No Surprises Act — what neurointerventionalists need to know

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So-called 'surprise medical billing', which occurs when a patient with commercial health insurance receives unexpected care from an out of network (OON) provider, has received significant attention over the past years.[1 2] Since the care is OON, insurers may pay less, and, the bill may be larger than if the care was in-network. As a result, patients may owe substantially more money than they were expecting. Although the phrase 'surprise billing' is commonly used, a more accurate description is 'surprise insurance gap' since the problem originates with a lack of insurer coverage. To protect patients from this gap, Congress enacted the No Surprises Act (NSA) as part of the Consolidated Appropriations Act, 2021. Although well-intentioned and thoughtfully drafted, the implementation of the law has led to various unintended consequences for hospital-based providers including neurointerventionalists (NI).

THE NO SURPRISES ACT

Congress enacted the NSA to protect privately insured patients from being billed the difference (or 'balance') between provider charges and the amount their insurance pays for unexpected OON care. Under the NSA, the patient's share of the owed amount is limited to their usual in-network payment amount. The insurers pay providers the balance of what they believe is an appropriate amount, and if the provider is dissatisfied, they can negotiate for a different rate. If that negotiation fails to satisfy the provider, they may request arbitration, known as independent dispute resolution (IDR). IDR is a 'baseball style' arbitration procedure where an independent arbiter receives bids from both sides and then selects one without having the ability to choose a compromise number. The law specifies multiple items for the arbiter to consider when making their determination, including previously contracted rates, the median of the insurer's contracted rates for that service (termed the 'qualifying payment amount' or QPA) and case complexity, among other factors.

The NSA was intended to protect the patient from surprise bills while preserving good faith contract negotiations that take place between insurers and providers. Congress was concerned that disruption of good faith negotiations would allow insurers to drive payment rates below sustainable levels, destabilizing medical providers' practices and thus impacting patients' access to care. They carefully designed the NSA to avoid this potential problem.

After passage of the law, the Administration (specifically, the Departments of Health and Human Services, Labor and Treasury) was charged with implementation of the law through rulemaking. It is largely the implementation of the law and payor behavior that is leading to unintended consequences on NI providers and their patients. First, in an era of acknowledged administrative burden, the IDR process adds another layer of bureaucracy and expense for providers. The NSA and its processes are leading to the formation and growth of an IDR specialist industry. In addition, this process is adding to delays in payments which can cause significant cash flow disruption for medical practices.[i] Lastly, the IDR process also requires a non-refundable administrative fee as well as a separate arbiter's fee for each case, which is only refunded to the winning arbitration party. The total amount can approach or even exceed $1000 per submitted dispute. This is a drain on practices' finances, redirecting resources away from patient care.

A major problem with implementation of the NSA concerns use of the insurer's median in-network rate (the QPA) for payment determinations. First, the QPA calculation methodology is not based on real-world economics or transparent. The QPA is insurer calculated and reported. Moreover, the requisite three contract rates to derive a median may not exist; in these cases, the NSA allows insurers to modify the

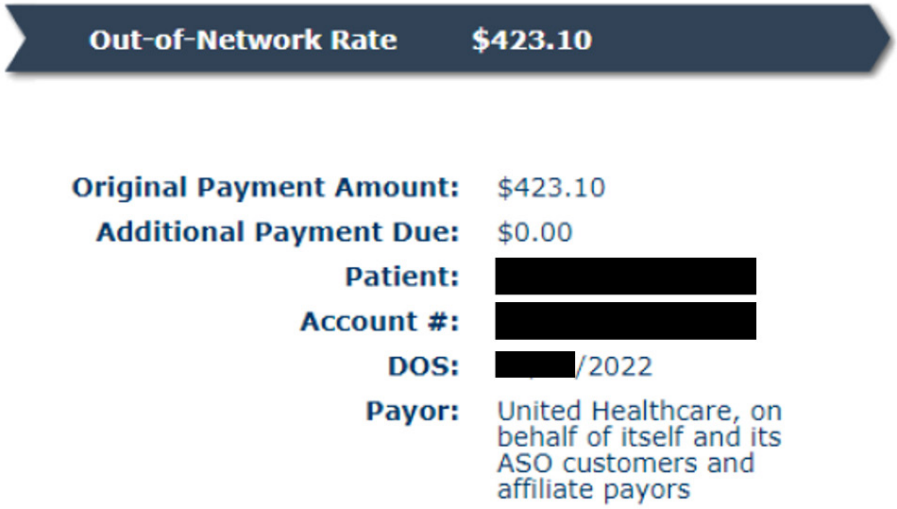

Figure 1 An example case, where an insurer submitted a counter-offer of $0 above the original payment amount in the pre-IDR "open negotiation" period.

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[i]URL:https://www.acr.org/-/media/ACR/Files/Advocacy/1-19-23-ACR-to-CCIIO-WT.pdf

IDR dispute status: Payment Determination Made
IDR reference number: DISP-[redacted]

Medical Evaluators of Texas has reviewed your Federal Independent Dispute Resolution (IDR) dispute with reference number **DISP-**[redacted] and has determined that Cigna Healthcare is the prevailing party in this dispute.

After considering all permissible information submitted by both parties, Medical Evaluators of Texas has determined that the out-of-network payment amount of $89.59 offered by Cigna Healthcare is the appropriate out-of-network rate for the item or service 72148 on claim number [redacted] under this dispute.

Medical Evaluators of Texas based this determination on a review of the following:

[redacted] submitted an offer of $349.56

Cigna Healthcare submitted an offer of $89.59

For each of the following determination factors, an "x" in the Initiating Party and/or Non-Initiating Party column means the party provided supporting information.

	Additional Circumstances	Initiating Party	Non-Initiating Party
1	The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act)	X	
2	The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided	X	
3	The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual	X	
4	The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service		
5	Demonstrations of good faith efforts (or lack of good faith efforts) made by the disputing parties to enter into network agreements and, if applicable, contracted rates between the disputing parties during the previous 4 plan years	X	
6	Additional information submitted by a party	X	

Final Determination Rationale

The initiating party did not provide credible information that would demonstrate a higher out of network rate than what the initiating party has already been paid.

Therefore, the total out-of-network payment amount offered by the non-initiating party under this dispute has been selected as the appropriate out-of-network (OON) rate.

Figure 2 An example, where an arbiter selected the insurer's offer in IDR without considering additional information from the medical provider.

QPA which is fraught with potential bias. Indeed, the rates used to calculate the QPA may not reflect the marketplace. For instance, since rulemaking stipulated that insurers use contracted rates, but did not specify that the rates had to 'be used', the QPA could be calculated using 'ghost rates'. These are rates that insurers have contracted but are rarely, if ever, used. For example, an internal medicine practice may contract with an insurer for a broad range of services, many of which they will never use. The insurer provides the book of codes with default payment rates that may be below market. Such services might include mechanical thrombectomy (MT). Since the internal medicine practice will never bill for MT, they do not negotiate for a better rate. However, since that contracted rate for the MT is on the books with the insurer, it is counted equally with the rates of practices that bills these codes regularly. Since there are far more non-NI groups than there are NI practices, ghost rates can outnumber negotiated rates and thus reduce the QPA to a non-market-based rate.[ii] [iii] This is further exacerbated by the fact that the insurers are only required to provide a QPA value and not the data used in their calculation.

As discussed in amicus briefs filed for lawsuits involving the NSA, there is a significant risk of anchoring bias with the QPA in the IDR system.[iv] This bias will likely be exaggerated by the baseball style format where there is no room for a compromise selection. Despite serious concerns about the calculation methodology and the non-transparent nature of the QPA, the Administration has tried to establish the QPA as the primary factor

[ii] Baron, Zachary L. Latest Twists and Turns in No Surprises Act Litigation: What it Means for Consumers and Ongoing Implementation. *Oneill Institute for National and Global Health Law. August 31, 2023.* https://oneill.law.georgetown.edu/latest-twists-and-turns-in-no-surprises-act-litigation-what-it-means-for-consumers-and-ongoing-implementation/

[iii] Avalere Health. PCP Contracting Practices and Qualified Payment Amount Calculation Under the No Surprises Act. August 2, 2022. https://www.acr.org/-/media/ACR/Files/Advocacy/2022-8-15-Avalere-QPA-Whitepaper_Final.pdf

[iv] Texas Medical Association v. United States Department of Health and Human Services. Brief amicus curiae of *Bernard v. Minnesota*. Amicus curiae brief of the physicians advocacy institute, fourteen state medical associations, and sixteen specialty medical societies. October 19, 2022. https://www.aans.org/-/media/Files/AANS/Advocacy/2022-news/October/Amicus-BriefofPAIStateAssociationsandSpecialtySocietiesTMAIIlitigationchallengingNSAFinalRule.ashx

that arbiters should use in making their determination.[v]

In the case of an artificially depressed QPA that anchors IDR arbitration, the result is disruption of good faith network contracting negotiations. Insurers are financially incentivized to threaten practices with removal from network contracting if they do not accept a reduction in reimbursement rates. If the practice objects, their alternative is to go out of network with the insurer. In such cases, the insurer can make an initial payment that is below market rates, forcing the provider group to consider requesting IDR. Since IDR is slow and expensive, practices must consider whether they can withstand the pressure on their cash flow. And if providers lose in IDR (for example, because the QPA is inappropriately prioritized), they must pay the arbiter's fee. As proof of this, a letter from Blue Cross Blue Shield of North Carolina sent to in-network practices throughout the state referenced the law and their ability to demand a rate reduction with the threat of contract termination.[vi][vii] Note that this is unrelated to the issue of surprise medical billing, which by definition can only be done by OON practices. However, *these letters were sent exclusively to in-network groups*, since an insurer can not threaten an OON practice with contract termination. It has been reported in a multispecialty survey that nationally there is a decrease in network contracting.[viii] This decreased network contracting will threaten access in many subspecialities, such as neurointervention.

Insurers profit from the invested capital they obtain by under-reimbursing providers. Since they have the capital from beneficiaries' premiums invested and earning returns, delays in payment to providers also benefit insurance companies. If insurers reasonably owe a practice $X but choose to pay them $Y (where X>Y), the insurer reaps the benefit of the $X−Y invested for the length of the dispute, even if they must pay it eventually.

HOW NSA COULD IMPACT NEUROINTERVENTION

As hospital-based providers, NI groups may be meaningfully impacted by the NSA. For example, they may bill a health plan for professional services, such as thrombectomy, embolization or kyphoplasty, delivered at an in-network hospital. If the health plan is OON with the provider (and states laws do not exist or apply), the NSA applies, and the insurance company might reimburse the physician at a below-market rate. Even if the NI group requests a more reasonable payment in the 'open negotiation' period, which is required before IDR, there is no guarantee that insurer will engage in meaningful negotiations, forcing the practice to consider arbitration through the federal IDR process. As an example, in figure 1, the insurer submitted a counter-offer of $0 above their original payment. While this technically counts as engagement in open negotiations, it is not meaningful engagement.

Another scenario could involve a neurointerventional group that has been in-network with an insurance company, their largest payor, for several years but receives notification that the insurer will be reducing their reimbursement rate by 30%. The group would have the option to accept the rate reduction or go OON. Because the hospital is in-network with the health plan, the NSA would apply. This means that if they go OON, they will have to either accept what the insurer chooses to pay for OON care for its enrollees or dispute the amount through the federal arbitration process. This IDR process can be a prolonged process lasting nearly a year from the date of service, and it is costly with fees and expenses. If the group takes the rate reduction, it could result in physicians leaving the practice, and the hospital could lose the ability to serve the public as a comprehensive stroke center.

LEGAL CHALLENGES TO THE NSA

Providers have not been sitting idle with the implementation of this legislation. A series of legal challenges have been filed by several groups. The Texas Medical Association (TMA) has challenged the flawed implementation of the law. Four separate times, the TMA sued the Administration; they won each case. The first lawsuit, TMA-1, challenged the rulemaking that established the QPA as the main determinant in IDR.[ix] The rule established a 'rebuttable presumption', since providers could challenge the QPA, but it was presumed to be correct, and the burden of proof fell to providers to demonstrate why it should not be the main (or only) factor used in arbitration decision making. In February 2022, a federal judge agreed with the TMA and vacated the rebuttable presumption. The government then issued a new rule to arbiters, but it still prioritized the QPA. Furthermore, if the arbiter chose to consider other factors, such as the previously contracted rate or case complexity, then they were required to explain in writing the reason for this decision and how the QPA does not already take that other information into account.

After this updated rule, the TMA filed a suit (TMA-2), again challenging the Administration's attempt to favor the QPA as the primary means for deciding the reimbursement rate.[x] In February 2023, a federal judge again agreed with the TMA's assertions that the emphasis on the QPA unfairly benefited the insurance companies and violated the statute. As the court put it, the formula 'unlawfully 'puts a substantial thumb on the scale in favor of the QPA.''[xi] The government responded by pausing the IDR process and filing an appeal. Demonstrating the impact of these rules, arbiters could select the insurer's offer without any additional information or context from the payor, giving no weight to information provided by the medical provider (figure 2).

While waiting for a decision on TMA-2, the TMA filed another suit (TMA-3) in November 2022, challenging the QPA calculation methodology.[xii] The TMA

[v]Pollitz, Karen. No Surpises Act Implementation: What to Expect in 2022. *KFF Health Reform*. December 10, 2021. https://www.kff.org/health-reform/issue-brief/no-surprises-act-implementation-what-to-expect-in-2022/

[vi]URL:https://www.acr.org/-/media/ACR/Files/Advocacy/20211105-BCBSNC-rate-reduction-notice_Redacted.pdf

[vii]Rodriguez, Sarai. Providers Accuse NC Payer of Abusing No Surprises Act, Cutting Rates. *Reimbursement News*. December 3, 2021. https://revcycleintelligence.com/news/providers-accuse-nc-payer-of-abusing-no-surprises-act-cutting-rates.

[viii]Americans for Healthcare. No Surprises Act (NSA) Impact Analysis. 2023. https://www.americansforfairhealthcare.org/_files/ugd/11639b_a39a37a219aa40ee8d68a219ec2e84ed.pdf

[ix]Texas Medical Association v. United States Department of Health and Human Services. Case 6:21-cv-00425. Filed 10/28/21. https://www.texmed.org/uploadedFiles/Current/2016_Advocacy/Surprise_Billing_Lawsuit_102821.pdf

[x]Texas Medical Association v. United States Department of Health and Human Services. Case 6:22-cv-00372. Filed 9/22/22.https://www.texmed.org/uploadedFiles/Current/2016_Advocacy/TMAIIComplaint.pdf

[xi]Texas Medical Association v. United States Department of Health and Human Services. Case 6:22-cv-00372-JDK. Document 99. Filed 2/6/23. https://litigationtracker.law.georgetown.edu/wp-content/uploads/2023/01/Texas-Medical-Association_99_OPINION-and-ORDER.pdf

[xii]Texas Medical Association v. United States Department of Health and Human Services. Case 6:22-cv-00450. Filed 11/30/22. https://www.texmed.org/uploadedFiles/Current/2016_Advocacy/TMAs_Third_

argued that the formula was flawed in several key aspects: (1) The inclusion of 'ghost rates' described above; (2) Inclusion of payment rates of providers in different specialties; (3) Exclusion of bonuses and other incentive payments; (4) Permission for companies to calculate QPAs for self-funded plans using the contracted rates of other self-funded plans. A federal judge in Texas again sided with the TMA in this lawsuit in August 2023, ordering that the government vacate these provisions.

In the Fall of 2022, the Administration announced that the non-refundable fee to access IDR would be unchanged in 2023, staying at $50 per dispute. However, in the final days of 2022, they announced they were altering that decision and the fee was increasing 600% to $350. The TMA filed a lawsuit (TMA-4) against this and provisions of the rule which restrict how arbitration claims could be grouped together for efficiency. In August 2023, a federal judge ruled in favor of the TMA.[xiii] In September 2023, the Administration announced a proposed rule to adjust the non-refundable IDR fee to $150.[xiv]

As a result of the TMA-3 and TMA-4 lawsuits, the Administration paused the IDR process. As of this writing in October 2023, the IDR system remains closed for new batched dispute submissions. This delay benefits the insurance companies who continue to collect and invest premiums from customers. As detailed previously, they can invest and profit from the amounts they under-pay OON providers. OON provider groups then receive the under-payment and must wait until the IDR process re-starts to submit disputes for arbitration. In the meantime, medical practices must continue to pay their staff, equipment costs and rent, among other expenses. In an ironic twist, at least one major health insurance company offers these struggling practices 'payday loans'.[xv]

CONCLUSION

The NSA was passed with bipartisan and house of medicine support to protect patients from so-called surprise medical bills. Flawed implementation of the law has led to a dysfunctional process where insurers are paradoxically incentivized to push medical practices and their patients OON and threaten their access to care. In September 2023, the House Committee on Ways and Means held a hearing on the issue.[xvi] Members of both parties expressed concern and frustration that the NSA has been poorly implemented. Whether Congress will need to handle this directly or the Administration will use future rulemaking to address the problems remains to be seen. For now, medical practices and their patients are experiencing the unintended consequences of a well-intentioned but poorly implemented law.

Lawsuit_Regarding_No_Surprises_Act_Rules.pdf?_zs=LNdEQ1&_zl=hAHw6

[xiii]Texas Medical Association v. United States Department of Health and Human Services. Case 6:23-cv-00059. Filed 1/3/23. https://www.texmed.org/uploadedFiles/Current/2016_Advocacy/TMAIVComplaint_NSA_01302023.pdf

[xiv]URL:https://www.govinfo.gov/content/pkg/FR-2023-09-26/pdf/2023-20799.pdf

[xv]A 'Payday Loan' From a Healthcare Behemoth. *An Arm and A Leg Podcast*. June 6, 2023. https://kffhealthnews.org/news/podcast/payday-loan-from-a-health-care-behemoth

[xvi]URL:https://waysandmeans.house.gov/event/hearing-on-reduced-care-for-patients-fall-out-from-flawed-implementation-of-surprise-medical-billing-protections/

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