CAP Insights on No Surprises Act Implementation

Jonathan L. Myles, MD, FCAP
Theresa S. Emory, MD, FCAP
Pamela Wright, Senior Director of CAP Economic & Regulatory Affairs, Advocacy

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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:
  o Independent dispute resolution (IDR) process with no minimum dollar amount threshold and an option to batch claims together
  o Removal of Medicare and Medicaid rates from IDR process
  o Insurers will make payments for out-of-network services that is determined through negotiation or IDR
  o Require a study on network adequacy
No Surprises Act Timeline

December 2020
No Surprises Act was signed into law.

July 2021
The agencies publish Part I of regulations detailing cost sharing responsibilities and its method for calculating qualified payment amounts.

October 2021
The departments publish Part II of its regulations detailing open negotiations and independent dispute resolution process.

January 2022
No Surprises Act goes into effect.

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.

September 2021
The CAP provides formal comments on the Part I regulations.

December 2021
The CAP provides formal comments on the Part II regulations.
CAP Guidance on Law Implementation

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

• CAP also sent comments to HHS in September and December 2021
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?
  o 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
  o It is also used to calculate patient cost-sharing requirements in certain circumstances

• How is it calculated?
  o 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.
  o 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

Payment/Denial
Within 30 days of bill for services, health plan must send initial payment or notice of denial of payment

Open Negotiation
Provider/facility and health plan enter 30-day “open negotiation period” to try to agree on payment amount; if at the end there's no agreement, you have 4 days to say you want IDR

IDR Process
Within 30 days of IDR notification, IDR entity must consider specified factors and select one of the offers submitted by IDR parties to be the payment amount
No Surprises Act Implementation Overview

• Initial payment or notice of denial of payment
  o Insurers are required to send an initial payment or notice of denial of payment not later than 30 calendar days

• Open negotiation
  o The open negotiation period may be initiated by any party during the 30-business-day period

• Independent dispute resolution (IDR)
  o 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.
  o More information will be available at: www.nsa-idr.cms.gov

• Notice of IDR Initiation must include:
  o Information identifying the services and whether they are designated as batched services
  o Amount of cost sharing allowed and amount of initial payment made by the insurer
  o Contact information
  o Initiating party’s preferred IDR entity (arbiter)
  o 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:
  o 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))
  o Payment would be made by the same group health plan or insurer
  o 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))
  o 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.
  o 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