Texas Federal Judge Sides with Providers in "No Surprises Act" Ruling

March 1, 2022

On February 23, 2022, Judge Jeremy D. Kernodle of the United States District Court for the Eastern District of Texas handed healthcare providers a significant preliminary victory when he issued an order (the "Order") invalidating key portions of an interim final rule (the "Rule") implementing the "No Surprises Act" (the "Act"). The Order vacates certain provisions of the Rule that—if implemented—likely would give health insurers leverage in negotiations with providers regarding billing practices that are subject to the Act.

The Act, discussed here, was enacted to address so-called "surprise billing" involving circumstances in which patients have little choice over the providers and the bills are unexpectedly high and typically cover services performed by: (i) an out-of-network emergency department; (ii) an in-network hospital billing for a provider who is out-of-network; and (iii) an out-of-network air ambulance provider. The Act provides (with certain exceptions) that such patients will be required to make only cost-sharing payments consistent with what they would have paid had the provider been in-network.

The Act requires insurers and providers to decide on an appropriate compensation amount for a service covered by the Act (unless it is set by state law)—effectively removing patients from that process. The Act provides for an independent dispute resolution ("IDR") process in which an arbitrator will determine the reimbursement amount if the provider and insurer do not agree. The arbitrator will select the reimbursement amount proposed by one of the parties based on the arbitrator's analysis of certain statutory "considerations." The first listed consideration is the "qualifying payment amounts" ("QPAs"), which in 2022 will be the insurer's 2019 median in-network reimbursement amounts for the same service in the same geographic market.[1] The arbitrator must also consider "[a]dditional circumstances," including: (i) the level of training, experience and quality outcomes of the facility or provider; (ii) the market share held by the facility or provider or the market share of the payor in the geographic region in which the service was provided; (iii) the complexity of the service furnished;

[1] The Act provides for upward adjustments to the QPA in subsequent years but at a rate that is likely to be lower than the rate of inflation in the healthcare industry.

(iv) the teaching status, case mix, and scope of services provided by the out-of-network facility; and (v) demonstration of good-faith efforts (or lack thereof) by the parties to enter into network agreements and, where applicable, the contracted rates between the provider/facility and payor during the prior four plan years.

On September 30, 2021, the Biden administration issued the Rule that implements the IDR process. The Rule provides that the arbitrator must select the amount closest to the QPA unless "credible information . . . clearly demonstrates that the [QPA] is materially different from the appropriate out-of-network rate."

On October 28, 2021, the Texas Medical Association (a trade association representing more than 55,000 physicians) and a Texas physician filed suit in the Eastern District of Texas seeking to vacate certain portions of the Rule governing the IDR process. The plaintiffs challenged the Rule on grounds that it gives "outsized weight" to the QPA and correspondingly downgrades the significance of the other statutory criteria. Unlike the QPA, which is the rate preferred by insurers, the other statutory factors could justify a higher rate of reimbursement. There are at least five pending lawsuits (tracked here) in which various provider organizations and providers are asserting similar arguments.

The Order vacates the challenged portions of the Rule for two reasons. First, the Order concludes that the Rule is in conflict with the statutory text, which "unambiguously establishes the framework for deciding payment disputes." The Order holds that the Act requires the arbitrator to consider all of the statutory factors and does not instruct arbitrators to accord greater weight to one factor over another. The Rule, by contrast, improperly "places its thumb on the scale for the QPA." Second, the Order invalidates the Rule because the administration did not provide an opportunity for notice-and-comment, as required by the Administrative Procedure Act, and did not have a valid excuse for its failure to do so. Until such time (if ever) that the Order is stayed or overturned, the challenged portions of the Rule cannot be put into effect.

The Order is far from the last word on the Rule, as there are likely to be subsequent opinions issued by district and appellate courts throughout the country. The ultimate outcome of these challenges to the Rule may ultimately have a significant impact on provider/insurer relations. Certain provider groups have asserted that insurers were using the Rule's default QPA rate as leverage to threaten to terminate provider agreements if providers did not agree to significant discounts. That leverage may dissipate (or even shift in favor of providers) if insurers face the prospect of arbitrations in which providers can seek reimbursements significantly in excess of the QPA.

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Please do not hesitate to let us know if you have any questions.

Andrew L. Bab
Partner, New York
+1 212 909 6323
albab@debevoise.com

Jennifer L. Chu
Partner, New York
+1 212 909 6305
jlchu@debevoise.com

Mark P. Goodman
Partner, New York
+1 212 909 7253
mpgoodman@debevoise.com

Maura Kathleen Monaghan
Partner, New York
+1 212 909 7459
mkmonaghan@debevoise.com

Kevin Rinker
Partner, New York
+1 212 909 6569
karinker@debevoise.com

Paul D. Rubin
Partner, Washington, D.C.
+1 202 383 8150
pdrubin@debevoise.com

Kim T. Le
Counsel, San Francisco
+1 415 738 5706
kle@debevoise.com

Jacob W. Stahl
Counsel, New York
+1 212 909 6874
jwstahl@debevoise.com

Adam Aukland-Peck
Associate, New York
+1 212 909 6703
aauklandpeck@debevoise.com

Adriana Kranjac
Associate, New York
+1 212 909 6126
akranjac@debevoise.com

Hannah R. Levine
Associate, New York
+1-212-909-6095
hrlevine@debevoise.com

Melissa Runsten
Associate, Washington, D.C.
+1 202 383 8073
mrunsten@debevoise.com