 2020, the No Surprises Act (NSA) was enacted as part of the Consolidated Appropriations Act, 2021 (Public Law 116-260). The law was intended to protect patients from surprise bills for out-of-network services while giving providers and insurance companies an independent dispute resolution (IDR) process to settle disputes over payment amounts for these services. Unfortunately, implementation of the statute has been chaotic, provided limited opportunity for public input, and led to a dysfunctional IDR process where disputes are bottlenecked, seriously impacting cash flow for physician practices and undermining our nation's emergency services safety net.

Given the January 1, 2022 effective date of most provisions under the statute, the U.S. Departments of Health and Human Services, Labor, and Treasury, with the Office of Personnel Management (the Departments), have proceeded to implement the law via several rulemaking vehicles, including:

- Requirements Related to Surprise Billing; Part I interim final rule with comment (86 Fed. Reg. 36,872 (July 31, 2021))
- Requirements Related to Surprise Billing; Part II interim final rule with comment (86 Fed. Reg. 55,980 (October 7, 2021))
- Requirements Related to Surprise Billing final rule (87 Fed. Reg. 52,618 (August 26, 2022))

The Departments have also issued an abundance of subregulatory guidance documents without providing opportunity for public input, yet missed the statutory rulemaking and implementation deadlines for other provisions (e.g., insurance ID card requirement and plan obligations to provide patients with an advanced explanation of benefits).

[1] Redacted data must be at least 3 months old; at least 5 data contributors per published dataset; no group contributing more than 25% of a data set; raw data only reviewed by a third-party independent consultant.
[2] https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf

Qualifying Payment Amount

One of the most detrimental aspects of NSA implementation centers on the "Qualifying Payment Amount" (QPA), which was established and defined by the statute as the median of a health plan's contracted rates for a particular item or service by insurance market and in a particular geographic area. The NSA further specified that a plan's QPA should reflect the median contracted rates for a provider in the same or similar specialty as the billing practitioner. Moreover, the statute relies on the QPA for only two purposes: (1) for defining patient cost-sharing protections when no state law governs; and (2) as one of the criteria for arbiters to consider in disputes eligible for federal IDR.

However, EDPMA members have found that the insurers' QPAs do not reflect market-based, contracted rates. Worse still, health plans are relying on these flawed QPAs beyond the two contemplated by the statute, including to pay providers at the QPA amount even though the statute sets no payment benchmark. The issues resulting from this are compounded by consistent health plan failures to actually pay the amounts owed in the timeframes specified in law and regulation, after a payment determination is made by IDR arbiters.

Dramatic fee Increase for Independent Dispute Resolution

Most recently, ***the Departments instituted a sudden sevenfold increase in the administrative fees that providers must pay to make use of the IDR process, putting in place a barrier that prevents the use of the IDR process.*** This fee, which skyrocketed from $50 to $350 for an individual dispute, is particularly egregious for disputes involving physician emergency visits where the total payment is less than $350 and the amount in dispute even smaller. For additional details, we see the letter we submitted to the Departments on this issue.

Impact of Ongoing Litigation

Due to these and other issues, providers have turned to the courts for relief. The Texas Medical Association (TMA) has filed several lawsuits in federal court related to the NSA, each of which centers on a different aspect of implementation:

- TMA I successfully challenged an interim final rule establishing a rebuttable presumption that the offer closest to the QPA should be chosen. The court found that this violated the express provisions of the NSA, which established the QPA as one of many factors in federal IDR. As a result, the Departments went back to the drawing board. In August 2022, they issued a final rule, replacing the court-vacated provisions with new requirements for arbitrators.
- TMA II[1] successfully challenged portions of that final rule, arguing that they unlawfully conflicted with the NSA in the same manner as before: they improperly restricted arbitrators' discretion and unlawfully tilted IDR in favor of the QPA. As a result of the TMA II decision, effective February 6, 2023, the Departments instructed certified IDR entities that they should not issue new payment determinations until receiving further guidance. Subsequently, the Departments instructed IDREs to begin payment determinations under previous guidance the Departments believe is in compliance with the TMA I and II court rulings, but only for disputes related to services provided prior to October 25, 2022.

[1] 6:22-cv-372-JDK (E.D. Tex. Feb. 6, 2023).

- TMA III challenged the methodology that the Departments enacted for calculating the QPA. The case is focused on the flaws in implementation that have resulted in QPAs that are not reflective of median market rates, thus conflicting with the statute and severely disadvantaging providers in their negotiation and IDR positions.
- TMA IV, filed on January 30, challenges the Departments' recent sevenfold increase in administrative fees for use of the IDR process. The complaint argues that the new fees are a functional barrier to IDR, particularly for specialties with small-value claims, such as radiology.

REQUESTS

EDPMA requests that Congress

- Write CMS to request immediate correction of the significant IDR process problems that are risking provider practices and the viability of the health care safety net, and strongly reiterate that Congress expects implementing regulations to be consistent with the letter and spirit of the law.
- Schedule oversight hearings that include CMS officials and health plan representatives to investigate implementation issues, including both IDR process issues and policy issues promulgated by regulations;
- Request that all required but remaining unresolved implementation issues be immediately addressed via appropriate rulemaking with notice and comment periods;
- Request information and data from CMS regarding any ongoing health plan audits, the results of those audits, and safeguards for providers who lost in arbitration where failed audit QPAs were utilized; and
- Demand the Departments issue the 2022 versions of the reports mandated by the NSA: "REPORTS.—Beginning for 2022, the Secretary shall annually submit to Congress a report on the number of plans and issuers with respect to which audits were conducted during such year pursuant to this subparagraph."[2]

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[2] 42 USC §300gg-111(a)(2)(A)(iii); 26 U.S. Code §9816§300gg-111(a)(2)(A)(iii).