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Texas District Court Vacates Portions of No Surprises Act Rule Related to Arbitration

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On February 23, 2022, Judge Jeremy Kernodle of the Eastern District of Texas ruled that certain parts of the Interim Final Rule Part II (the Rule) implementing the No Surprises Act (the Act) are invalid. Specifically, the provisions of the Rule governing the methodology for how arbitrators determine the amount of payments insurers and self-funded health plans (collectively, insurers) will make to nonparticipating (also known as out-of-network) providers for certain services. The lawsuit was brought by the Texas Medical Association and three of its physician members against the federal agencies that promulgated the Rule. This lawsuit is one of several around the country challenging the Rule.

Broadly speaking, the Act prohibits insurers from charging members more than in-network cost sharing amounts in certain situations, as well as prohibits out-of-network providers from balance billing patients for certain medical services. The scope of the Act includes:

1. Emergency services (including ancillary services and post-stabilization services),

2. Nonemergency services furnished by nonparticipating providers at participating facilities, and

3. Air ambulance services

The Act also set up an independent dispute resolution (IDR) process by which out-of-network providers and insurers are required to arbitrate the payment rates for emergency services provided by a nonparticipating provider, nonemergency services furnished by nonparticipating providers at participating facilities, and air ambulance services. The Health and Human

Services, Department of Labor, Treasury Department, and Office of Personnel Management (the Departments) jointly issued two rules implementing the Act. The Departments issued the Interim Final Rule Part II on September 30, 2021, and its provisions went into effect on January 1, 2022.

In this IDR process, providers and insurers each submit a proposed payment amount and explanation to an arbitrator. The arbitrator must choose, in a "baseball style arbitration," the final payment amount for the out-of-network services. Under both the Act and the Rule, the arbitrators will consider numerous factors in determining the out-of-network rate, including what is called the Qualified Payment Amount (QPA). The QPA is, essentially, the median rate the insurer would have paid for the item or service if it was provided by an in-network provider or facility. In deciding the final payment amount an insurer is required to pay for the item or service being arbitrated, the Rule requires the arbitrator to presume the QPA is the correct amount unless the provider presents credible information otherwise.

The court held that the Rule's presumption that the QPA is the correct amount and the requirement for the arbitrator to give more weight to the QPA over other permissible factors conflicted with the "unambiguous terms of the Act." The court vacated that portion of the Rule. According to the opinion, the court directs arbitrators to defer to the Act's express language regarding the various factors to be considered in making their decisions in arbitrations, which are set to begin in March. The court also determined that the Departments improperly bypassed the notice and comment period under the Administrative Procedure Act when implementing the Rule. Part II of the Interim Final Rule is remanded to the Departments for review and reconsideration.

This ruling is generally applicable, meaning that the portion of the Rule regarding QPA presumption and weighting is vacated throughout the country.

Contact us

If you have questions about this update and how it might affect your business, contact Ellee Cochran, Craig Kovarik, Tracey O'Brien, Noreen Vergara, Mark Waterbury or your Husch Blackwell attorney.