The No Surprises Act: A Patient Centered Approach

August 18, 2022

hfma™
lone star chapter

Risk factors associated with burden from out of pocket costs

- Uninsured/Self-Pay
- Out-of-Network
- Low income
- Advanced Age
- Multiple Comorbidities
- High Deductible Health Plan
- Black and Hispanic Adults

Healthcare Market Disruption

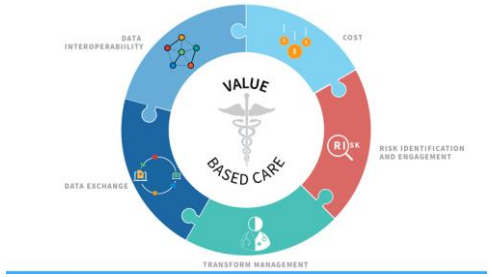
The Current State of Disruption

- Healthcare as a Commodity
- Disruptors
- Disbanded Disruptors
- Opportunities

SOMATUS
REVOLUTIONIZING KIDNEY CARE

MARK CUBAN CostPlus DRUG COMPANY

brightline



DG

ginger

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AMAZON TO ENTER HEALTH-CARE INDUSTRY

amazon

BERKSHIRE HATHAWAY INC.
amazon
JPMORGAN CHASE & CO.

Brightside Behavioral Health

theranos

Carbon Health
hims & hers

Google

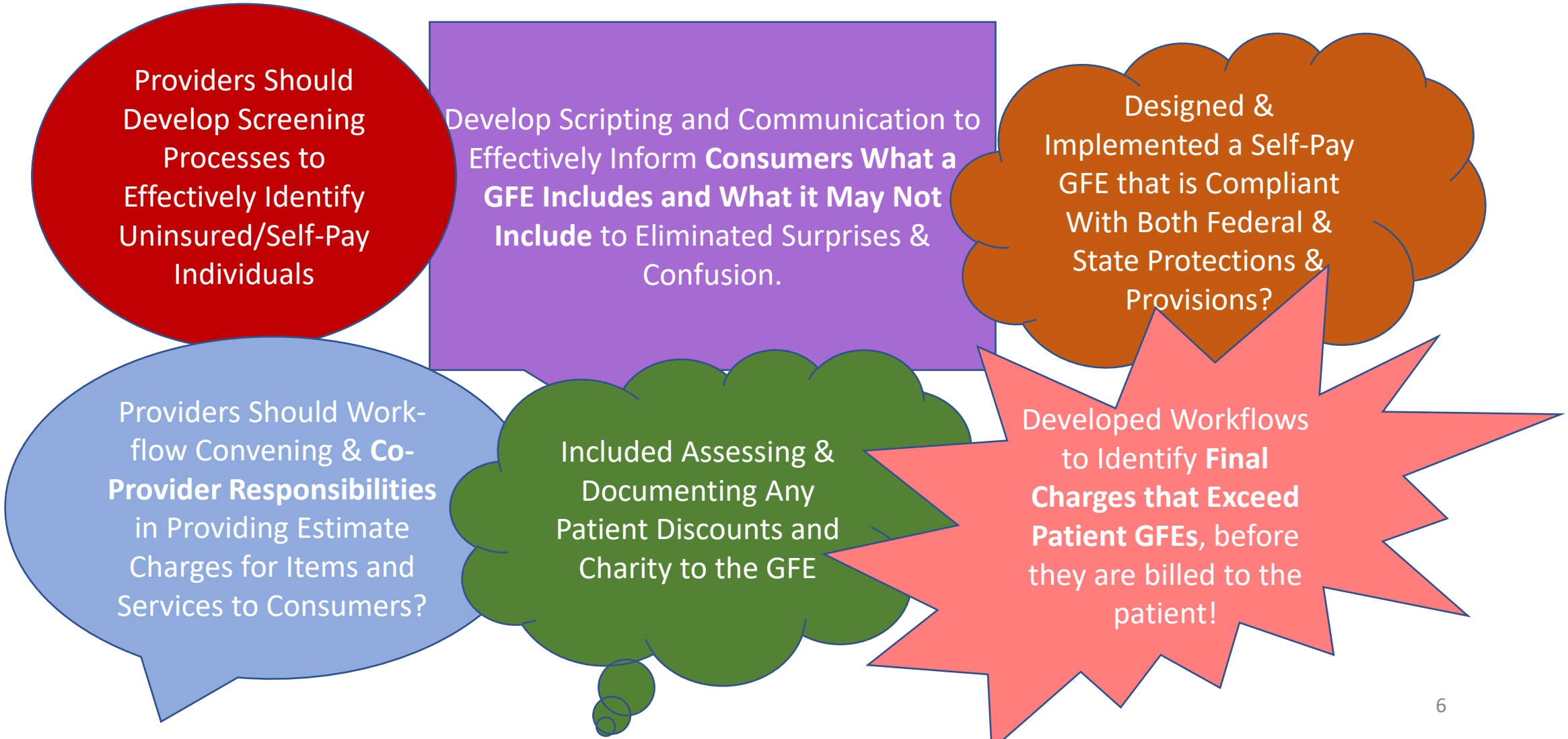
Uninsured/Self-pay Regulations

Lecture

NSA Uninsured/Self-Pay Good Faith Estimates

- Inclusive list of all items and services expected to be delivered by the scheduling provider during the individual's period of care.
- Applicable diagnosis codes and service codes.
- Expected charges or costs for each item or service.
- An estimate of patient responsibility (*reflecting any discounts or charity available to the patient).*
- Notification that if billed charges are higher than the GFE, patient can ask the provider to update the bill to match the GFE, negotiate, or ask if there is financial assistance available.
- Notification on how to dispute the bill if it is at least $400 higher for any provider than the GFE received from the provider or facility.

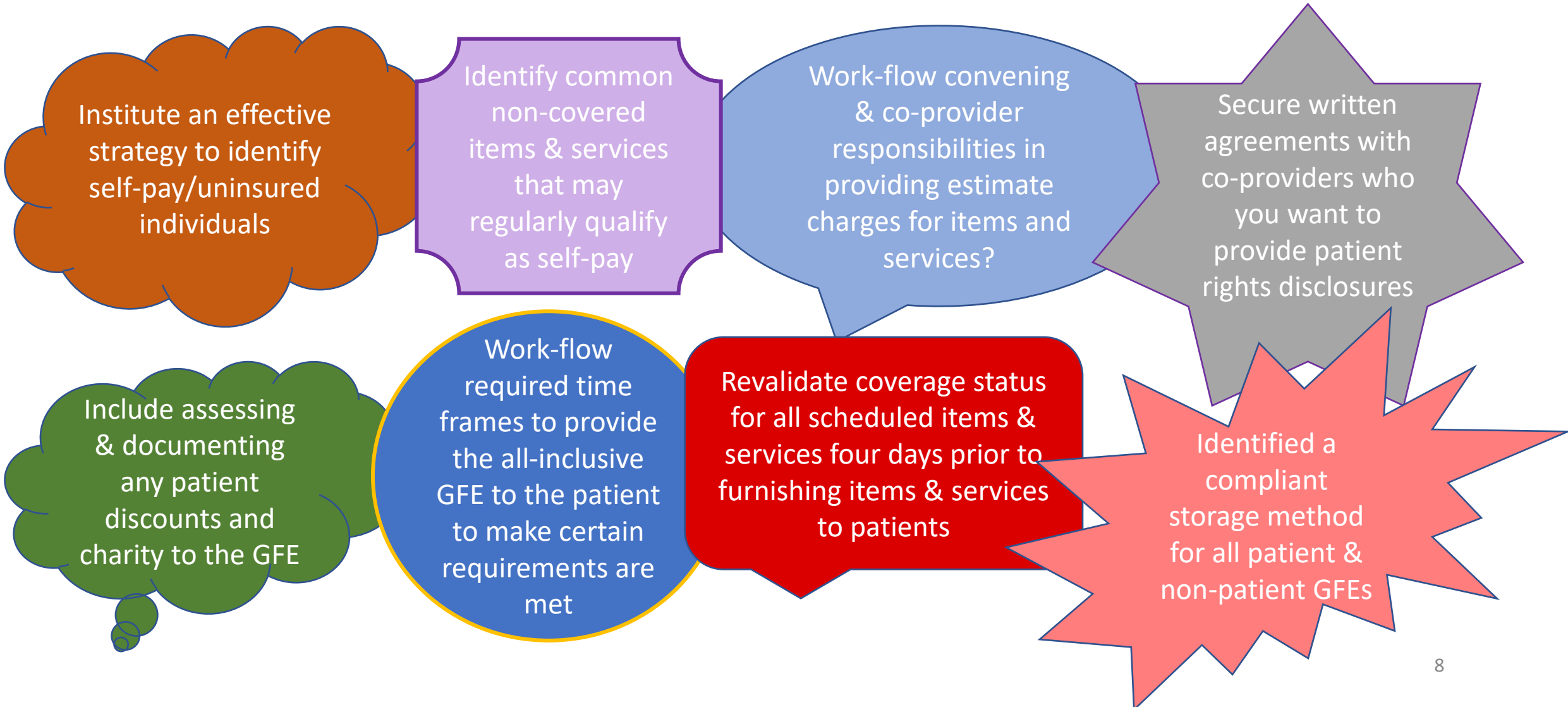
Uninsured/Self-Pay Patient-Centered Practices



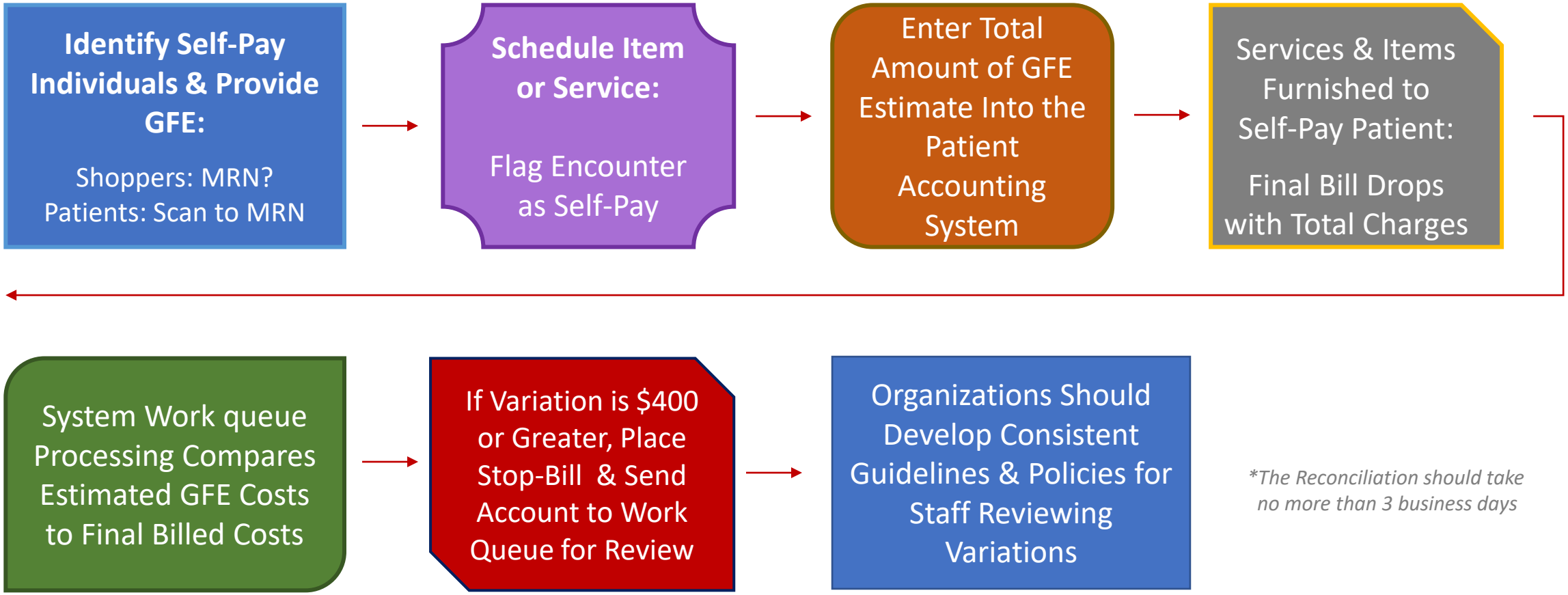
NSA Uninsured/Self-Pay Provider Engagement

- All -inclusive self-pay GFEs must be in place in 4 months.
- Convening and co-providers must work together to comply with the Good Faith Estimate requirements.
- Convening providers dictate the turn-around time a co-provider must provide their estimate charges to be include in the combined GFE.
- Convening providers may take-on disclosure requirements for co-providers and co-facilities, but only if there is a written agreement between the parties (liability shifts).
- Organizational Workflows should be executed on how and who will handle patient inquiries and disputes for the all-inclusive good faith estimates.

Uninsured/Self-Pay Internal Workflow Best Practices



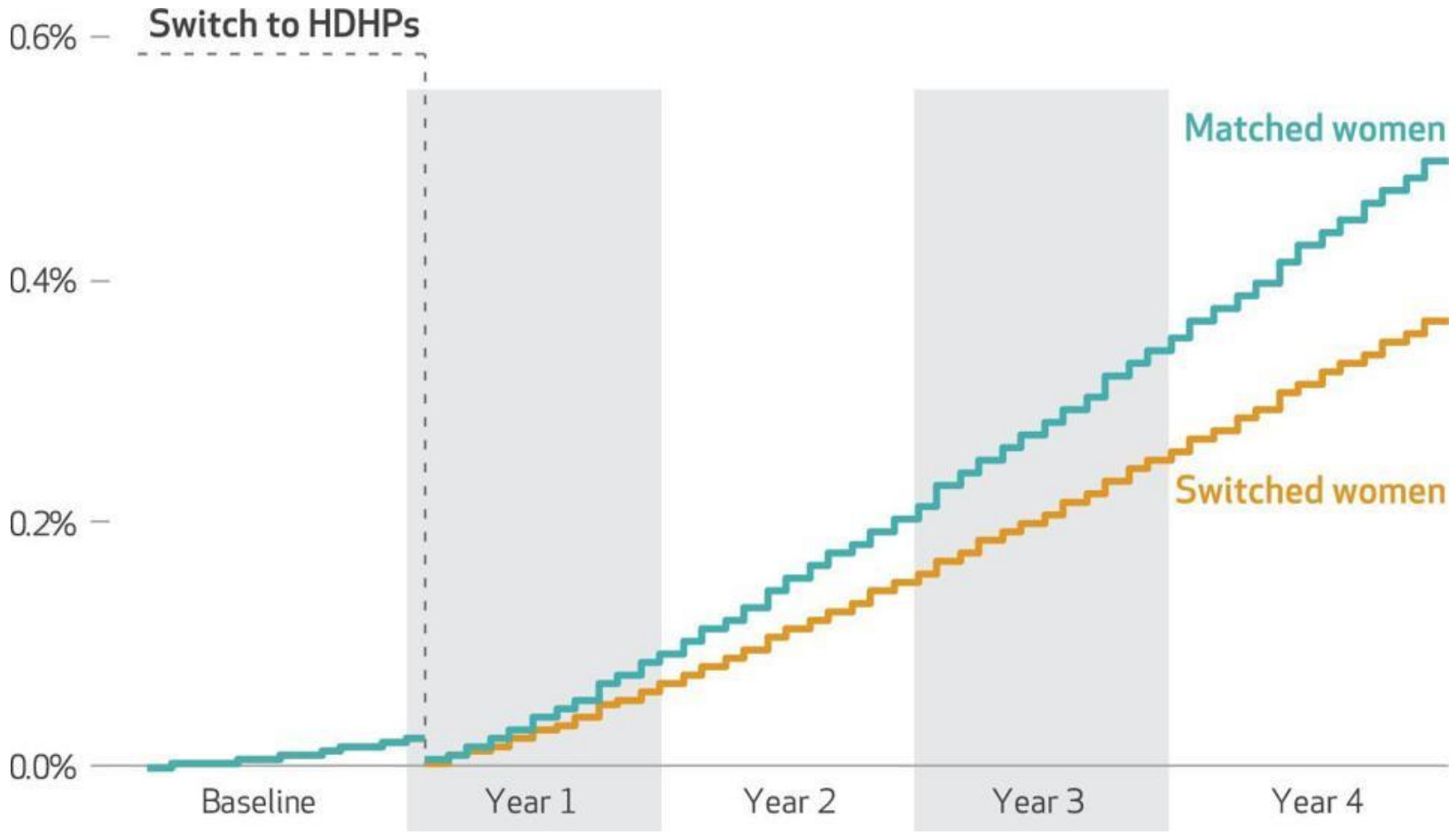
Reconciling Self-Pay Final Charges with Estimates



**The Reconciliation should take no more than 3 business days*

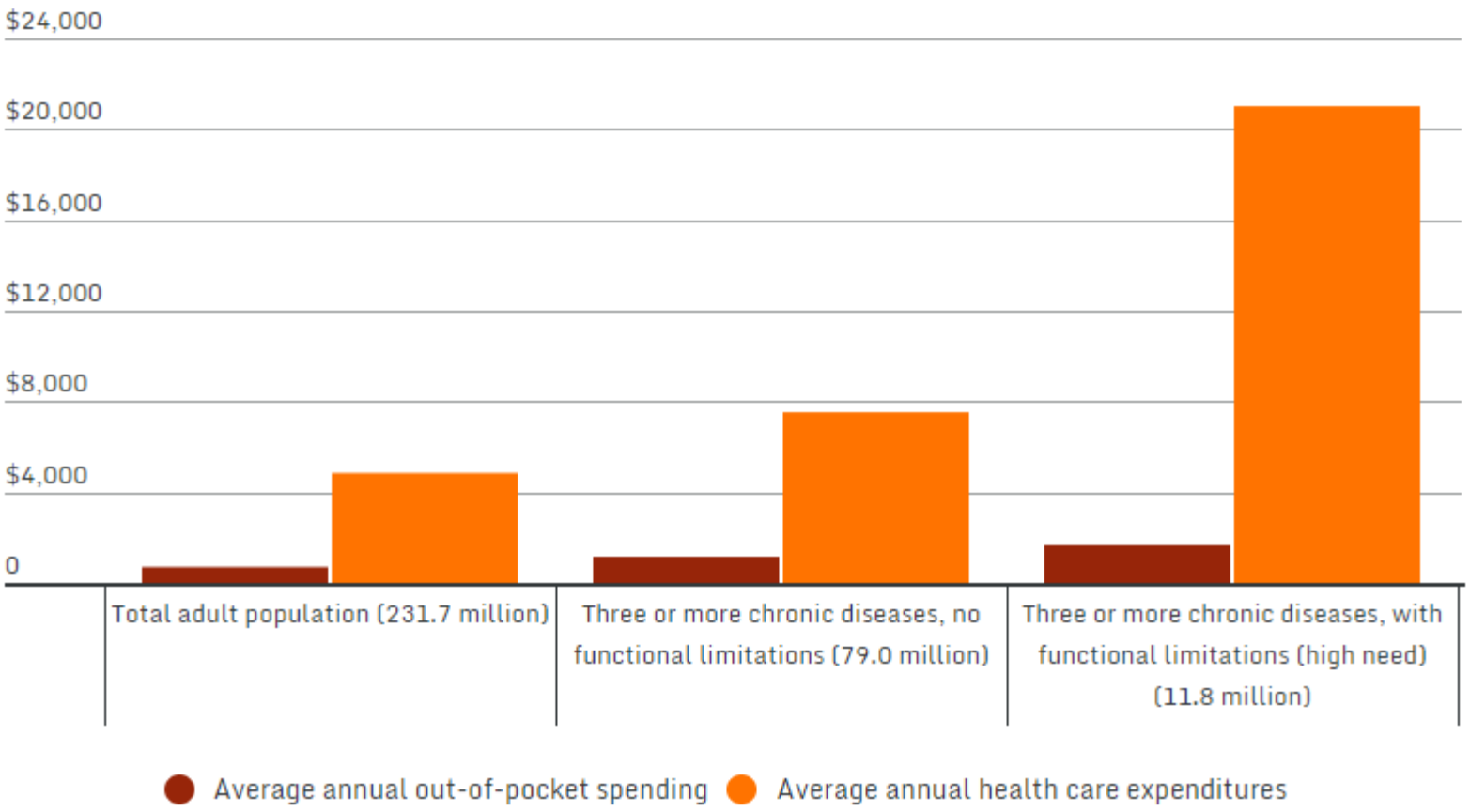
Those with high cost medical conditions and lower income are less likely to receive treatment

Women less likely to receive chemotherapy for breast cancer if facing high out of pocket costs



High Need Adults have out of pocket costs 3x higher than those with chronic conditions only, and 4x higher than the average US adult

Adults with High Needs Have Higher Health Care Spending and Out-of-Pocket Costs



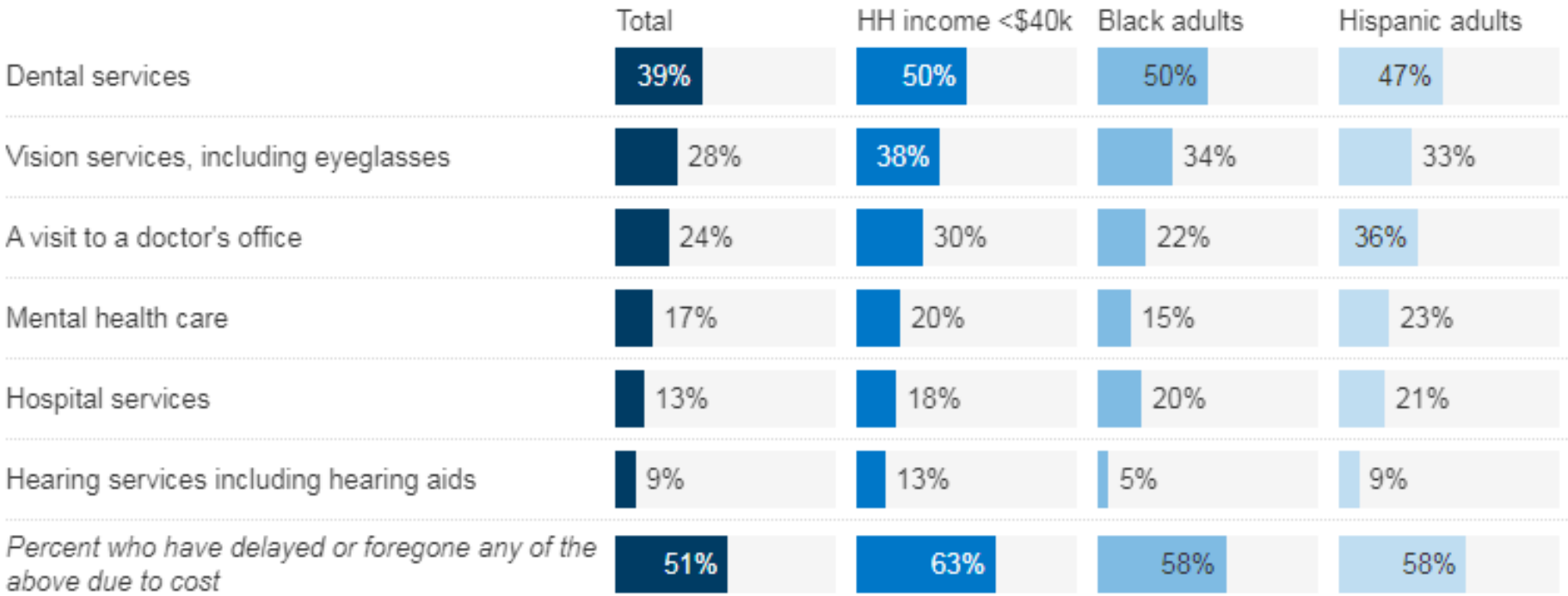
Note: Noninstitutionalized civilian population age 18 and older.

Data: 2009-2011 Medical Expenditure Panel Survey (MEPS). Analysis by C. A. Salzberg, Johns Hopkins University.

Black and Hispanic Adults more likely to delay or skip care

Half Of U.S. Adults Report Skipping Or Delaying Medical Care Due To Cost, Including About Six In Ten Lower Income, Black and Hispanic Adults

Percent who say they have delayed or gone without each of the following in the past year due to the cost:



NOTE: See topline for full question wording.
SOURCE: KFF Health Tracking Poll (Sept. 23-Oct. 4, 2021) • PNG

KFF

Out of Pocket Costs as Side-effects

- “Discussing out-of-pocket costs enables patients to choose lower-cost treatments when there are viable alternatives”
- “Such discussions could assist patients who are willing to trade off some chance of medical benefit for less financial distress.”
- “Discussing out-of-pocket costs could benefit patients by enabling them to seek financial assistance early enough in their care to avoid financial distress.”
- “A growing body of evidence suggests that including consideration of costs in clinical decision making might reduce costs for patients and society in the long term.”

Full Disclosure — Out-of-Pocket Costs as Side Effects Peter A. Ubel, M.D., Amy P. Abernethy, M.D., Ph.D., and S. Yousuf Zafar, M.D., M.H.S. N Engl J Med 2013; 369:1484-1486 October 17, 2013

When topic of healthcare spending arose during clinical encounters, physicians discuss strategies to reduce expenses 44% of the time.

Hunter WG, Zhang CZ, Hesson A. Davis JK, Kirby C. Williamson LD et al. “What strategies to physicians and patients discuss to reduce out of pocket costs?” Med Decis Making 2016 Jan 19

Engage Clinicians in Cost of Care

Help patients make informed decisions about treatment plans

Physicians can consider less expensive alternatives and long-term solutions

When financial concerns are raised by patients, explore further

Peter A. Ubel, Cecilia J. Zhang, Ashley Hesson, J. Kelly Davis, Christine Kirby, Jamison Barnett and Wynn G Hunter, Study of Physician and Patient Communication Identifies Missed Opportunities to Help Reduce Patient's Out-of-Pocket Spending. Health Affairs 35, no.4 (2016);654-661

Engage Clinical Team

Recognize the needs of price-sensitive patients

- Be alert to risk factors associated with burden from out of pocket costs (advanced age, multiple comorbidities, low income, self pay, HDHP)
- Invite patients to raise their concerns

Help patients identify providers that offer the best value

- Minimize expenses by using generic and lower cost brand names

"Patient –Physician Communication About Out-of-Pocket Costs" JAMA, August 20, 2003—Vol 290 No 7

Questions on Self-Pay Regulations?

Insured Out-of-Network Regulations

Lecture

Out-of-Network Notice & Consents

Emergency Care	Post Stabilization	Nonemergency Care
Out-of-Network balance billing is <u>prohibited</u> • Additional out-of-network cost-sharing amounts cannot be billed to the patient for emergency care up to the point of stabilization. • The patient's in-network cost-share must remain unchanged.	**Balance billing is <u>conditional</u> and only allowed when:** • The attending or ED physician must be the one to determine the patient's ability to travel to an in-network provider by means on their own transportation. • The attending or ED physician assess that the patient is in a mental and physical condition to comprehend and give consent for OON post-stabilization care. • The Notice & Consent must be provided a minimum of 3 hours prior to care • Please note consent DOES include a good faith estimate	**May provide Notice & Consent to bill OON <u>except</u> for the following:** • Some ancillary services: anesthesiology, pathology, radiology, neonatology and diagnostic services, • Items and services provided by assistant surgeons, hospitalist and intensivist, • Unforeseen services that arise due to urgent medical care during a consented medical service, and • If there is no in-network provider available to furnish the item or service at the facility the patient is seeking care.

No Surprises Act Key Impacts

Insured Patients

Health Plan Requirements

- The Health Plan **must cover emergency services as if they were in-network** – without any more restrictive utilization management requirements and at no more than the in-network cost-sharing amounts.
- Health Plans are no longer permitted to look to final diagnosis to determine medical necessity, they **must refer to admitting diagnosis/ chief complaint and consider prudent layperson.**
- Health Plans are **permitted to deny for medical necessity or non-coverage.**
- Providers **must bill the health plan to ascertain the amount to bill patients.** The amount the health plan calculates is to be based on state law or qualifying payment amount (QPA).
- Plans will need to **provide an "Advanced Explanation of Benefits" (AEOB)** prior to scheduled care or upon request by patients seeking more information prior to scheduling items and services.

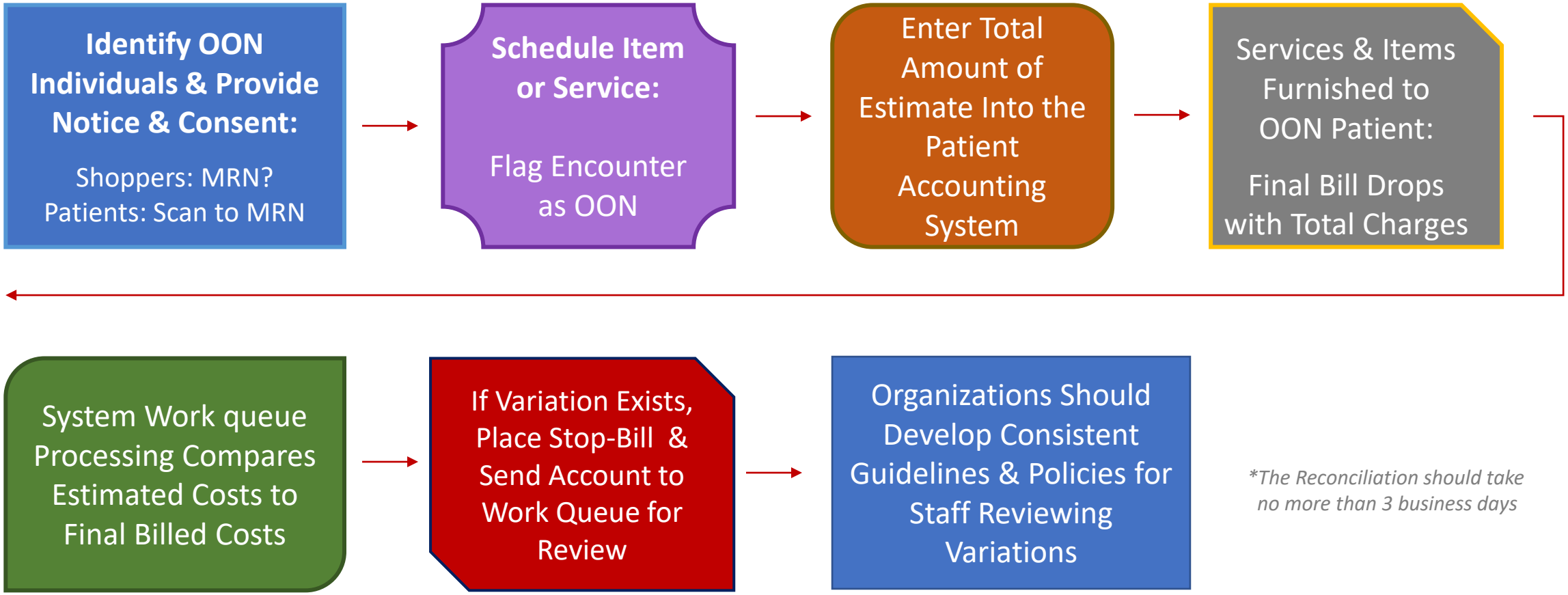
Delay until Further Rulemaking

The Advanced Explanation of Benefits (AEOB)

AEOBs must include:

- Whether the provider and facility are in-network and either the contracted rate for the item or service (if in-network) or information on finding in-network providers for the item or service (if out-of-network).
- The “good faith estimate” provided by the provider, with a delineation by the health plan of the portion the patient should expect to pay and the portion the health plan is expected to pay.
- An estimate of the amount the patient has incurred toward their deductible and cost-sharing limits.
- Information on any medical management (prior authorization) required for the item or service.
- A disclaimer that all information included in the notice is an estimate and subject to change.

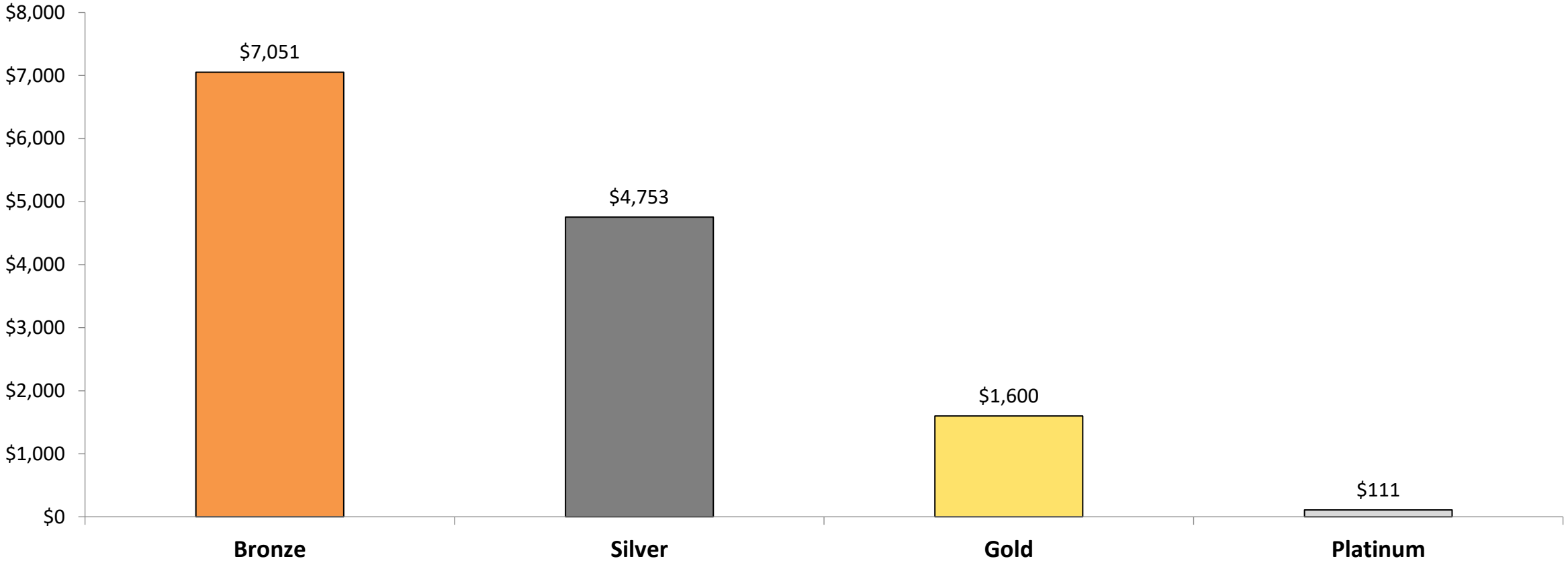
Reconciling OON Final Charges with Estimates



**The Reconciliation should take no more than 3 business days*

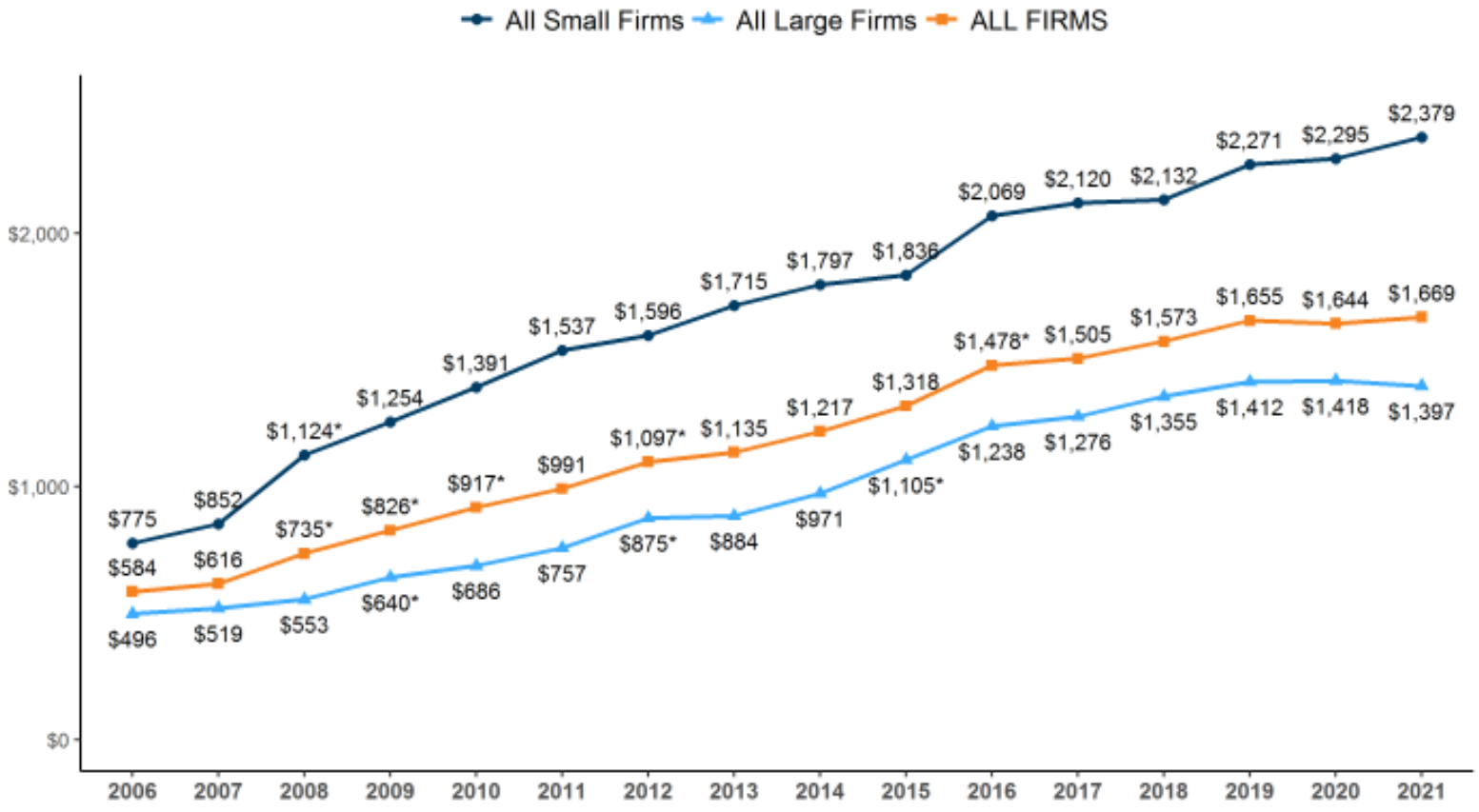
Cost Sharing in Federal Marketplace Plans:

Average Medical Deductible in Plans with Combined Medical and Prescription Drug Deductibles (2022)



SOURCE: KFF analysis of Marketplace plans in states with Federally Facilitated or Partnership exchanges in 2022. Data are from Healthcare.gov.

Average Deductible for Single Coverage



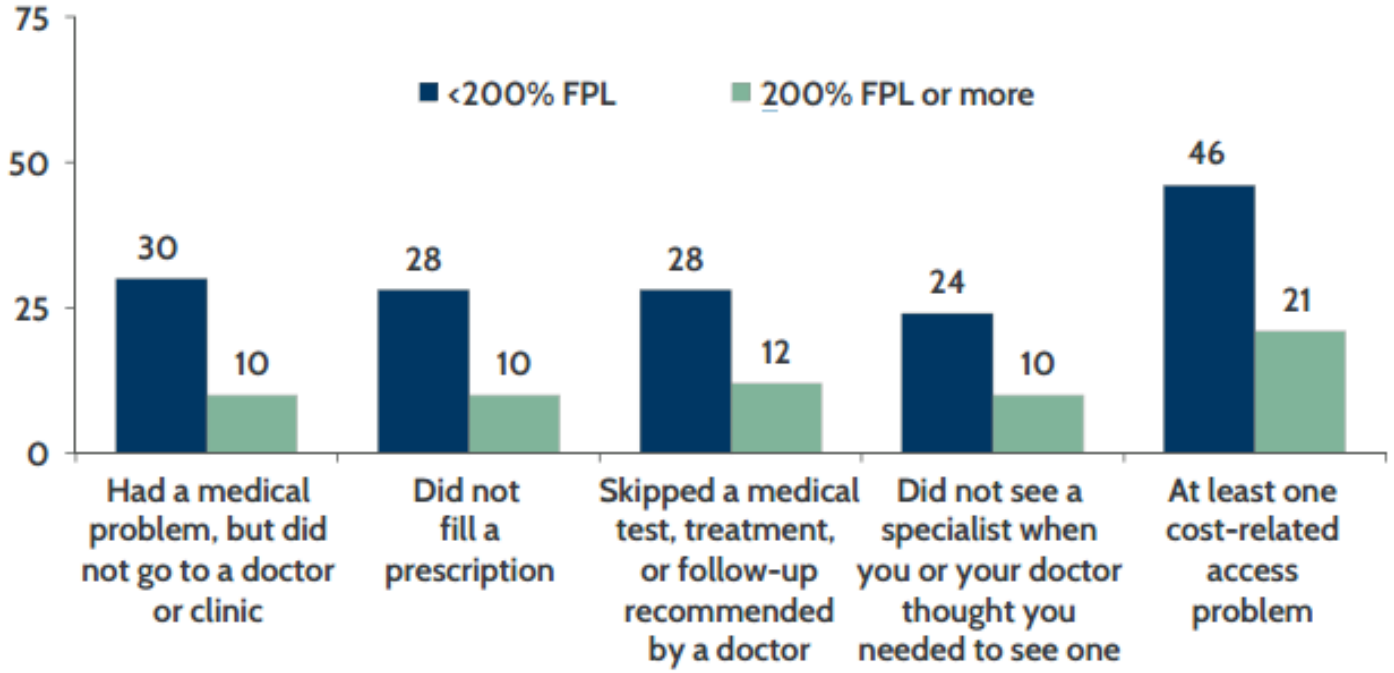
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual deductibles are for in-network providers.

SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Patients Delay or Avoid Care Because of Copayments or Coinsurance

Half of U.S. adults say they put off or skipped some sort of health care or dental care in the past year because of the cost. Three in ten (29%) also report not taking their medicines as prescribed at some point in the past year because of the cost.



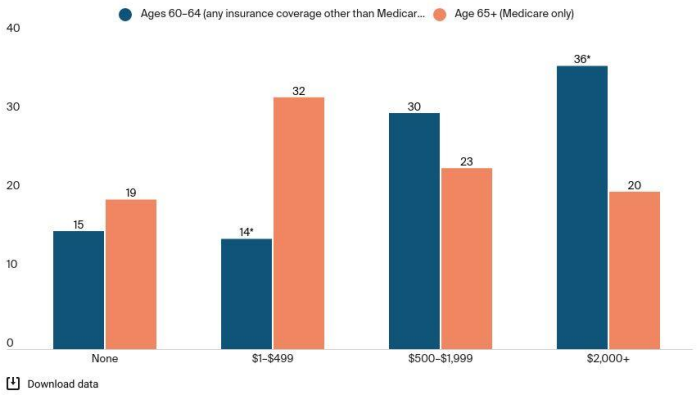
Insured adults ages 19–64 who pay a copayment or coinsurance

Note: FPL refers to federal poverty level.
Source: The Commonwealth Fund Health Care Affordability Tracking Survey. September-October 2014.

Older Adults face Cost Barriers to Care

In 2020, more than a third of insured adults ages 60–64 paid $2,000 or more out of pocket for health care, compared to a fifth of people age 65 and older.

Percentage of out-of-pocket costs for U.S. adults, by age



Download data

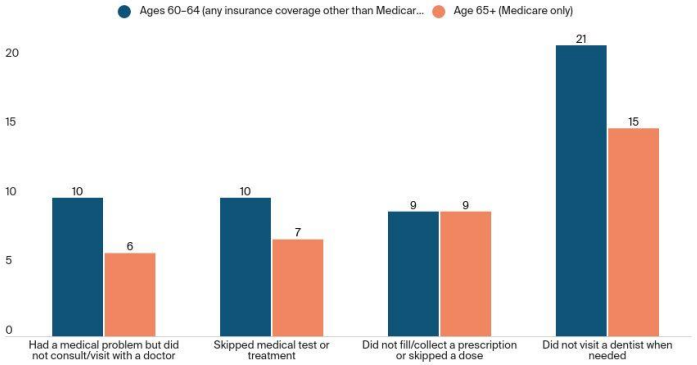
Note: The age 65+ group includes only respondents who reported Medicare coverage. The ages 60–64 group excludes those who did not report a source of insurance coverage and those who reported Medicare coverage.
* Indicates result is statistically different from the age 65+ group at the p < 0.05 level.

Data: Commonwealth Fund 2021 International Health Policy Survey of Older Adults.

Source: Gretchen Jacobson et al., "Older Adults on Medicare and Those Near Medicare Age Face Cost Barriers to Care," *To the Point* (blog), Commonwealth Fund, Nov. 2, 2021. https://doi.org/10.26099/H3GY-2N66

Similar shares of insured adults ages 60 to 64 and those age 65 and older on Medicare reported postponing or forgoing health care because of cost.

Percentage of older Americans who reported the following because of cost, by age:



Download data

Note: None of the differences are statistically significant at the p < 0.05 level. The age 65+ group includes only respondents who reported Medicare coverage. The ages 60–64 group excludes those who did not report a source of insurance coverage and those who reported Medicare coverage.

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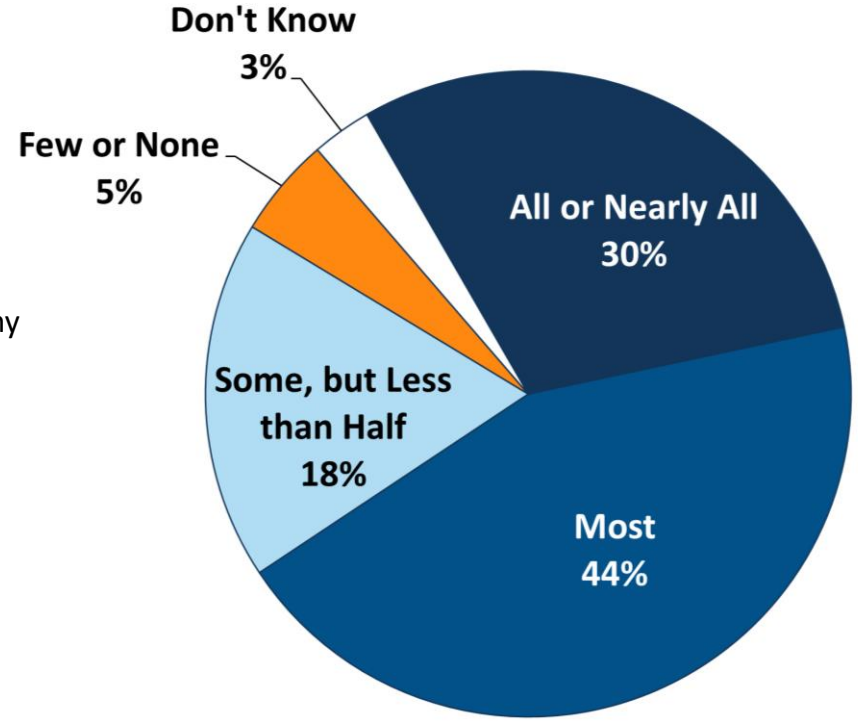
Patients Don’t Speak the Language of Health Insurance…

Consumers Needing Help Understanding Basic Insurance Concepts

Among your Program’s clients who considered or purchased QHPs, how many needed help understanding basic insurance terms, such as “deductible” or “in-network service”?



price • estimates • copayment • premium • explanation of benefits • code • insurance • allowed amount • contracted services • debt • high-deductible health plan • cost sharing • noncovered • health savings account • out-of-pocket • bills • coinsurance

Note: Data may not sum to 100% due to rounding.
Source: Kaiser Family Foundation, *2015 Survey of Health Insurance Marketplace Assister Programs and Brokers*, August 2015.

Consumers Want Better Price Information

January 2013

Robert Wood Johnson Foundation

Consumer Attitudes on Health Care Costs: Insights from Focus Groups in Four U.S. Cities

Anger and Confusion as Rising Premiums and High Deductibles Claim a Bigger Share of Household Budgets

Workers covered through their employer pay 97 percent more for their family insurance premiums than they did in 2002, while their wages increased just 33 percent over the same period.[1] New focus group research shows that families are well aware of the rising cost of health care, and some participants say they are changing their behaviors to avoid illness as they struggle to pay insurance premiums and out-of-pocket medical costs.

To gain a better understanding of what consumers think about the rising cost of health care, the Robert Wood Johnson Foundation (RWJF) recently convened a series of eight focus groups with consumers in four U.S. cities: Philadelphia; Charlotte, N.C.; Chicago; and Denver. The participants had diverse backgrounds. Half of the groups were comprised of people with employer-sponsored insurance with deductibles of $500 or more. Two groups were comprised of people who purchased their insurance on the private market, and also had deductibles of $500 or more. One group was made up of Medicare beneficiaries, and one group was uninsured. This brief contains key insights from the focus group discussions.

Few participants seemed to really understand how insurance works and/or how doctors are paid, though there was considerable commentary about doctors no longer making the salary that they once did. The issue of massive Medicare costs hardly came up, unless it was in reference to Medicare deductibles or one falling into the so-called 'donut-hole' of non-covered prescription costs.

Participants were aware of rising costs of care, but didn't understand why it's happening.

Universally, participants were extremely aware of the effects the rising cost of care had on their pocketbooks and the accelerating speed at which costs have risen in recent years. That said, they didn't know why costs are going up or how to decipher them.

Nearly all of the participants said they experienced increased out-of-pocket costs in recent years, primarily due to rising premiums and deductibles. Since what comes out of participants' pockets or paychecks has been increasing, they were highly attuned to it. For those with employer-sponsored insurance, one or two credited their employer with paying more in recent years to help share the increasing cost burden. Others reported employers changing health plans multiple times in recent years in an effort to cut costs, but most participants seemed to view the insurance cost increases as largely being absorbed by employees themselves.

"Participants repeatedly said they wanted to see a resource, or ask their doctor, to better understand what a particular test or procedure would cost before they agreed to it, and wanted to comparison shop among providers when possible. They said that they also wanted the ability to know what a treatment *should* cost before they agreed to it, and needed more transparent information on price in order to do this….They were very interested in efforts to share information on price and quality."

Source: Robert Wood Johnson Foundation. Consumer Attitudes on Healthcare Costs: Insights from Focus Groups in Four U.S. Cities. January 2013. http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/01/consumer-attitudes-on-health-care-costs--insights-from-focus-gro.html

An Actionable Definition of Price Transparency

Readily available information on the price of healthcare services, that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value.

Guiding Principles

Price transparency information should:

- Empower patients and other care purchasers to make meaningful price comparisons
- Be easy to use and easy to communicate
- Be paired with other information that defines the value of services for the care purchaser
- Enable patients to understand the total price of their care and what is included in that price

And price transparency will require the commitment and active participation of all stakeholders.

Consumerism Resources

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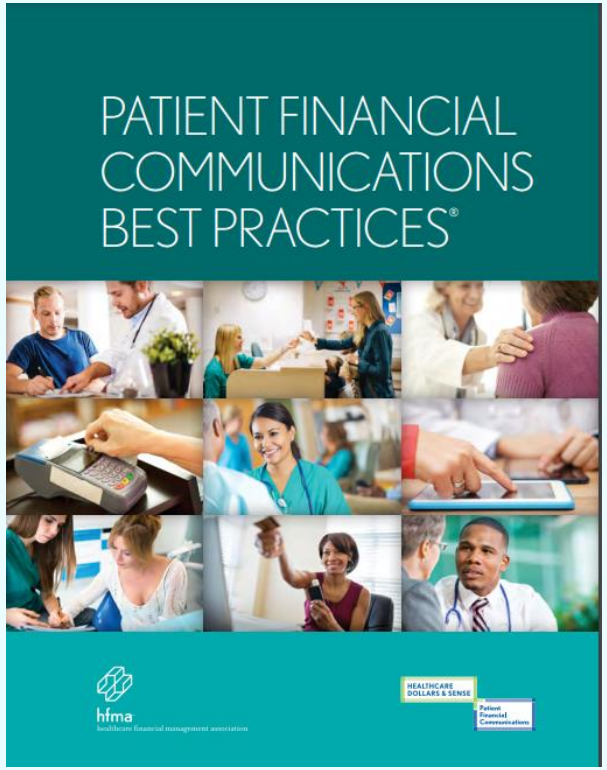
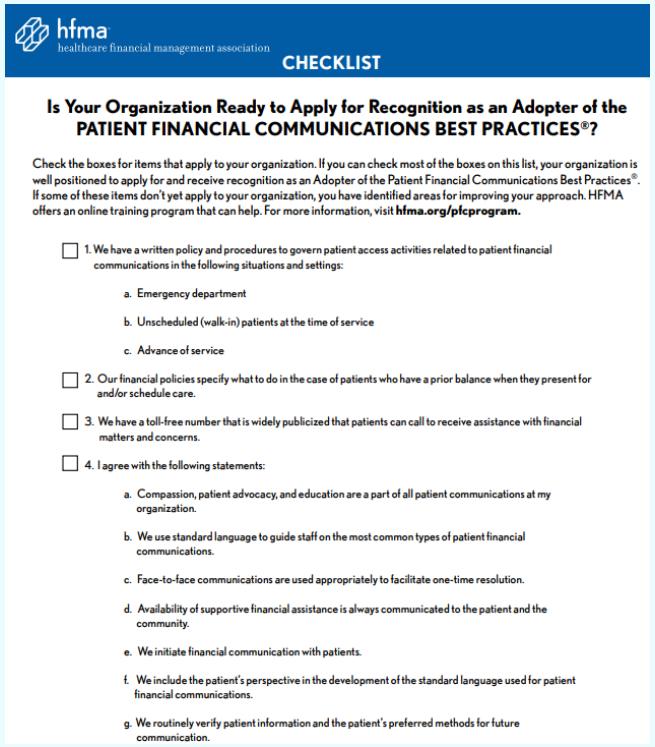
Patient Financial Communications Adopter Recognition Program





hfma healthcare financial management association

CHECKLIST

Is Your Organization Ready to Apply for Recognition as an Adopter of the PATIENT FINANCIAL COMMUNICATIONS BEST PRACTICES®?

Check the boxes for items that apply to your organization. If you can check most of the boxes on this list, your organization is well positioned to apply for and receive recognition as an Adopter of the Patient Financial Communications Best Practices®. If some of these items don't yet apply to your organization, you have identified areas for improving your approach. HFMA offers an online training program that can help. For more information, visit **hfma.org/pfcprogram.**

☐ 1. We have a written policy and procedures to govern patient access activities related to patient financial communications in the following situations and settings:

- a. Emergency department
- b. Unscheduled (walk-in) patients at the time of service
- c. Advance of service

☐ 2. Our financial policies specify what to do in the case of patients who have a prior balance when they present for and/or schedule care.

☐ 3. We have a toll-free number that is widely publicized that patients can call to receive assistance with financial matters and concerns.

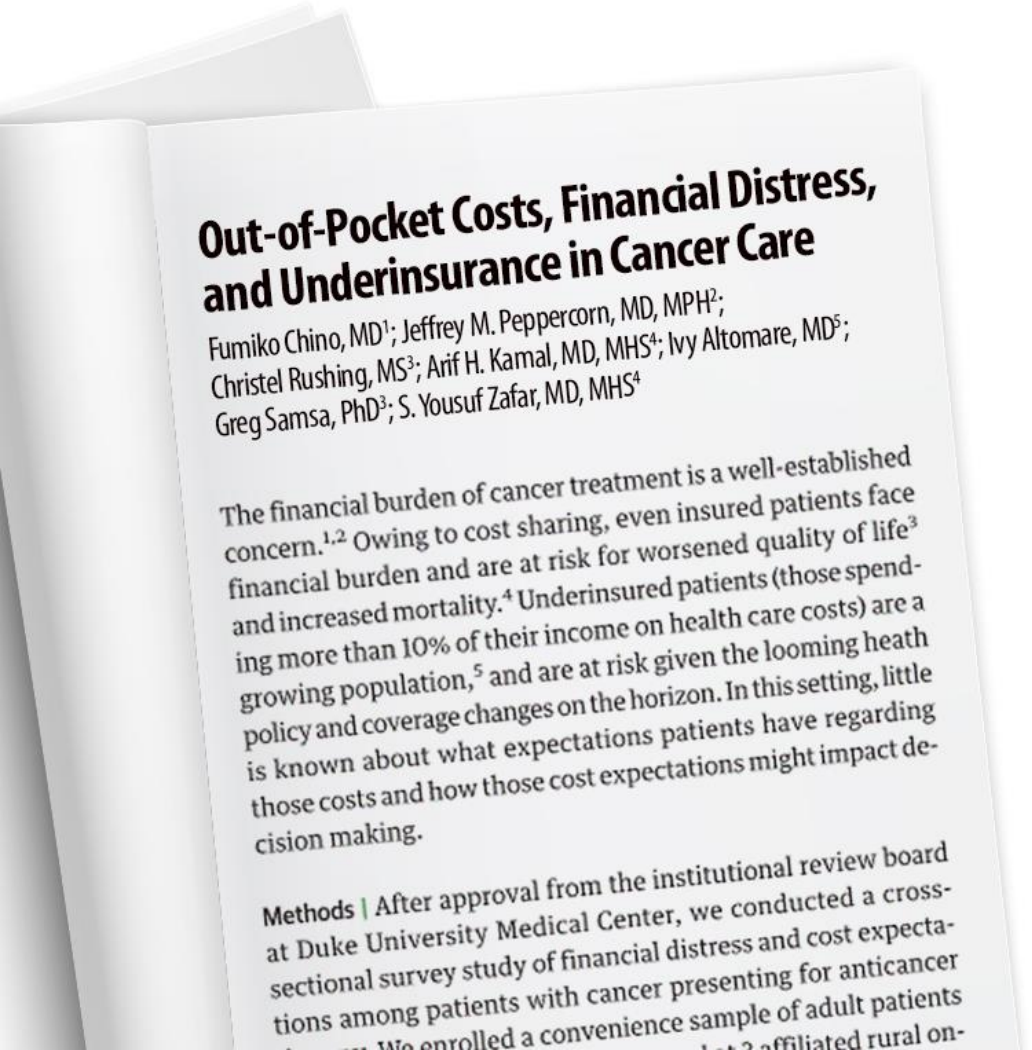
☐ 4. I agree with the following statements:

- a. Compassion, patient advocacy, and education are a part of all patient communications at my organization.
- b. We use standard language to guide staff on the most common types of patient financial communications.
- c. Face-to-face communications are used appropriately to facilitate one-time resolution.
- d. Availability of supportive financial assistance is always communicated to the patient and the community.
- e. We initiate financial communication with patients.
- f. We include the patient's perspective in the development of the standard language used for patient financial communications.
- g. We routinely verify patient information and the patient's preferred methods for future communication.

hfma.org/dollars

- Complete the Checklist to see if you are ready to apply
- Complete an application to become a "Supporter of the Patient Financial Communications Best Practices"
- Adopter organizations receive a certificate and are listed on HFMA's Website.

It Doesn't Always Have to be Complicated



Out-of-Pocket Costs, Financial Distress, and Underinsurance in Cancer Care

Fumiko Chino, MD[1]; Jeffrey M. Peppercorn, MD, MPH[2]; Christel Rushing, MS[3]; Arif H. Kamal, MD, MHS[4]; Ivy Altomare, MD[5]; Greg Samsa, PhD[3]; S. Yousuf Zafar, MD, MHS[4]

The financial burden of cancer treatment is a well-established concern.[1,2] Owing to cost sharing, even insured patients face financial burden and are at risk for worsened quality of life[3] and increased mortality.[4] Underinsured patients (those spending more than 10% of their income on health care costs) are a growing population,[5] and are at risk given the looming heath policy and coverage changes on the horizon. In this setting, little is known about what expectations patients have regarding those costs and how those cost expectations might impact decision making.

Methods | After approval from the institutional review board at Duke University Medical Center, we conducted a cross-sectional survey study of financial distress and cost expectations among patients with cancer presenting for anticancer

"One easy thing for a provider to do is to ask very simply,

'Are you able to afford this treatment?'

For patients who say no, we can refer them to financial counselors, or social workers or pharmacists to get them resources in a timely fashion."

Yousuf Zafar, M.D., M.H.S.
Duke University Medical Center

Questions on Out-of-Network Cost Estimates?


BONUS

The Public Health Emergency Phase-out

- The Extension of the Public Health Emergency expires on Oct. 13, 2022
- Talks that the PHE will be extended through the end of the year.
- Most states are saying they are well prepared now for redeterminations.

- Non-MAGI Medicaid related eligibility to be impacted the most.
    - States are estimating a 10% reduction of Non-MAGI enrollment after PHE period
    - Non-MAGI aged and disabled individuals
    - Individuals with changes in income during pandemic
    - Inability to contact for redeterminations

The 340B Lawsuit & Settlement

- June 15, 2022: the Supreme Court found that HHS' cuts to outpatient reimbursement rates for certain hospitals participating in the 340B Drug Pricing Program were unlawful
- The Court did not, however, specify the remedy for reimbursement cuts.
- Aug. 3, 2022: the case was remanded to the U.S. District Court to determine how the affected 340B hospitals should be repaid.
    - Motion to halt 340B reimbursement cuts to hospitals for the remainder of 2022
    - Motion to include 2020-2022 cuts (previously only 2018-2019 included)
    - Motion to correct underpayment for 2018-2022 in a non-budget neutral manner

The Inflation Reduction Act Healthcare Impacts

- **Drug Price Negotiations** -
    - Beginning in 2026, Medicare can negotiate the prices of 10 drugs; increasing to 15 drugs in 2027 and 20 drugs in 2029
- **Limit Out-Of-Pocket Drug Costs** -
    - $2,000 drug cost cap for older Americans and those with disabilities
- **Drug Inflation Costs** -
    - Requires drug manufactures to pay rebates if their medication prices increase faster than inflation.
- **Curb Insulin Costs** -
    - Cap the price of insulin at $35 per month for Medicare patients
- **Affordable Care Act Subsidies -**
    - Extend subsidies for low-and middle-income Americans buying exchange plans set to expire at the end of this year hiking premiums $6,600 with the average middle class couple nearing retirement seeing premium hikes close to $16k