ADDRESSING THE SURPRISES IN THE NO SURPRISES ACT

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PURPOSE OF PRESENTATION

- To provide an understanding of the fundamental principles at work in the NSA
- Reveal the "Surprises" in the No Surprises Act
- To describe the paths forward to face these challenges
- Explain why we are and should remain cautiously optimistic.

THE PURPOSE OF THE NSA AND ITS ESSENTIAL PROVISIONS

- **Patient Protection-Protect the Patient from an OON balance bill when they did not choose to go OON**
  - Emergency
  - “Inadvertent”
- **Arbitration between the Carrier and the OON medical provider**
  - Extremely tight timeframes
  - Factors to be considered in determining reimbursement

HOW DOES THE NSA INTERACT WITH SIMILAR STATE LAWS?

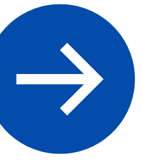
- States with Surprise Bill Laws (SBL's)--bifurcated
- States without SBL's—all to the federal process
- Out-of-state plans

THE FACTORS IN THE LAW TO BE CONSIDERED BY THE ARBITRATOR IN DETERMINING REIMBURSEMENT

- Qualified Payment Amount (QPA), defined as the median in-network rate
- Experience of provider
- Market share
- Acuity of the patient
- Teaching status of facility
- Good faith efforts to participate and previous “contracted” rates

THE 1ST SURPRISE AND CMS'S 1ST GIFT TO THE INSURANCE INDUSTRY.

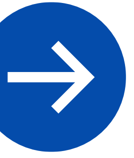
Though the Qualified Payment Amount (QPA) or the Median In-network (INN) Rate is one of several factors, CMS determined that the QPA enjoyed a “Rebuttable Presumption” in its favor.



THE CARRIERS TAKE FULL ADVANTAGE

The insurance industry takes full advantage and drops out-of-network (OON) reimbursements immediately down to a median INN rate,

Even for elective surgeries, to which the QPA does not apply, and beginning 1/1/22.



Delay and delay.

- The portal for filing arbitrations is not established until April.
- Worse--Arbitration decisions were not forthcoming even by December of 2022.
- 90,000 filed in the second and third quarters of 2022 and supposedly 4% resolved.

THE 2ND SURPRISE AND CMS'S 2ND GIFT TO THE INSURANCE INDUSTRY

THE TEXAS MEDICAL ASSOCIATION CHALLENGES THE QPA + WINS

A victory in the context of arbitration, but the arbitration decisions are still not forthcoming.

"Nothing in the Act . . . instructs the arbitrators to weigh any one factor or circumstance more heavily than the others."

CMS issues new "Guidance" without the rebuttable presumption" in favor of the QPA.

THE 3RD SURPRISE AND 3RD GIFT

Batching

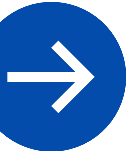
The "batching" provisions of the law, which permit multiple similar claims to be brought against the same payor do not permit "batching" of more than 1 CPT Code in an arbitration.

Per Claim Basis

The result is that arbitrations must be on a per-code basis, not on a per-claim basis.

No Common Sense Interpretation

An interpretation that has no connection to common sense, is not supported in the language of the law, and is contrary to every industry standard in existence across the country, to say nothing of the inefficiency this generates.



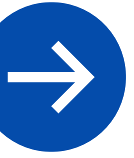
Effective 1/1/23

- A 7X increase in the filing costs—from $50 to $350
- Increases in the arbitrator fees.

THE 4TH SURPRISE AND THE 4TH GIFT TO THE INSURANCE INDUSTRY

THE TEXAS DISTRICT COURT THROWS OUT - FOR THE SECOND TIME - CMS'S RULES REGARDING THE QPA

On 2/6/23, the Court concluded that the rules still unduly favor the QPA even though the rebuttable presumption has been removed.

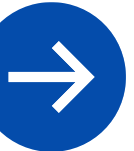


2/10/23 CMS TURNS LEMONADE BACK INTO LEMONS

Moratorium on all arbitration resolutions.

This means arbitrations have to continue to be filed—no moratorium there—but there will be a hold on resolutions.

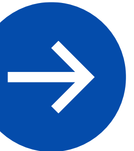
So, the medical industry is expected to keep filing (at an increased cost) with no revenue coming in from successful arbitrations and no guidance on how to succeed from arbitrators.



BEGINNING 2/27/23

CMS LIFTS THE MORATORIUM ON ARBITRATION RESOLUTIONS FOR DATES OF SERVICE PRIOR TO 10/25/23, AND A SHORT TIME LATER ISSUES NEW GUIDELINES FOR THE ARBITRATORS.

Resolutions are finally coming in and are encouraging but it will take time for the arbitrators to catch up.



THE TEXAS MEDICAL ASSOCIATION CHALLENGES BOTH THE PER-CODE REQUIREMENT AND THE COST INCREASE

An April briefing and argument scheduled on these issues, which, in legal terms is fairly short.

CAUTIOUS OPTIMISM AT THE FEDERAL IDR LEVEL

- Moratorium on resolutions is lifted
- A better success rate in light of new regs

It is possible that by Summer

- The Court throws out the per-code requirement
- The Court throws out the CMS rate increase

CAUTIOUS OPTIMISM GENERALLY?

- There is a friendly forum in the Texas District Court for continuing to challenge problematic aspects of the law.
- The arbitrators themselves are incentivized to at least be considerate of the most important player in this process—the medical industry.
- If the regulators get this wrong, they will destroy the emergency medical industry across America.
- The state processes have at least settled down into something predictable and often friendly, and hopefully the Federal process will do the same.

THANK YOU

Q&A

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