COLLEGE of AMERICAN PATHOLOGISTS

CAP Insights on No Surprises Act Implementation

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December 7, 2021

Welcome

Jonathan L. Myles, MD, FCAP

- **Chair, CAP Council on Government and Professional Affairs**
- **Co-Chair of the CAP Council on Scientific Affairs**

Welcome

Theresa S. Emory, MD, FCAP

- **Chair, CAP Payment Policy Subcommittee, Economic Affairs Committee**

Agenda

- Review the enactment and implementation of the No Surprises Act
- Detail how qualifying payment amounts are determined
- Review the independent dispute resolution process rules
- Discuss how the No Surprises Act impacts state laws
- Introduce the good faith estimate requirements and the patient-provider dispute resolution process
- Questions/answers

CAP Advocacy on Surprise Medical Bills

- **The CAP had lobbied Congress for several years to hold patients financially harmless from bills for out-of-network services provided at in-network hospitals/facilities**
- **Congressional leaders struck an agreement and passed legislation, the "No Surprises Act," in December 2020**
- **Key provisions advocated for by the CAP, include:**
  - **Independent dispute resolution (IDR) process with no minimum dollar amount threshold and an option to batch claims together**
  - **Removal of Medicare and Medicaid rates from IDR process**
  - **Insurers will make payments for out-of-network services that is determined through negotiation or IDR**
  - **Require a study on network adequacy**

No Surprises Act Timeline

December 2020

No Surprises Act was signed into law.

June 2021

The CAP writes to HHS that strong regulations are needed to prevent health plan manipulation along with a balanced system to resolve payment disputes.

July 2021

The agencies publish Part I of regulations detailing cost sharing responsibilities and its method for calculating qualified payment amounts.

September 2021

The CAP provides formal comments on the Part I regulations.

October 2021

The departments publish Part II of its regulations detailing open negotiations and independent dispute resolution process.

December 2021

The CAP provides formal comments on the Part II regulations.

January 2022

No Surprises Act goes into effect.

CAP Guidance on Law Implementation

- CAP sent the HHS a letter in June 2021 calling for regulations to support:
  - Establishing “an equitable and balanced” system for resolving payment disputes
  - Accounting for the range of activities within pathology services when considering qualifying payment amounts
  - Addressing inadequate insurer networks as the cause of surprise medical bills
- CAP also sent comments to HHS in September and December 2021

COLLEGE of AMERICAN PATHOLOGISTS

June 21, 2021

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Becerra:

The College of American Pathologists (CAP) understands that the Department of Health and Human Services (HHS), together with other agencies of jurisdiction, has begun the process for implementing the recently enacted *No Surprises Act*. While waiting for rulemaking, we write to provide our initial recommendations, which we believe will further safeguard patients from surprise expenses while appropriately balancing disputes between our members and insurers. As the world's largest organization of board-certified pathologists and leading provider of laboratory accreditation and proficiency testing programs, the CAP serves patients, pathologists, and the public by fostering and advocating excellence in the practice of pathology and laboratory medicine worldwide.

The CAP worked closely with Congress and other stakeholders in the development of the *No Surprises Act*, and we have repeatedly called for protections that keep patients out of the middle of billing disputes. While sometimes described as “ancillary,” pathologists provide a full range of services critical to patient care. For example, pathologists direct clinical and anatomic pathology laboratory services and serve as expert laboratory consultants to other physicians and to hospital leadership; this is in addition to triaging and interpreting biopsies, and diagnosing surgical, cytology, and autopsy specimens. Clinical pathology services include development, approval, and evaluation of appropriate test methods, pre- and post-analytical oversight, interpretation of clinical laboratory tests and consultation to other physicians, and direct involvement with both technologists and clinical colleagues to ensure prioritization and proper response to test results. During the COVID-19 crisis, pathologists in hospitals and laboratories around the country have been responsible for developing and selecting new test methodologies, validating and approving testing for patient use, and expanding the testing capabilities of the communities they serve to meet emergent needs. The impact of all these pathology services on clinical decision-making is pervasive and constitutes a critical infrastructure and foundation for appropriate care.

Beyond argument, the COVID-19 pandemic has shaken and challenged every health care system and organization. What has remained the same for health care providers is their unwavering commitment to care for their patients and communities. Today more than ever, patients should not be financially penalized for the failure of health insurance plans to establish adequate in-network access to hospital-based physician specialties. Yet, health insurance plans are increasingly relying on narrow and often inadequate networks of contracted physicians, hospitals, and other providers in order to shift medically necessary health care costs onto their enrollees. Even now, health plans are finding ways to circumvent the protections provided in the *No Surprises Act*; for example, by proposing to subject patients to full liability for services received at facilities

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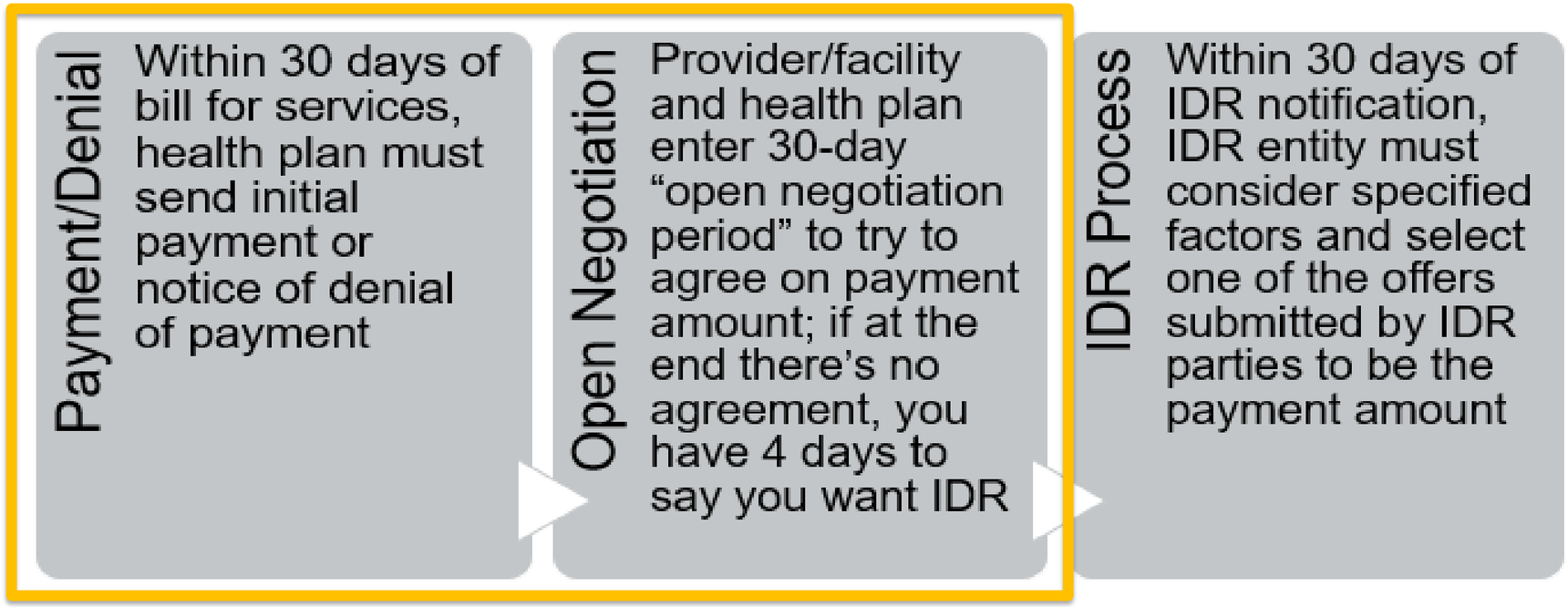
No Surprises Act Implementation

- **The July regulation included patient cost-sharing protections, notice and consent standards for waivers, rules for calculating the "qualifying payment amount," disclosure requirements, and complaints processes**

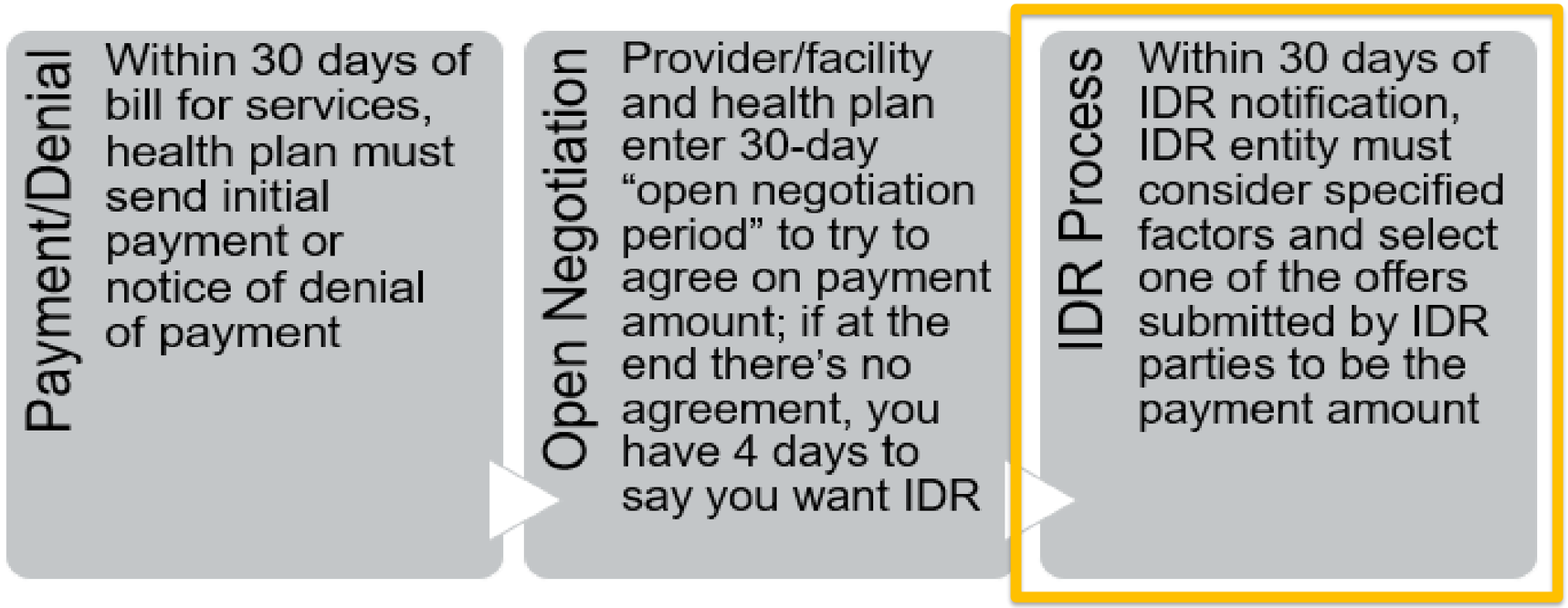


"Qualifying Payment Amounts"

- **What is it?**
  - The "QPA" is a factor that, by statute, must be considered by IDR entities when selecting between the offer submitted by an insurer and the offer submitted by a physician/facility
  - It is also used to calculate patient cost-sharing requirements in certain circumstances
- **How is it calculated?**
  - Generally, the median of the contracted rates recognized by the insurer on January 31, 2019 for the same or similar service by the specialty provided in a geographic region where furnished.
  - Annually adjusted for inflation based upon CPI

No Surprises Act Implementation

- **The October regulation detailed the IDR process**
- **The CAP, AMA, and many other physician organizations found major deficiencies in how the administration established the IDR process**



No Surprises Act Implementation Overview

- **Initial payment or notice of denial of payment**
  - **Insurers are required to send an initial payment or notice of denial of payment not later than 30 calendar days**
- **Open negotiation**
  - **The open negotiation period may be initiated by any party during the 30-business-day period**
- **Independent dispute resolution (IDR)**
  - **If the parties have not reached an agreed-upon amount of the out-of-network rate by the last day of the open negotiation period, either party may initiate the federal IDR process**

IDR Process – Initiation

- **Physicians/facilities and insurers can initiate the IDR process during a four-day period after the end of open negotiations.**
- **The party initiating the process submits their "Notice of IDR Initiation" to the other party using a standard form developed by the federal agencies and provides notice to the agencies through an online portal.**
  - **More information will be available at: www.nsa-idr.cms.gov**
- **Notice of IDR Initiation must include:**
  - **Information identifying the services and whether they are designated as batched services**
  - **Amount of cost sharing allowed and amount of initial payment made by the insurer**
  - **Contact information**
  - **Initiating party's preferred IDR entity (arbiter)**
  - **Qualifying payment amount (QPA) and additional information about the QPA**

IDR Process – Batching

- **Multiple claims for services can be batched (considered jointly as part of a single determination) for IDR if:**
  - **Claims are billed by the same provider or group of providers or facility (billed with the same National Provider Identifier (NPI) or Tax Identification Number (TIN))**
  - **Payment would be made by the same group health plan or insurer**
  - **Claims include the same or similar services (those items and services that are billed under the same service code, or a comparable code under a different procedural code system (CPT, HCPCS, DRG))**
  - **Items and services have been furnished within the same 30-business-day period**

IDR Process – IDR Entity and Fees

- **Once the IDR process is initiated, the parties must select a “certified IDR entity” (arbiter) no later than 3 business days following the date of the IDR initiation. If the parties cannot agree, the agencies will select**
- **Each party must submit an offer for a payment amount and other additional information related to the offer within 10 business days of selection of IDR entity through the federal IDR portal**

IDR Process – Payment Determination

- **If parties reach an agreement on the payment determination prior to arbiter's decision, each party pays half the fees.**
- **No later than 30 days after selection of the IDR entity, the entity must select one of the offers submitted by the insurer and the physician/facility.**
- **Unfortunately, the regulations state that the IDR entity MUST presume the QPA is the appropriate out-of-network amount and select the offer closest to the QPA unless credible information submitted supports a more appropriate payment.**

Federal IDR Process and State OON Laws

State With OON Law

- State law applies to fully insured plans that the state regulates
- Federal law applies to self-insured plans (ERISA) not regulated under state law.
- Under the No Surprises Act rules, states can regulate self-insured (ERISA) plans that opt-in to state regulation where the state law provides that option.
  - Four states (NJ, NV, VA, and WA) currently provide such an option, that will be allowed under federal law.

State Without OON Law

- Federal law applies to fully insured plans otherwise regulated by states.
- Federal law applies to self-insured plans (ERISA) not regulated under state law.

Good Faith Estimates

- **Health care providers and facilities inquire about the individual's health coverage status and provide a notification of the "good faith estimate" of the expected charges**

- **The CAP agrees that patients must be able to make informed decisions about their health care, but we're concerned about risk for patient harm stemming from any delays in determining the cost of pathology services in advance of patient care**

Patient-Provider Dispute Resolution

- **The No Surprises Act also establishes a process for uninsured (or self-pay) individuals to seek a determination from a selected dispute resolution entity for the amount to be paid by the uninsured (or self-pay) individual to the provider or facility for items or services**
- **An uninsured (or self-pay) individual is eligible for the patient-provider dispute resolution process after being furnished an item or service for which they received a good faith estimate if the individual is billed charges that are "substantially in excess" of the good faith estimate**

CAP Advocacy Going Forward

- The CAP strongly opposes relying on the QPA during the IDR process.
- The No Surprises Act sought to ensure an equitable and balanced system to resolve disputes with no single factor given preference over others.
- The CAP remains engaged with Congress and the administration to ensure regulators follow statute
  - Formal comments submitted December 6
  - Working with stakeholder groups to oppose adverse regulatory positions
  - Activate grassroots to urge Congress to oppose rules that are in the insurance industry's favor

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Questions

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