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No More Surprise Medical Bills: Biden Administration Issues New Surprise Billing Rulemaking Proposing Batching and Procedural Changes to Arbitration Process Under No Surprises Act

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On October 27, the US Departments of Treasury, Labor, and Health and Human Services (the Departments) issued new proposed rules intended to revamp the negotiation and arbitration proceedings established under the No Surprises Act

(the Act). Under the proposed rule, the Departments would permit broader batching of eligible claims and implement additional changes to the Open Negotiation and Independent Dispute Resolution (IDR) processes established under the Act.

A link to the proposed rule is **here**.

As background, Congress passed the Act to prevent "surprise" medical bills – bills patients receive when they are forced to obtain emergency care at an out-of-network facility or non-emergency care from an out-of-network provider at an in-network facility. Rather than billing patients for unpaid charges, out-of-network health care providers instead may engage in a "baseball style" arbitration process with insurers to determine the appropriate out-of-network reimbursement rate for the services rendered. Under that process, an independent dispute resolution entity (IDRE) selects one offer – either that of the provider or the insurer. **As detailed previously**, health care providers have already mounted numerous successful legal challenges to various aspects of the Departments' prior rulemaking implementing the Act. With this new round of rulemaking, the Departments are seeking to adjust several prior portions of the rules that were previously struck down in court.

Broader Batching Permitted

In one of the most highly anticipated aspects of the rulemaking, the Departments have proposed several revisions to the batching regulations that permit parties to submit multiple claims together for a single adjudication. Under the Act, parties may "batch" claims together so long as the services were rendered by the same provider, within the same 30 business days, were paid for by the same payer, and were related to the treatment of a similar condition. Under prior rulemaking, the Departments had taken the position that services were "similar" only when *billed under the same service code*. However, following a **Texas federal district court's ruling striking down those regulations**, the Departments issued this new round of rulemaking in an attempt to allow for broader batching. Of note, the Departments have proposed:

- Continuing to allow parties to batch all services billed under the same service code, whether a current procedural terminology (CPT) code or another type of code.
- Allowing parties to batch services billed with comparable codes across different coding systems.
- Allowing parties to batch all services billed for the care of one patient on the same claim form (i.e., batching by single patient encounter).
- For certain specialties (i.e., anesthesia, radiology, or pathology and laboratory services), allowing batching of services billed under codes from the same CPT code section or group.

Notably, the Departments have also proposed limiting the total number of claims a party may submit in a batch to 25 line items per dispute.

While the Departments have indicated some positive departures from their previous same-service-code-only approach, the new proposals would still impose significant administrative hurdles for providers seeking to use the arbitration process under the Act, particularly ancillary providers whose singular claims may be too small to make arbitration worthwhile unless they can be batched together. For example, anesthesia providers have urged the Departments to permit batching based on anesthesia conversion factors (i.e., the same per-unit reimbursement rates sought for timed anesthesia services). While the new proposed regulations have not implemented that approach, the Departments have requested comment from stakeholders, so the ultimate framework for future batching remains in flux.

If implemented, these proposals would become effective on the later of August 15, 2024, or 90 days after the effective date of the final rules.

Open Negotiation and IDR Procedural Changes

The Departments have also proposed significant modifications to the provisions of the regulations governing the mandatory open negotiation process that precedes the initiation of arbitration under the Act. Notably, the Departments have proposed:

- Requiring parties to conduct open negotiations through the online portal operated and maintained by the Centers for Medicare & Medicaid Services (CMS). Currently, the portal is used solely for the arbitration process following claim negotiation.
- Requiring the initiating party to include additional information with its negotiation notices, including more details about the disputed items or services.

- Requiring the non-initiating party (usually the insurer) to file a response within 15 business days of receiving the initiating party's open negotiation notice.

Currently, the negotiation process, which must be exhausted during a short window prior to arbitration, has operated between the parties only and has not proved as successful as the Departments would like. The Departments believe that implementing additional information-sharing requirements in the negotiation period will lead parties to resolve more claims prior to initiating arbitration, thereby reducing the **backlog of claims currently pending in the arbitration process**.

Additionally, the Departments have proposed hefty modifications to the rules that govern the arbitration process following the negotiation period. Notably, the Departments have proposed:

- Requiring the Notice of IDR Initiation (the opening of an arbitration) to include additional information, most of which would be identical to the requirements for the open negotiation notice.
- Requiring the non-initiating party (usually the insurer) to furnish a written response regarding claim eligibility within three business days of receiving the Notice of IDR Initiation.
- Implementing a preliminary three-business-day selection window in which the parties could negotiate regarding IDRE selection, followed by a final selection window in which the IDRE would undergo conflicts screening.

If implemented, these proposals would all become effective on the later of August 15, 2024, or 90 days after the effective date of the final rules.

Administrative Fees Revised

Finally, the Departments have proposed modifications to the non-refundable administrative fee parties must pay to access the Act's arbitration proceedings. Initially, this fee was set at $50. Following CMS's unexpected increase of the fee to $350 in late 2022, providers filed a separate lawsuit in a federal district court in Texas, resulting in those fee provisions **being struck down**. In September 2023, **a separate round of rulemaking** set the administrative fee at $150, effective in 2024.

In the latest set of new proposed rules, the Departments have now proposed:

- Implementing a tiered fee structure under which initiating and non-initiating parties would pay different portions of the $150 fee depending on the overall value of the dispute and whether the case is ultimately deemed eligible for arbitration by the IDRE.
- Requiring payment of the administrative fee within two business days following IDRE selection.
- Requiring parties to submit the administrative fee directly to CMS, as opposed to remitting the payment to the IDRE assigned to the case (who previously paid it over to CMS).

If implemented, these proposals would become effective for disputes initiated on or after January 1, 2025.

Looking Ahead: Notice and Comment Periods and Partial Resumption of Arbitrations

The proposed rule is currently undergoing review during a notice and comment period, and the Departments are accepting comments on the proposed regulations. Meanwhile, two of the

Texas federal district court's previous orders, which struck down portions of the Departments' previous rulemaking, have been appealed. The Fifth Circuit is slated to hear oral arguments in the first case in February 2024. This case challenges the Departments' regulations governing how IDREs must weigh the various statutory factors that determine the out-of-network reimbursement rate. Various physician groups and others have argued, and the Texas federal court agreed, that those regulations improperly give primacy to one factor ? the Qualifying Payment Amount (QPA), calculated exclusively by the insurer ? over the other mandatory factors.

The particulars of the arbitration process under the Act remain far from settled. Accordingly, while the regulatory dust settles, health care providers should consider filing comments on the portions of the rules most impactful to their practices. While the Departments consider comments and finalize their rulemaking, providers should continue filing open negotiation notices and timely initiating all eligible claims for arbitration in accordance with the existing regulations.

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