SPECIAL REPORT

NO SURPRISES ACT UPDATE: THE *TMA III* DECISION

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INTRODUCTION

The Texas Medical Association and additional plaintiffs have brought four Administrative Procedure Act (APA) challenges to the rules and guidance implementing the No Surprises Act (NSA) (termed *TMA I, II, III* and *IV*). The plaintiffs filed all four challenges in the US District Court for the Eastern District of Texas, Tyler Division. District Judge Jeremy Kernodle heard all four actions and released his opinion in *TMA III* on August 24, 2023. The US Department of Justice (DOJ) has not yet stated whether it will appeal or seek a stay of *TMA III*. If *TMA III* stands, it will have a significant impact on processing and payment of out-of-network claims, out-of-network cost sharing paid by patients and operation of the federal independent dispute resolution (IDR) process. This report summarizes the *TMA III* court decision and assesses the potential next steps available to the US Departments of Health and Human Services, Labor and Treasury (the Departments).

BACKGROUND

The plaintiffs in *TMA III* challenged the following:

1. The Departments' rule and subsequent guidance[1] on how plans and issuers calculate the qualifying payment amount (QPA). The QPA is typically the plan or issuer's median contracted rate. Plaintiffs argued that the regulations and guidance permit plans and issuers to artificially depress the QPA, tilting the IDR process in their favor and resulting in unacceptably low payments to providers.
2. The disclosure requirements for plans and issuers. Plaintiffs argued that the requirements are insufficient and prevent effective review of plans and issuers' calculations of the QPA.
3. Additional regulations and guidance on issues affecting air ambulance providers, including the exclusion of single case agreements from QPAs for air ambulance services, the deadline for plans and issuers to make an initial payment determination, and the use of two arbitration proceedings to adjudicate a single air transport.

The district court held that rule and guidance on the following issues were unlawful and vacated them:

- **Including "ghost rates" in the calculation of QPAs**. The district court held that the NSA requires insurers to calculate the QPA using only rates for items and services that are actually furnished or supplied by a provider, not those that a provider has not furnished or never supplied. By permitting insurers to include "ghost rates" in calculating the QPA, the Departments' rules and guidance conflicted with the NSA.
- **Including out-of-specialty rates in the calculation of QPAs**. The NSA requires insurers to always calculate the QPA based on the rates of providers "in the same or similar specialty."[2] The Departments' rule[3] , however, directed insurers to calculate rates by specialty "only where the [insurer] otherwise varies its contracted rates based on provider specialty," as part of its "usual business practice." The Departments' subsequent FAQs stated that insurers need not separately calculate rates by specialty unless insurers "purposefully" vary "contracted rates based on provider specialty" or determine "that there is a material difference in the median contracted rates . . . between providers of different specialties."[4] The district court found that the rule and guidance deviated from the plain text of the NSA by allowing insurers to include out-of-specialty rates in calculating the QPA.
- **Excluding risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments from the calculation of QPAs**. The NSA states that the QPA is "the median of the contracted rates recognized by the plan or issuer . . . as the total maximum payment . . . under such plan or coverage," without exclusions or exceptions. According to the district court, the text of the NSA requires insurers to calculate the QPA using the "entire" "highest possible" payment that a provider could receive for an item or service

[1] The QPA methodology was established in the first interim final rule implementing the NSA, released in July 2021: Requirements Related to Surprise Billing: Part I, 86 Fed. Reg. 36,872 (July 13, 2021). In August 2022, the Departments answered a series of "frequently asked questions" related to various provisions in the July 2021 rule. *FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55* (Aug. 19, 2022).

[2] 26 U.S. Code § 9816(a)(3)(E) of the Code, section 716(a)(3)(E) of ERISA, section 2799A-1(a)(3)(E) of the PHS Act.

[3] Requirements Related to Surprise Billing: Part I, 86 Fed. Reg. 36,872 (July 13, 2021).

[4] *FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55* (Aug. 19, 2022), Question 14.

under the contracted rate. The exclusion of incentive-based payments from "the total maximum payment" conflicted with the NSA.

- **Allowing a self-insured group health plan to use rates from all plans administered by its third-party administrator in calculating the QPA**. The NSA defines the QPA to mean "the median of the contracted rates recognized by the plan or issuer, respectively (determined with respect to *all* such plans of *such sponsor* . . . that are offered within the same insurance market . . .)" According to the district court, the NSA requires plans and issuers to calculate QPAs using the rates of "all such plans of such sponsor." The Departments' rule permitted self-insured group health plans, "at the option of the plan sponsor," to "allow their third-party administrators to determine the QPA for the sponsor by calculating the median contracted rate using the contracted rates recognized by all self-insured group health plans administered by the third-party administrator (not only those of the particular plan sponsor)." The district court therefore found that the rule was not "in accordance with the law."
- **Starting the 30-day deadline for payment or notice of denial of payment when the plan or issuer receives the information "necessary to decide a claim."** The NSA requires the plan or issuer to send its initial payment or notice of denial of payment to the provider "not later than 30 calendar days after the bill for such services is transmitted to the provider." The district court found that the NSA is unambiguous and provides no exceptions. The Departments' rule nonetheless stated that the 30-day deadline "begins on the date the plan or issuer receives the information necessary to decide a claim for payment for the services." The district court therefore vacated the rule on the ground that it was contrary to law.
- **Requiring two separate IDR processes for a single medical air transport**. The NSA states that "the term 'air ambulance service' means medical *transport* by helicopter or airplane for patients." If negotiations between the air ambulance provider and the insurer fail, the statute provides that the parties "may . . . initiate the independent dispute resolution process . . . with respect to *such item or service*." In August 2022, the Departments issued guidance stating that "multiple qualified IDR items or services" can be consolidated, or "batched," into a single IDR only if, among other requirements, each service is "billed under the same service code." Because a single air ambulance transport requires two service codes—one code for the base rate and one for mileage—the Departments informed IDR entities that disputes about air ambulance payments would require two IDR processes. The district court held that the guidance was contrary to the unambiguous text of the NSA.
- **Excluding case-specific or single-case agreements from the calculation of air ambulance service QPAs**. The NSA defines the QPA as the "median of the contracted rates recognized by" an insurer "under such plans or coverage." Many "case-specific" or "single case" agreements for air ambulance services—which pay a specific rate for an air ambulance transport for the plan's or issuer's beneficiaries, participants or enrollees—fall within the statutory definition. The district court found that the Departments' rule excluding such agreements from the QPA was contrary to the text of the NSA.

The district court declined to vacate the provisions of the Departments' rule governing plans' and issuers'

disclosures related to the QPA. The district court reasoned that the NSA gave the Departments wide latitude in issuing a disclosure rule, and the Departments showed that their rule was the result of reasoned decision-making. The Departments also established a complaint process for providers to question whether the QPA was calculated correctly.

IMMEDIATE AFTERMATH OF DECISION

The QPA serves two primary purposes under the NSA. First, it is the basis for calculating patient cost-sharing for out-of-network services.[5] Second, it is a circumstance for IDR entities to consider when selecting a party's offer in the federal IDR process.[6]

In concept, an IDR entity may adjudicate an IDR proceeding after *TMA III* without an updated QPA from the plan or issuer. The IDR entity weighs the QPA relative to other statutory circumstances and may assign comparatively low weight to the QPA based on *TMA III*. While plans and issuers may object to such an approach, the adjudication of the IDR proceeding has no impact on the patient.

The determination of cost sharing is different because it impacts the patient directly. If the plan or issuer calculates the QPA using an unlawful methodology, then the cost sharing determined by the plan or issuer may reflect the unlawful methodology. The patient may pay more or less in cost sharing than the patient would owe under a QPA calculated using a lawful methodology.

The Departments mooted the IDR-related concerns by promptly suspending the IDR process altogether. They have not yet announced any further next steps. They also have not provided any guidance related to how plans or issuers should determine patient cost-sharing.

Several legal and policy alternatives are available in the short term. First, the Departments may seek a stay of *TMA III* pending an appeal to the US Court of Appeals for the Fifth Circuit. If *TMA III* is stayed, then plans, issuers and IDR entities would continue to use existing QPAs. Second, the Departments may follow the district court's suggestion and exercise enforcement discretion for a fixed period of time while plans and issuers recalculate their QPAs consistent with *TMA III*. Plans, issuers and IDR entities would continue to use existing QPAs during the exercise of enforcement discretion. Third, the Departments may maintain the suspension of the IDR process until plans and issuers recalculate their QPAs consistent with *TMA III*. Fourth, the Departments may use some combination of suspension of the IDR process and enforcement discretion to do the same.

If the Departments decline to seek a stay, they must still decide whether to pursue an appeal of *TMA III*, conduct notice-and-comment rulemaking or do some combination of both on an issue-by-issue basis. Most of the district court's rulings in *TMA III* were on questions of statutory interpretation. Those rulings would be the starting point for any future notice-and-comment rulemaking absent a successful appeal.

The Departments have 60 days to file a notice of appeal under Federal Rule of Appellate Procedure 4(a)(1)(B). The resolution of any appeal may take years. It may

[5] These services include emergency services and non-emergency services performed by an out-of-network provider within an in-network facility. They do not apply to services by health plans that are governed by a state law regarding balance billing or surprise medical bill.

[6] The federal IDR process is conducted through "baseball-style" arbitration, where an independent arbiter, based on a review of factors, selects an offer from either party (the insurer or provider).

take even longer for the Departments to complete any future rulemaking because any appellate ruling would guide the rulemaking.

Only one thing is certain at this point: it will take considerable time for the many legal and policy questions presented by *TMA III* to be resolved. The path forward should become clearer over the course of the next 60 days, during which the Departments will most likely announce next steps and file any notice of appeal.

ONGOING REGULATORY PROCESS

The Departments are currently working on an IDR Operations Proposed Rule[7] and an IDR Process Fees Proposed Rule.[8] Both proposed rules are at the White House's Office and Management and Budget (OMB) for review. This internal governmental review stage is required before a rule is released publicly. Therefore, a rule in OMB clearance provides an indication to the public that the rule could be released soon, although there is no required timetable for its release. Further, once at OMB, the public can request meetings with OMB to discuss the rule.

We expect the IDR Operations Proposed Rule to address the batching issues that were litigated in *TMA IV*. It is unclear whether it will address the QPA methodology. The IDR Process Fees Proposed Rule may propose a new IDR administrative fee. Timing on these or other rules is extremely uncertain. In general, the finalization of a proposed rule may take as little as six to nine months, or several years.

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[7] More information on the Independent Dispute Resolution Operations Proposed Rule (CMS-9897) can be found here: https://www.reginfo.gov/public/do/eoDetails?rrid=326164.

[8] More information on the Federal Independent Dispute Resolution Process Fees Proposed Rule (CMS-9890) can be found here: https://www.reginfo.gov/public/do/eoDetails?rrid=329212.

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