Implementation of the No Surprises Act

Overview

On Dec. 27, 2020, the No Surprises Act (NSA) was signed into law as part of the Consolidated Appropriations Act of 2021. These provisions were intended to address unexpected gaps in insurance coverage that result in “surprise medical bills” when patients unknowingly obtain medical services from physicians and other providers outside their health insurance network.

Because the No Surprises Act, which takes effect on Jan. 1, 2022, imposes limits and confers some rights on physicians caring for patients in these situations, it is important for physicians to understand how the law will affect them.

Read the AMA’s summary of the NSA (PDF).

Toolkits for physicians

Access an initial toolkit (PDF) for physicians on implementation of the No Surprises Act (NSA). Many of the provisions of the NSA take effect on Jan. 1 and this document provides guidance on several of those provisions. The AMA will be updating this document as additional guidance is available, as well as developing new resources on the remaining provisions of the NSA not included in this toolkit.

Access a second toolkit (PDF) for physicians on implementation of the billing process for certain out-of-network care under the No Surprises Act (NSA). The AMA will be updating this toolkit as additional information becomes available and changes to existing guidance are issued, including guidance related to the Independent Dispute Resolution process.

Status of lawsuits

The Departments issued an Interim Final Rule (IFR) in September (the September Rule) outlining the processes for payers and health plans to settle disputes over out-of-network payments, beginning with

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an initial payment or notice of denial, followed by an open negotiation period and the formal IDR process, if pursued. Unfortunately, this rule directs the IDR entities to presume that the Qualifying Payment Amount (QPA) (considered the plan's median in-network rate) is the appropriate out-of-network rate. Under the September Rule, other factors relevant to payment and enumerated in the statute are only to be considered in limited circumstances, despite no statutory language creating this presumption.

The AMA and the American Hospital Association (AHA) filed a complaint (PDF) and motion for a stay or for summary judgment (PDF) on Dec. 9, 2021, in the U.S. District Court for the District of Columbia. arguing that the September Rule conflicts with the NSA by establishing a presumption in favor of the QPA. The text, context, purpose and history of the NSA make clear that the statutory IDR procedure Congress created leaves no room for the agencies to require the arbitrator to put a thumb on the scale in favor of health insurers over providers.

On Jan. 24, the government responded (PDF) to the AMA/AHA complaint, making the following arguments (among others):

- Congress had two purposes in enacting the NSA—to protect patients and control health care costs—and the Departments issued the September Rule with these two purposes in mind.
- The September Rule directs arbitrators to determine which offer to accept based on a particular decision-making sequence (QPA first, then the "additional" factors). The agencies did not explicitly create a "presumption" in favor of the QPA. Because the non-QPA factors are described as "additional circumstances," moreover, they are subordinate to the QPA.
- The overall statutory scheme demonstrates Congress's expectation that the QPA would serve as a proxy for the in-network price, and that the in-network price would ordinarily be the appropriate payment rate. That is especially true because the QPA already accounts for many of the non-QPA factors.
- Congress delegated decision-making authority to the Departments, not the arbitrators, to decide how to weigh the QPA factors. Under the Departments' reading of the NSA, arbitrators' discretion would be "unfettered."
- The agencies are owed *Chevron* deference (i.e., generally, that the court should defer to the agencies' interpretation of the statutory language) because, at the very least, theirs is a permissible reading of the NSA. They are also owed deference because Congress specifically delegated to the Departments the authority to establish the IDR process.

The AMA/AHA responded (PDF) to the government's response (PDF) on Feb. 8 and made the following arguments (among others):

- The government cannot run away from the QPA presumption they established in the September Rule. That presumption conflicts with the act's unambiguous text:

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    - The text requires the arbitrator to consider all listed factors, and the arbitrator—not the Departments—has discretion to weight those factors.
    - Moreover, “additional” does not mean subordinate.
- The QPA presumption conflicts with the act’s context—the NSA does not suggest Congress expected the QPA ordinarily to be the appropriate payment rate.
- The QPA presumption undermines congressional intent—Congress intended to protect patients but also balance the interests of providers and insurers. The QPA presumption puts a thumb on the scale in favor of insurers.
- The QPA presumption is unnecessary to achieve cost savings. Regardless, the government overemphasizes the importance of cost reduction to the NSA.
- The agencies are not owed *Chevron* deference because the government interpretation is contrary to the act’s plain and unambiguous meaning. Congress did not delegate authority to the agencies to direct the arbitrator on how to select appropriate payment rates.
- AMA/AHA members will suffer severe harm due to the September Rule and thus swift action is needed.

On March 21, the U.S. District Court for the District of Columbia (DDC) held a hearing on the AMA/American Hospital Association (AHA) lawsuit challenging a narrow provision of the No Surprises Act Interim Final Rule (IFR) that implemented the Independent Dispute Resolution (IDR) process for resolving payment disputes between health plans and physicians/facilities. The provision being challenged is the IFR’s requirement that IDR entities (arbiters) presume that the Qualifying Payment Amount (QPA)—which is essentially the median in-network rate—is the appropriate out-of-network payment amount unless a party submits credible information that clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate. This rebuttable presumption weighs in favor of health plans.

The AMA/AHA argue that the federal Departments (Health & Human Services, Labor, Treasury and Personnel Management) that issued the IFR acted contrary to law and beyond their statutory authority by mandating a presumption in favor of the QPA.

The AMA/AHA lawsuit is substantively similar to the lawsuit brought by the Texas Medical Association in the U.S. Federal District Court for the Eastern District of Texas. In February, that court found in favor of TMA and vacated the provisions in the IFR that weighted the IDR process in favor of health plans. Of note, for the purposes of the DDC hearing, the DDC Judge combined the AMA/AHA lawsuit with a similar lawsuit brought by the Association of Air Medical Services (AAMS), although AAMS is also challenging a separate IFR involving the methodology of how the QPA is calculated.

Prior to issuing a ruling, the DDC Judge will be considering supplemental briefs on the issues raised during the hearing, including the AMA/AHA’s supplemental brief (PDF). A decision is not expected until after mid-April.

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Interim Final Rule (Part I)

On July 1, 2021, the Departments of Health and Human Services (HHS), Department of Labor (DOL) and Department of Treasury (the Departments) and the Office of Personnel Management (OPM) issued an interim final rule (IFR) (PDF) implementing several provisions of the NSA, enacted as part of the Consolidated Appropriations Act, 2021 (CAA).

Given statutory timeframes required under the NSA and the pending implementation of most provisions by Jan. 1, 2022, the Departments made the decision to issue an IFR. As a result, the requirements outlined in the IFR are final and will become effective on Sept. 13, 2021.

In general, the IFR provides the following:

- In determining how the qualifying payment amount (QPA) is calculated, the IFR reduces the likelihood that plans will need to use data from outside, independent databases. This is done through broad definitions of “markets” and “geographic regions,” allowing reliance on small data sets, benchmarking for “new service codes,” etc.
- Reduces the role of bonuses, risk sharing, penalties and other incentive-based and retrospective payments or payment adjustments in the calculation of the QPA.
- Establishes a structure for the interaction of state and federal surprise billing requirements, where state law preempts federal law when either a set payment amount or dispute resolution process is in place for state-regulated plans and, when applicable, self-funded Employee Retirement Income Security Act (ERISA) plans that opt-in to the state law.
- Outlines a process by which a patient receives notice and potentially provides consent to receive out-of-network care and forgo the financial protections of the NSA.
- Establishes criteria for facilities and physicians/providers to provide required disclosure to patients about balance billing protections—both state and federal.
- Broadens complaint processes for patients, physicians and plans.
- Reaffirms several patient protections for emergency medical care, including the prudent layperson standard.

The AMA has several concerns about the way the QPA (median contracted rate) will be determined. Additionally, while the Departments attempt to consolidate and standardize some administrative requirements on physicians, in other areas the Departments expand requirements in ways that may not benefit patients but result in burdens on physicians.

Download the PDF for part one of the summaries on the IFR of the No Surprises Act.

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AMA comments (PDF) to the Departments on IFR Part I.

Interim Final Rule (Part II)

On September 30, 2021, the Departments issued a second IFR implementing the NSA. This IFR implements the following parts of the NSA:

- The open negotiations and independent dispute resolution (IDR) processes between providers (physicians, hospitals, etc.) and health plans.
- Section 110 of the NSA expanding the scope of the federal external review process to cover adverse benefit determinations under the NSA.
- The good faith estimate (GFE) requirements for uninsured patients and patients who are not planning to use their coverage (i.e., self-pay).
- The dispute resolution process for uninsured or self-pay patients when the GFE significantly exceeds the costs of care.
- Establishes a federal IDR portal to be used for IDR entity (IDRE) certification, the initiation of the IDR process, the selection of an IDRE by parties, the submission of supporting documentation to IDREs and the submission of IDRE reporting metrics.

The AMA has serious concerns with several provisions of IFR Part II, including the way in which the dispute resolution process is structured. The IFR establishes the qualifying payment amount (QPA) as a presumptively reasonable out-of-network payment and directs the IDR entities to select the offer closest to the QPA unless credible information submitted by the parties clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate.

With this requirement, the Departments are underscoring their objective to reduce the frequency with which the IDR is used and ultimately bringing down the in-network rates of providers. Although the QPA is meant to represent the median in-network rate, the method used to calculate it (as outlined in Part I IFR), will often result in much lower amounts. Together, the Part I and Part II IFRs will make it more difficult for physicians to receive fair payment for out-of-network services and to enter into meaningful contract negotiations with health plans which now have little incentive to offer fair contracted rates.

Download the PDF for part two of the summaries on the IFR of the No Surprises Act.

Notice of proposed rulemaking: Enforcement provisions

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On Sept. 10, 2021, the Departments issued a proposed rule to implement additional components of the NSA. Of importance to physicians as it relates to the NSA, the proposed rule would establish a similar enforcement structure over providers to that established under the Affordable Care Act (ACA), allowing states to enforce NSA provision to the extent of their authority and, if a state fails to substantially enforce the requirements, the federal government will step in.

AMA comments (PDF) on the proposed rule.

Correspondence about the No Surprises Act implementation

March 2022

- **March 7:** AMA comments on the administrative burden (PDF) associated with the Good Faith Estimate requirements under the NSA.

Dec. 2021

- **Dec. 6:** AMA comments on NSA IFR Part II (PDF) urging revisions to the independent dispute resolution process.

Nov. 2021

- **Nov. 17:** Medical association sign-on letter (PDF) to Departments urging changes to IDR process in IFR Part II.
- **Nov. 5:** Congressional sign-on letter (PDF) to Departments urging changes to IFR Part II to align the law's implementation with the legislation Congress passed.

Oct. 2021

- **Oct. 18:** Comment letter (PDF) proposed rules implementing certain provisions of Title I (No Surprises Act) and Title II (Transparency) of Division BB of the Consolidated Appropriations Act, 2021 (CAA).

Sept. 2021

- **Sept. 7:** Comment letter (PDF) on the July 12, 2021, Interim Final Rule (IFR): Requirements Related to Surprise Billing; Part I, implementing provisions of the No Surprises Act (NSA).

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Aug. 2021

- **Aug. 11:** Comment letter (PDF) to CMS on implementation of the No Surprises Act, advanced explanation of benefits and good faith estimates.

June 2021

- **June 17:** Congressional sign-on letter (PDF) to Departments, urging to "reflect congressional intent in your rulemaking by ensuring a balanced process to settle payment disputes between health plans and providers," in regard to the NSA.
- **June 14:** Comment letter (PDF) to CMS administrator on IDR process.

May 2021

- **May 21:** Comment letter (PDF) to CMS acting administrator on QPA and related calculations in the NSA.

Webinars on the No Surprises Act

AMA Advocacy Insights webinar series: Implementing the No Surprises Act

During the premiere AMA Advocacy Insights webinar, experts discuss the implementation of the NSA, including issues addressed in the AMA's surprise billing toolkit, enforcement challenges and the interaction between state and federal surprise billing requirements.

AMA Advocacy Insights webinar series: Out-of-network payment process under the No Surprises Act

As a follow-up to the first NSA webinar, this AMA Advocacy Insights webinar focuses on the payment process for physicians and other providers in surprise medical billing situations.

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