A Proskauer Webinar Series

Proskauer's Health Care Webinar Series:
Bracing for the Impact of the No Surprises Act

Proskauer

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Agenda

- Background
  - Prior to the Enactment of the No Surprises Act (NSA)
- What the NSA Changed
  - Emergencies
  - Out-of-Network (OON) Elective Services
- New Protections for Uninsured Patients
- Takeaways

Prior to the Enactment of the NSA

- Emergency situations
  - If a patient was taken to a hospital in an emergency, the hospital was required to treat without assurance of payment or participation in patient's insurance
  - If a patient was not covered by a health insurance plan ("Plan") that the hospital and any of its providers "participated" in, the hospital and providers could charge the full list price for the items and services provided to the patient
- Elective hospital admissions
  - OON providers would generally negotiate higher payment rates with Plans and patients would face unexpected and very large financial obligations
  - If a patient went to an in-network hospital on an elective basis, but the physicians who treated the patient were (without the patient's knowledge) OON with respect to a Plan, the out-of-network physician was permitted to charge the full list price for the items and services provided to the patient

Legislative Response

- Result: Frequent “surprise” bills that patients could not afford and did not anticipate
- Many States, such as New York, began adopting their own laws to prevent or limit surprise bills
- Congressional Response: The NSA (effective January 1, 2022)
- Departments of Treasury, Labor, Health and Human Services have also adopted implementing regulations

Rights and Requirements

- NSA avoids surprise bills
  - All patients insured under virtually all non-governmental Plans must be informed of their rights that preclude unexpected medical bills
  - Patients covered by governmental plans were not subject to surprise billing
- Notice
  - Hospitals are required to publicly post (on website and physically at sites of service) and distribute directly to patients, a statement mandated by Federal regulators that advises patients of their rights
- Patient's financial liability
  - Patients are not liable for OON charges when treated in a hospital on an emergency basis
    - Any ancillary services (e.g., radiology, anesthesiology, laboratory, neonatology and pathology) are tied to the emergency admission and cannot be billed OON
    - Other services, such as surgery or follow up care, also cannot be billed OON unless strict conditions are met
  - In an emergency, any patient with any standard insurance plan must be treated as "in-network" for purposes of their financial liability
    - The payment rate is determined between the patient's Plan, the hospital, and other providers in accordance with the NSA

Negotiating Payment Rates

- Payment rates
  - The Plan will make an initial payment at the Qualifying Payment Amount (QPA) to the emergency service provider (hospital or physician)
    - QPA is the median rate paid by the Plan for a specific service to hospitals in the area
      - Calculated by arranging in order (from least to greatest) the contracted rates of all Plans of the Plan sponsor for the item or service that is provided by a provider or facility in that geographic region and selecting the middle (median) rate
    - Patient's co-pay is based on the QPA
  - If the hospital or provider is not satisfied with the QPA, then they may challenge the adequacy of the rate
  - Initially, there is a period of direct negotiations (30 days)
  - If negotiations are unsuccessful, then there is a mandatory dispute resolution process

Independent Dispute Resolution Process

- IDR process
  - Federal process to settle disputes over OON payment rates
    - Either party may initiate; Both parties are required to pay a small administrative fee
    - Ultimate amount to be paid is determined through baseball-style arbitration with the losing entity paying IDR Entity fees
  - NSA supplements state surprise billing laws which continue to apply
  - Process is critical to the economic performance and viability of providers
  - Parties are permitted to submit additional information to the IDRE to prove the QPA is materially different from the appropriate OON rate
  - ERISA Plans, which are not subject to State regulation, can agree to use a State IDR process if available, and payers that are subject to State regulation (insurers) must use the State IDR process. Two different processes may be applicable depending on the Plan

Out-of-Network Rate Factors

- IDRE may consider the following factors in its assessment of the appropriate OON rate:
  - The QPA
  - Level of training, experience, and outcome measurements of a physician or facility
  - Market share held by the OON physician or facility, or the Plan
  - Patient acuity or the complexity of furnishing a particular item or service
  - Teaching status, case mix and scope of services of the OON facility
  - Demonstrations of good faith efforts made by the OON provider, facility and/or Plan to enter network participation agreements between the provider or facility and the Plan
  - Any other credible and relevant information submitted by either party

QPA Presumption

- Notwithstanding the many factors noted in the regulations, the regulations require the IDR entity to begin with the presumption that the QPA is the appropriate OON rate
- The presumption, which is not in the NSA itself, has been challenged by medical and hospital associations
- In *Tex. Med. Ass'n & Adam Corley v. U.S. Dept. Health and Human Servs., et al.,* a Federal district court in Texas held that the QPA presumption "conflicts with the [NSA]" and the regulatory agencies failed to engage in necessary notice-and-comment rulemaking
    - Effect: Court vacated the requirement that the QPA serve as the presumptive payment amount in the IDR process
        - The remaining unchallenged provisions of the regulations remain in effect
- Conundrum with the presumption:
    - If Plan is only required to pay median amount of payment to all providers (no negotiated rate), then there is little incentive to negotiate anything higher
    - Historically, if provider was in-network, then provider sees more patients, but receives less payment per patient
    - If OON, then the provider was paid for fewer services but at higher rates (bill the Plan their full list charge)
        - Participation negotiations reflected as much
        - Historical calculus no longer applies
    - Many providers depend on high OON rates – these changes could be dramatic for these providers
- Even without the presumption, rates will be materially lower for OON providers

Advanced Explanation of Benefits

- For all insured patients in non-emergency contexts, hospitals and Plans are required to ensure that patients receive an Advanced Explanation of Benefits (AEOB) that explains how their Plan will pay
  - The AEOB must be given to patients when an appointment is made for services or when requested by patients, even without an appointment
    - The AEOB must be issued in certain timeframes, after the provider submits to the Plan or insurer a good-faith cost estimate of charges, for each service
  - Note: The implementation of the AEOB requirement has been deferred until January 1, 2023

OON Patient Requirements

- OON providers providing services at in-network facilities are required to provide patients notice and to seek their consent on a standard Federal form before rendering their services
  - Form specifies the expected bills the patient will incur and explicitly requires their consent to be charged the OON rate
- Patients *cannot* consent if they do *not* have a choice of an in-network provider or facility for a specific service

New Protections for Self-Pay Patients

- Self-pay patients→ patients without insurance *and* those with insurance who have decided not to use their insurance
- NSA entitles consumers to a written good faith estimate (GFE) of expected charges
  - GFE requirement triggered when a patient schedules health care services—or requests the information (even without scheduling care)
- Expected charges include any care that is reasonably expected to be provided in conjunction with the scheduled or requested care
  - Must reflect charges from *all* providers and facilities who are reasonably expected to provide care to the patient
  - Includes any related services such as facility use, telehealth, imaging and lab services, and pre- or post-operative services if not scheduled separately by the patient
- HHS requires providers and facilities to provide a single, comprehensive GFE to patients (rather than separate GFEs from each provider or facility involved in the care)
  - Single comprehensive GFE requirement has been delayed until January, 1, 2023

GFE Timelines

- Timelines:
  - For individuals who schedule care at least three business days and less than 10 days in advance → GFE provided within one business day after the date of scheduling
  - If care is scheduled at least 10 business days in advance → GFE must be provided within three business days of scheduling
  - If the patient requests a GFE but care has not been scheduled → GFE must be provided within three business days of the request
  - For services scheduled less than 3 days in advance → regulations are silent as to the time when the GFE estimate must be given. Some have read this to indicate there is no GFE requirement in this context, but it is unclear if this reading is correct
- Note:
  - If the information changes, the convening provider or facility must provide a new good faith estimate at least one business day before the scheduled care
  - A provider or facility does not fail to comply simply because its estimate reflects an error or omission (so long as the entity acted in good faith, with reasonable due diligence, and took steps to correct the information as soon as possible)

Patient-Provider Dispute Resolution

- If the amount billed is substantially in excess of the GFE (exceeding $400), then patients can use the patient-provider dispute resolution process to determine the appropriate payment amount
  - Note: This does not apply to the dispute resolution process for the notice and consent
- Initiate the dispute resolution process within 120 calendar days of the patient receiving the bill
  - Administrative fee of no more than $25
  - Once initiated, HHS appoints a selected dispute resolution entity (SDRE) to make an appropriate payment determination within 30 business days
  - Separate binding determination for each item or service charged
- SDRE required to use expected charge in the GFE as the presumed appropriate amount
  - Provider allowed to justify the difference, demonstrate unforeseen circumstances
- Payments
  - If provider or facility loses, they are responsible for the administrative fee and must reduce the amount that the patient owes
  - If the patient loses, they are responsible for the administrative fee and owe the total billed charges
- If the state operates its own patient-provider dispute resolution process that meets minimum requirements under federal IDR, then HHS will defer to the state process

Takeaways

Takeaways

Status of Patient, Provider, and Facility	Does the NSA apply?
Insured patient and in-network provider and facility	No, but patient receives AEOB starting in 2023
Insured patient and OON provider and facility	Yes*
Insured patient, OON provider, and in-network facility	Yes*
Insured patient, in-network provider, and OON facility	Yes*
Non-insured patient or patient elects self-pay	Yes, a good faith estimate must be provided to the patient

*But, if permitted by NSA (non-emergency and patient can travel), OON provider and/or facility can obtain notice and consent for OON treatment.

Takeaways (cont.)

- NSA represents a critical change in the effect of insurance coverage on care
- A great boon for patients and protects insurers
  - However, will largely leave providers bearing the cost

Potential Impact

Potential Impact

Type of Provider	Near Term Impact	Long Term Impact
▪ Emergency Services (Health Affairs Study – Percentage of care likely leading to a surprise medical – ED care – ranging from 14% to 22% under different data sets)	Significant compliance implementation; loss of revenue and increased margin pressures	Cost cutting and reduction of services in certain markets; potential M&A, and possibly more significant restructuring
▪ Anesthesiology & Radiology Providers	Potential difficulties scheduling a surgery at a hospital or ASC as those facilities may have no or very few available anesthesiologists who are in-network. The No Surprises Act requires clinicians providing non-emergency care to provide good faith estimates of services when care is scheduled at least 72 hours in advance or upon request from individuals who are uninsured or self-pay. You do not need to issue a good faith estimate for emergency radiologic care. Termination of existing provider contracts unless lower rate is accepted; if not accepted – OON – payment through IDR or proposed reimbursement by payer (qualifying payment amount). Implications of site of care in determining market	Potential acquisition of Anesthesiology Providers by hospitals; negotiation with payers to be in-network – potential implications of payers walking away from negotiations; right sizing of practices Change in value of practices; cost cutting and potential reduction in services/ modalities Strategic considerations: Restructure – sell Restructure – acquire Distribute – dissolve – employment/ reconstitute Restructure – live to fight another day

Potential Impact

Type of Provider	Near Term Impact	Long Term Impact
▪ Community Hospitals and Small Health Systems	Lower and loss of revenue and increased margin pressures. Potential narrowing of networks	Further financial instability, Cost cutting and reduction of services in markets; potential M&A (anti-trust implications), staffing pressures, and possibly more significant restructuring/ possible clinical integration considerations.
▪ Rural Hospitals	More than 130 rural hospitals have closed over the past decade, and nearly 900 additional rural hospitals — over 40% of all rural hospitals in the country — are at risk of closing in the near future Hospitals in rural areas more likely to have high unit costs as patient volume is lower	Closure may be accelerated Likely government support and/ or payer support Large health system support
▪ Teaching hospitals and specialized hospitals	Have higher cost structures because of the intensity of the services provided do have exposure Lower revenue and increased margin pressure	Redetermination of investment in and continuance of certain services that have been supported by the teaching hospital Cost cutting; potential devaluation of brand May accelerate joint venture opportunities and transition from health system to health (community focus to spread cost structure more broadly)

Questions?

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