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The No Surprises Act: What Neuroradiologists Should Know

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The No Surprises Act (NSA) is the first federal law to address surprise medical billing and became effective as of January 2022. This law prohibits balance billing to patients who receive unexpected out-of-network care and limits patient payments to their in-network cost-sharing (coinsurance, copay, or deductible). The remaining balance is determined through negotiations between insurers and providers. If negotiations are unsuccessful, these parties enter an arbitration process termed independent dispute resolution (IDR). Many neuroradiologists and neurointerventionalists are involved in care that may be subject to the NSA, such as stroke or trauma work-ups from the emergency department, and, thus, should be aware of the implications.

While the patient protections of this law are commendable, the IDR process is problematic because it uses a benchmark-like approach to determine disputed payments, favoring insurers. In IDR, payment determinations are largely based on the median in-network contracted rate of a health plan, termed the qualifying payment amount (QPA). Because of how the QPA is calculated, this amount may often be lower than typical contract rates for the services. The federal arbitration process is thus likely to lower payments from insurers for out-of-network emergency care as well as increase costs to physician groups requiring arbitration. Moreover, if insurers can pay lower prices for out-of-network care, they are less incentivized to maintain robust provider networks and have greater leverage in network contract negotiations. Therefore, while the NSA pertains to out-of-network emergency care, it is anticipated to also disrupt in-network contracts and good faith contract negotiations.

Background

Personal health care costs, especially unexpected medical bills, are a major concern among Americans, even for those with health insurance.[1] An important-but-often misunderstood issue is unanticipated out-of-network costs. If a person with private health insurance receives care from an out-of-network provider, his or her health plan typically pays at least a portion of the bill. The patient is then billed for the remaining amount, which can be much greater than expected. This practice is known as balance billing, and an unexpected balance bill is called a "surprise bill."[2] The term surprise billing is a misnomer because the practice actually reflects a surprise gap in insurance coverage.[3]

The NSA is a federal law that went into effect in 2022 to address surprise medical billing. The name "No Surprises Act" places emphasis on balance billing and unfortunately does not also highlight surprise gaps in coverage. The NSA prohibits balance billing to patients in specific situations. Relevant to hospital-based specialties like radiology, the NSA covers out-of-network emergency care or nonemergency care delivered by out-of-network providers at an in-network facility. The NSA is considered a minimum standard, which means it applies if a state does not already have laws meeting minimum standards for protections against balance billing. The NSA does not apply to services payable by Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or TRICARE Health Insurance because each of these programs already largely prohibit balance billing.

Many neuroradiologists and neurointerventionalists are involved in care that may be subject to the NSA, such as stroke or trauma work-ups from the emergency department. With the NSA effective as of January 2022, practices should be aware of the situations in which the law applies, how insurers may act, and how to navigate out-of-network disputes. In this article, we also discuss aspects of the law that can be problematic for radiology practices and anticipated disruptions to in-network contracts as an insidious adverse effect.

Key Features of the NSA

Under the NSA, patient payment for unexpected out-of-network care is generally limited to in-network cost-sharing (coinsurance, copay, or deductible).[4] The remaining out-of-network balance is determined through negotiations between insurers and providers. If negotiations are unsuccessful, these parties enter an arbitration process, termed IDR.[5]

IDR uses third-party arbiters to settle disputed out-of-network payments between insurers and providers. In this process, the insurer and provider each propose a payment amount, and an arbiter selects one of the proposals as the final payment. The law provides a list of factors for the arbiter to consider in making the determination, of which the QPA is the first mentioned. The QPA is the median in-network contracted rate of a health plan (as of January 31, 2019) for a certain service in a particular geographic area. Additional criteria mentioned in the law include the training level of the physician, the complexity of care, and the previously contracted rate, among other factors. Information that cannot be considered in the IDR includes billed charges and public payor (eg, Medicare) reimbursement rates, which usually represent the highest and lowest payments, respectively. More detailed information about the IDR process can be found on the Centers for Medicare & Medicaid Services Web site (https://www.cms.gov/).[5]

Why the QPA Is Problematic

Rulemaking by the government has attempted to establish the QPA as an appropriate out-of-network payment amount. The government asserts that the QPA reflects rates achieved through typical contract negotiations and should therefore be a reasonable out-of-network rate.[4] However, the QPA calculation methodology does not reflect real-world economics. Instead of establishing the median in-network rate at the claims level, it is set at the contract level. This is an important distinction because contracted rates from providers who do not perform a service (and thus may not carefully negotiate

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that rate) are given the same weight in the QPA calculation as rates from providers who do frequently provide that service.

For example, a radiology practice with a robust neurointerventional section performs thousands of cerebral angiograms each year. This practice will value reimbursement for cerebral angiograms in network negotiations. In contrast, a group that rarely bills for cerebral angiograms may not focus on this rate during their contract negotiations because it will not significantly affect their revenue. The contracted rate from each of these practices is given equal weight when calculating the QPA. This calculation methodology may skew the QPA below the typical contracted rate of providers that generally perform the examination. This concern is more than hypothetical: A study found that more than half of surveyed primary care providers had contracted rates for advanced medical imaging examinations.[6] The government seems to acknowledge this problem of "ghost rates" and attempts to address the issue, though the end result remains to be seen.[7] Also of concern, when there are not at least 3 contracts from which to calculate the median (once subsegmented by procedures, provider, group, geography, and so forth), there is leeway for the insurer to modify the calculation.[8] This leeway provides an opportunity for insurers to influence the QPA value.

Before passage of the NSA, there was a great deal of debate about how to settle out-of-network payment disputes between insurers and providers. Ultimately, the law settled on an approach rooted in negotiation and arbitration. The arbitration process is intended to protect good faith contract negotiations. With arbitration, each party submits a proposed payment and evidence supporting that amount. The arbiter then selects an offer, by using "baseball style" rules, in which 1 of the 2 offers must be selected; the arbiter cannot split the difference. Baseball style arbitration promotes reasonability among participants because an unreasonable offer will be rejected (unless the other offer happens to be more unreasonable). As opposed to good faith negotiations with an arbitration backstop, insurers generally favor a benchmarking process to determine payment. This entails establishing a fixed rate for a service,[3] such as use of the QPA. By establishing a reimbursement ceiling, the benchmark approach can disrupt good faith contract negotiations.

Between passage of the NSA in December 2020 and the start date of January 1, 2022, the government established the policies of the law through a series of interim final rules (IFRs). The first IFR, released in July 2021, clarified situations in which the ban on surprise billing would apply and detailed the process for determining the QPA.[9] In September 2021, the second IFR was released outlining the federal IDR process. In this rule, arbiters were directed to presume that the QPA is the appropriate IDR payment amount unless there is credible information that demonstrates why the appropriate payment is materially different from the QPA.[8] This action essentially established the QPA as the main determinant of reimbursement.

Implications for Radiology Groups

The implications of the NSA for medical practices including radiology are substantial.

While the NSA pertains to out-of-network care, it can influence in-network contracting. If in-network practices are reimbursed at a rate higher than the QPA, insurers can opt not to renew contracts and instead deal with them as out-of-network providers. Given the many benefits of network contracting for medical practices, including timely payment and a less costly revenue cycle process, many practices may have to accept the reduced rates to stay in-network. The Congressional Budget Office and the Joint Committee on Taxation estimated that legislation using a median in-network benchmark rate would cause in-network rates to drop 15%–20% on average at the national level.[10] This result is because insurers would likely reduce rates for providers with higher contracted payments, while those with lower contracted payments would demand an increased rate (assuming a frictionless environment, in which groups that are below the median rate can actually go out of network to achieve higher rates if negotiations fail). The reality is that due to economics and hospital requirements, many medical practices do not have that luxury.

As proof of this threat, shortly after the second IFR, which benchmarked out-of-network payments to the QPA, was released, a large commercial insurance company in North Carolina sent letters to dozens of their in-network medical practices with take-it-or-leave-it offers. The practices were told that they must accept a substantial rate reduction or their contracts would be terminated and they would be pushed out of network.[11] Although the intent of the NSA was to end surprise out-of-network billing, these letters were sent exclusively to in-network practices. There is no evidence that the groups targeted in North Carolina ever participated in surprise billing. Furthermore, while a goal of the NSA was promotion of network contracting, a result of this benchmark approach was network disruption, as seen in North Carolina.

An insidious aspect of the benchmark approach using the QPA is that it disincentivizes health plans from maintaining robust provider networks. Smaller provider networks decrease the in-network patient population of a practice and limit patient access to physicians in nonemergent settings. Proponents of the benchmark approach argue that providers previously avoided being in-network to profit from surprise billing.[12] The claim specifically mentions radiology. In fact, there is no evidence that radiology practices chose to stay out of network to use surprise billing as a revenue-generating strategy.[3] Furthermore, it seems that a major health insurance company used undisclosed connections with a researcher to promote its narrative and frame the debate as the fault of provider groups.[10]

Insurers have financial advantages in the IDR process. By pursuing IDR, insurers can delay payments and retain profits. Medical practices, on the other hand, may struggle with cash flow as a consequence of delayed payments.[3] Insurers also have more financial resources than most radiology practices, so the IDR arbitration fees and increased legal or administrative work will be more burdensome to practices. Increased costs and delayed payments may impair the ability of a practice to staff facilities and deliver quality services. These costs also take up resources that could be used to improve patient care. Together, the process adds additional cost to the system and perhaps to the detriment of patient care.

Increased consolidation in health care may be another inadvertent consequence of the NSA.[13] Larger practices, with the advantages of scale, may have greater success with insurers. For

example, if a large radiology group develops in-house resources for successful IDR, insurers may find it more efficient to contract reasonably with them and reserve their aggressive tactics for smaller groups with fewer resources. A recent court case in Nevada demonstrated that health insurers may systematically underpay even large provider organizations; however, such groups can successfully fight back in court.[14]

Legal Challenges and Evolution of the NSA

The interim final rule in September 2021 placed the QPA above all other criteria in IDR and created a de facto benchmark for determining IDR payments unless it can be proved that the QPA is materially different from an appropriate payment rate. In law, this practice is referred to as a "rebuttable presumption." Because this was contrary to both the words and spirit of the law, the move prompted more than a half dozen lawsuits, including from the American College of Radiology.[15,16]

In February 2022, the judge in a lawsuit brought by the Texas Medical Association ruled that the creation of a rebuttable presumption was inappropriate and vacated that section of the rule.[17] The federal government filed an appeal in this lawsuit but later placed this on hold and revised its final rule to comply with the Texas court ruling.[18] In August 2022, the government released the final rule on the IDR process, including updates to comply with the Texas lawsuit decision. While the rule acknowledged that the QPA could not be a rebuttable presumption, it nonetheless highlighted the significance of the QPA in IDR determination. Specifically, the rule instructs arbiters to first consider the QPA and then consider additional credible information.[19]

The implication of the August final rule is that the QPA has outsized importance. Not only are arbiters instructed to first consider the QPA, the rule also specifies that if the arbiter assigns weight to non-QPA additional information, he or she must explain in writing why this information is not already accounted for by the QPA. For example, if a radiology group submits information regarding the level of training and experience of the neuroradiologist who provided the care (which is a criterion described in the law and rule), the arbiter would have to deem this irrelevant if he or she believes that this information was already considered in the QPA calculation. Because this approach of placing the QPA above the other criteria is contrary to the law, in September 2022, the Texas Medical Association filed a second lawsuit.[20]

CONCLUSIONS

Brain and spine imaging are frequently performed in emergency departments, and radiologists do not know or consider a patient's insurance status when interpreting these scans. It is expected that many neuroimaging studies may be out of network and subject to the NSA arbitration process to receive reimbursement. Because insurers are disincentivized to maintain robust provider networks if they can pay lower prices for out-of-network care through IDR, neuroradiologists will increasingly encounter out-of-network patients. A narrower network will also decrease the in-network population for routine outpatient imaging.

Physicians' efforts to re-establish a balanced law continue to emphasize patient protections. While the patient protections of the NSA are notable, it is easy to overlook the concerning implications of the arbitration process.[1,11] The QPA calculation and arbitration process can have substantial effects on radiology practices and the patients we serve. These complex challenges may be addressed in future rulemaking, underscoring the importance of awareness and advocacy.

Until those changes can be implemented, radiology practices may benefit from having a designated expert to handle out-of-network payment negotiations and navigate the IDR process. It may be tempting to decrease out-of-network cases by expanding network contracts, but this recourse might not always be worthwhile or possible. We have already seen an insurer attempt to force rate reductions on practices to remain in-network.[11]

These new out-of-network complexities and insurer tactics to unilaterally reduce physician reimbursement are a concern to practices and the patients they serve. Future research may focus on how access to care is impacted by implementation of the law. In the meantime, we advise practices to be aware of the law and insurer actions and emphasize the importance of physician advocacy.

Disclosure forms provided by the authors are available with the full text and PDF of this article at www.ajnr.org.

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