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No Surprises Act Déjà Vu: New Texas Medical Association Lawsuit

The saga between health care providers and the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury ("Departments") continues as the parties are poised, yet again, to fight in court about the appropriate standard that arbitrators must use when determining the rate for out-of-network health care provider services under the No Surprises Act ("NSA"). Once again, a group of providers has filed litigation against the Departments claiming that the rules unfairly tilt the playing field against them in favor of payors and artificially depress their reimbursement rates.

This new lawsuit creates yet more uncertainty as to the correct process for setting out-of-network reimbursement rates under the NSA. Providers should watch closely how it develops to see what the final standards will be.

In a previous client alert, we discussed the holding in *Texas Medical Association v. United States Department of Health and Human Services, et al. ("TMA I"),* a case that invalidated key portions of regulations implementing the out-of-network rate-setting arbitration process mandated by the NSA. In *TMA I,* the Eastern District of Texas vacated the Departments' interim final regulation requiring independent dispute resolution ("IDR") entities to employ a rebuttable presumption in favor of the negotiating position closest to the median in-network rate as represented by the payor, referred to as the qualifying payment amount or QPA.[1] The court held that this presumption conflicted with the NSA's plain text, which listed a series of factors (only one of which was the QPA) to be considered in determining an appropriate out-of-network rate, none of which were entitled to greater weight than the others.[2] *TMA I* further held that the "Departments' interpretation of the statute" was "owed no" deference because the NSA already "sp[eaks] clearly on the issue relevant here" by "unambiguously establish[ing] the framework for deciding payment disputes."[3]

Just a few months after the Eastern District of Texas decided *TMA I,* the Departments issued new regulations governing the arbitration process to determine out-of-network rates under the NSA. And once again, the Texas Medical Association ("TMA") has filed suit to challenge these regulations on grounds that they still unfairly weight the QPA and unfairly favor payors.

BACKGROUND

The NSA was enacted to protect consumers from large, often unpredictable, bills for out-of-network emergency care services or non-emergency services provided by an out-of-network provider at an in-network facility. Under the NSA, in these "surprise billing" situations, consumers are generally only liable for the in-network cost-sharing payment. The out-of-network provider and the health plan are then tasked with negotiating an appropriate reimbursement rate for these out-of-network services. If the provider and the health plan fail to reach a resolution, the NSA provides for "baseball arbitration," administered by the Centers for Medicare and Medicaid Services ("CMS"), in which the arbitrator must choose between the parties' competing rate proposals.

To guide the arbitrator in making this decision, the statutory text of the NSA lists six factors that arbitrators "shall consider" in determining the appropriate out-of-network rate:

(1) The qualifying payment amounts [*i.e.,* the median in-network rate]
(2) The level of training, experience, and quality and outcome measurements of the provider or facility that furnished the…item or service,
(3) The market share held by the provider or facility in which the…item or service was provided,
(4) The acuity of the recipient of the…item or service,
(5) The teaching status, case mix, and scope of services of the facility that provided the…item or service, and
(6) Demonstration of good faith efforts (or lack thereof) made by the provider, facility, or plan to enter into network agreements with each other.

After their initial attempt at a rulemaking for NSA arbitrations was rejected in *TMA I,* on August 19, 2022, the Departments released a new Final Rule setting out an arbitrator's ability to consider and apply these factors.

TMA II: TMA CHALLENGES THE AUGUST 2022 FINAL RULE

On September 22, 2022, TMA filed a complaint against the Departments challenging the August 2022 Final Rule. Specifically, TMA challenges four aspects of the newly published regulations.

First, TMA challenges the Final Rule alleging that it, like the previously rejected interim final rule, wrongly requires arbitrators to prioritize the QPA in violation of the NSA's plain language. In particular, the Final Rule requires arbitrators to consider the NSA first and then only later to consider the other statutory factors.

Second, TMA argues that the Final Rule exempts the QPA from the credibility requirements that other NSA factors are subjected to.[4] This assertion stems from the fact that the QPA amount is unilaterally calculated by the payor without any transparency, while the other factors are to be weighed in part based on the credibility of their supporting information.[5] TMA alleges that because there is little oversight on how payors calculate the QPA, such a provision is manifestly unlawful and would unfairly skew IDR results in the insurer's favor, which would "grant them a windfall they were unable to obtain in the legislative process."[6]

Third, TMA contends that the Department's new regulations require arbitrators to evaluate all information—except for the QPA—to determine whether it "relates to the offer[s] submitted."[7] TMA further asserts that the Final Rule prohibits arbitrators from giving weight to any other information—including information on the "additional circumstances" that Congress already mandated arbitrators "shall consider"—if it "does not relate to either party's offer."[8] TMA alleges that this portion of the regulation directly contradicts language expressly written in the NSA.[9]

Finally, TMA challenges aspects of the Final Rule that purportedly prohibit arbitrators from giving weight to any information revealed through the process of exploring the additional factors enumerated under the NSA to the extent the information is "already accounted for by the [QPA]."[10] TMA asserts that this requirement is unreasonable because it fails to "explain how IDR entities or providers would determine whether the QPA had already accounted for a piece of information, given that the QPA is a figure calculated in secret by the insurer and is transparent to the insurer alone."[11]

For additional information or assistance, contact Barak A. Bassman, Triston Chase O'Savio, or another member of Blank Rome's Healthcare industry group.

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1. T*ex. Med. Ass'n v. United States HHS,* 2022 WL 542879, at *1, *15 (E.D. Tex. 2022)
2. *Id.*
3. *Id.* *7-8.
4. *Id.* at ¶ 60.
5. *Id.* at ¶ 79.
6. *Id.* at ¶ 10.
7. *Id.* at ¶ 60.
8. *Id.* at ¶ 61.
9. *Id.* at ¶ 3.
10. *Id.* at ¶ 62.
11. *Id.*

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