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Whitepaper

Surprise Billing Dispute Resolution Process Upends In-Network Negotiations

April 28, 2023

The real-world application of the No Surprises Act (NSA) has been fiercely contested by physician groups and has resulted in a much larger volume of payment disputes between plans and providers than originally anticipated. The dispute process has reshaped contract negotiations and has a growing backlog of cases for arbitrators to still decide. To implement the law, federal agencies jointly released guidance outlining how to protect patients from providers balance billing for out-of-network care. It is also important to note that many states already have their own balance billing protections in place that may apply in certain situations. The NSA applies to patients in employment-based or individual exchange health plans subject to federal regulations and who receive:

- Emergency medical care
- Non-emergency care from out-of-network physicians for certain specialties and provider types at in-network facilities, typically physicians in hospital settings
- Emergency out-of-network air ambulance transport

Non-Emergency Facility-based Providers Included in the NSA						
Anesthesiologists	Pathologists	Radiologists	Neonatologists *(newborn care physicians)*	Assistant Surgeons	Hospitalists *(inpatient physicians)*	Intensivists *(critical care physicians)*

Additional rulemaking for surprise billing established an Independent Dispute Resolution (IDR) process for providers and facilities and instructed certified IDR entities on how to handle dispute resolutions but had specific portions vacated by a Texas district court. Soon after, the federal agencies responsible for the rule released an updated version of the rule with modified language so that IDR requests could continue to be processed. Physician groups had argued that regulatory agencies had overstepped their authority and unfairly favored health plans over providers in the arbitration process. A court ruling agreed that using the Qualified Payment Amount (QPA) as the baseline for negotiations was biased towards health plans.

The IDR receives information on a health plan's Qualifying Payment Amount (QPA) for making payment decisions, which is the median in-network contracted rate for a specific service in a geographic area. Previous regulations stated that the QPA must be the starting point for rate negotiations while later regulations stated that it should only be be considered first alongside other moderating factors.

Other Evidence Available for Arbitrators Making Final Payment Decisions					
Provider's level of training and experience	Quality of care outcomes	Provider market share	Patient acuity	Facility teaching status	Good faith efforts of contract negotiations

Health plans must first either make an initial payment to a provider based on the QPA or issue notice of payment denial. Afterwards, an 30 days of open negotiation are required to reach a total out-of-network rate, before both parties are eligible to begin the IDR process and pay an administrative fee plus an entity fee that goes directly to the arbitrator. CMS recently announced that the administrative fee for both parties would increase from $50 to $350 in 2023 to account for the higher than expected costs to the government for data collection and analysis. Finally, a "baseball-style" method is used to determine the payment amount due – both parties propose a payment amount for the service but only one offer is chosen by the arbitrator based on all available evidence.

The NSA has already transformed out-of-network billing for insurance systems and forced health plans to review their network contracts and provider directories more closely. The law makes revenue cycle management more complex for providers who now have higher incentives to closely negotiate their network contracts and ensure compliance with the law. The NSA may have had an unintended effect of removing health plan incentives to negotiate in-network contracts and instead pursue an IDR process that is more favorable. At the same time, IDR entities have become backlogged with a high volume of disputes and often lack the information necessary to decide if a claim is eligible or not. Stakeholders should evaluate their contracting methods and their liabilities from these surprise billing reforms and stay alert for any new legal updates on this process.