No Surprises Act: Government Enforcement and Potential Litigation

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Introduction

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- No Surprises Act and Good Faith Estimate requirements became effective January 1, 2022.
- As providers continue to fine-tune compliance plans, also need to focus strategies for independent dispute-resolution processes.
- Additionally, assess risk and develop risk-mitigation strategies related to potential government enforcement and private civil litigation.

Roadmap

- Pre-No Surprises Act (NSA) Landscape
- Brief NSA Overview
- Dispute Resolution Provisions Established by the NSA
- Private Rights of Action under NSA
- Government Enforcement of NSA

Surprise Billing

- What is a surprise bill?
  - Term of art. Generally, an out-of-network bill received either: (i) for emergency services provided at an out-of-network facility or (ii) services provided by an out-of-network provider at an in-network facility
  - Not merely a bill the patient didn't expect to receive
- Issue has received sustained attention in past years.
  - Sample headlines: "The Case of the $489,000 Air Ambulance Ride"; "When a Surprise Helper During Surgery is Out-of-Network"; "For Her Head Cold, Insurer Coughed Up $25,865."

Source: https://khn.org/news/article/the-case-of-the-489000-air-ambulance-ride/; https://khn.org/news/watch-when-a-surprise-helper-during-surgery-is-out-of-network/ ; https://khn.org/news/medical-bill-of-the-month-head-cold-throat-swab-dna-tests-insurer-coughed-up-25k/

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Surprise Billing – Fast Facts

- Surprise bills lead the list of affordability concerns; 2 in 3 adults are worried about unexpected medical bills.
- 1 in 5 emergency claims and 1 in 6 in-network hospitalizations include at least one out-of-network bill.
- Balance billing on surprise medical bills can reach hundreds or thousands of dollars.
- In 2020 study, mean potential balance bill per surgical episode with in-network primary surgeons and facilities was $2,011.

[1] Source: https://www.kff.org/private-insurance/fact-sheet/surprise-medical-bills-new-protections-for-consumers-take-effect-in-2022/

Pathway to Federal Action

- Over half of all states had partial or full protection for patients against surprise bills but:
  - Protections vary based on site of care, type of care, insurance type, etc.
  - Non-existent in some states
  - ERISA preemption: States cannot regulate ERISA plans (which cover more than half of the US population)
- Federal Action:
  - No Surprises Act passed as part of the Consolidated Appropriations Act, 2021.
  - Most provisions took effect January 1, 2022.
  - Good Faith Estimate Requirement

Two Purposes

1. Protect *commercially-insured patients* from “surprise” bills
   - Those who through no fault of their own receive services from out-of-network provider
   - Process for provider to secure payment from patient’s health plan
2. Provide *self-pay patients* with good faith estimate of charges

Surprise Billing

Application

- Provider cannot balance bill out-of-network patient for-
  - Emergency services furnished at hospital, freestanding ED, or ASC
    - Includes post-stabilization services
    - No prior authorization for emergency services
    - No defining “emergency services” by diagnosis code
  - Non-emergency services furnished at *in-network* hospital or ASC
    - Opportunity for patient to consent to balance billing only if patient selects provider in advance

Patient Charges

- Cannot charge patient more than in-network cost-sharing amount
- Calculated based on Qualifying Payment Amount (QPA)
  - Plan's median contracted rate for specific service in tsame geographic region within same insurance market as of 1/1/2019 adjusted annually by CPI-U
  - Plan must furnish to provider within 30 days of claim submission

Independent Dispute Resolution Process

Step in the Process	Must Be Completed By
1. Payer sends provider initial payment or notice of denial of payment (also sends QPA)	**30 business days** *Starting on day payer receives all relevant data*
2. Provider initiates 30-business-day open negotiation period	**30 business days** *Starting on day of initial payment or notice of denial of payment*
3. Either party initiates IDR process following failed negotiations	**4 business days** *Starting business day after the open negotiation period ends*
4. Mutual agreement on certified IDR entity selection; each party pays $50 administrative fee	**3 business days** *After IDR initiation date*
5. Feds select IDR entity if no agreement by parties	**6 business days** *After IDR initiation date*
6. Parties submit payment offers to IDR entity	**10 business days** *After date of certified IDR entity selection*
7. Payment determination made; loser pays IDR entity fee	**30 business days** *After date of certified IDR entity selection*
8. Payment completed	**30 business days** *After payment determination*

Relevant Factors

- ✓ Provider's training, experience, and quality and outcomes measures
- ✓ Provider's or plans' market share in relevant geographic region
- ✓ Patient acuity or complexity of furnishing the item/service
- ✓ Demonstration of good faith efforts (or lack thereof) made by provider or plan to enter into network agreements with each other, and, if applicable, parties' contracted rates during previous 4 plan years
- ✓ Additional relevant and credible information BUT NOT usual & customary charges or Medicare/Medicaid reimbursement rates

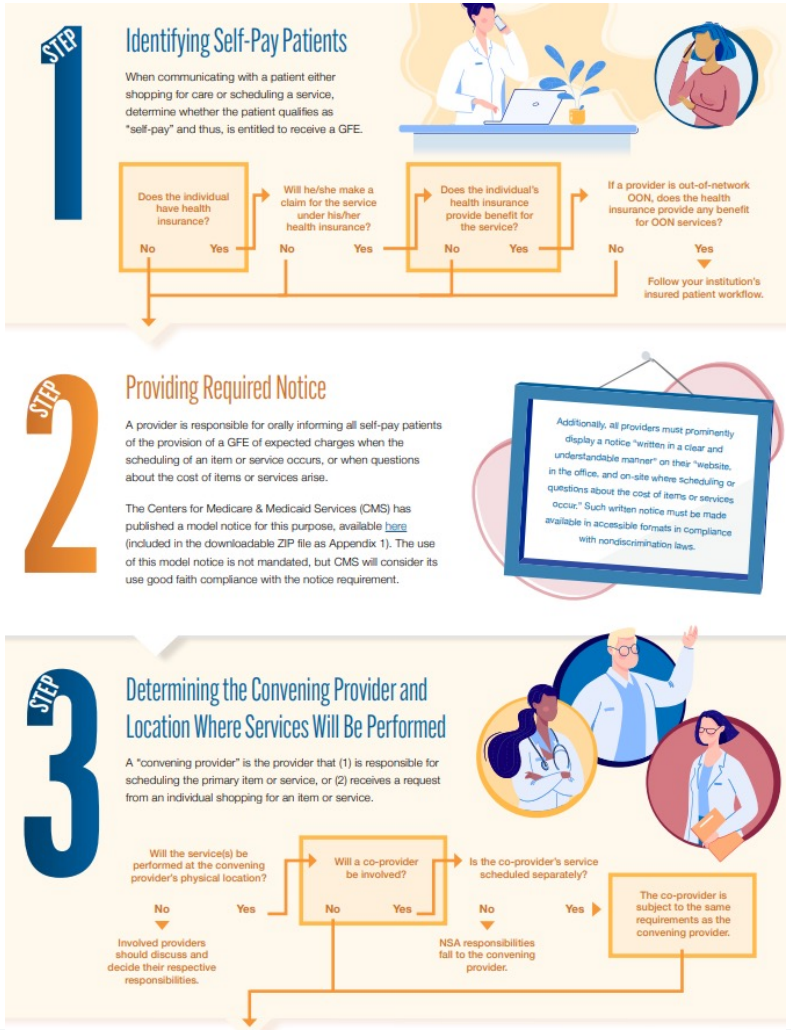
Good Faith Estimates

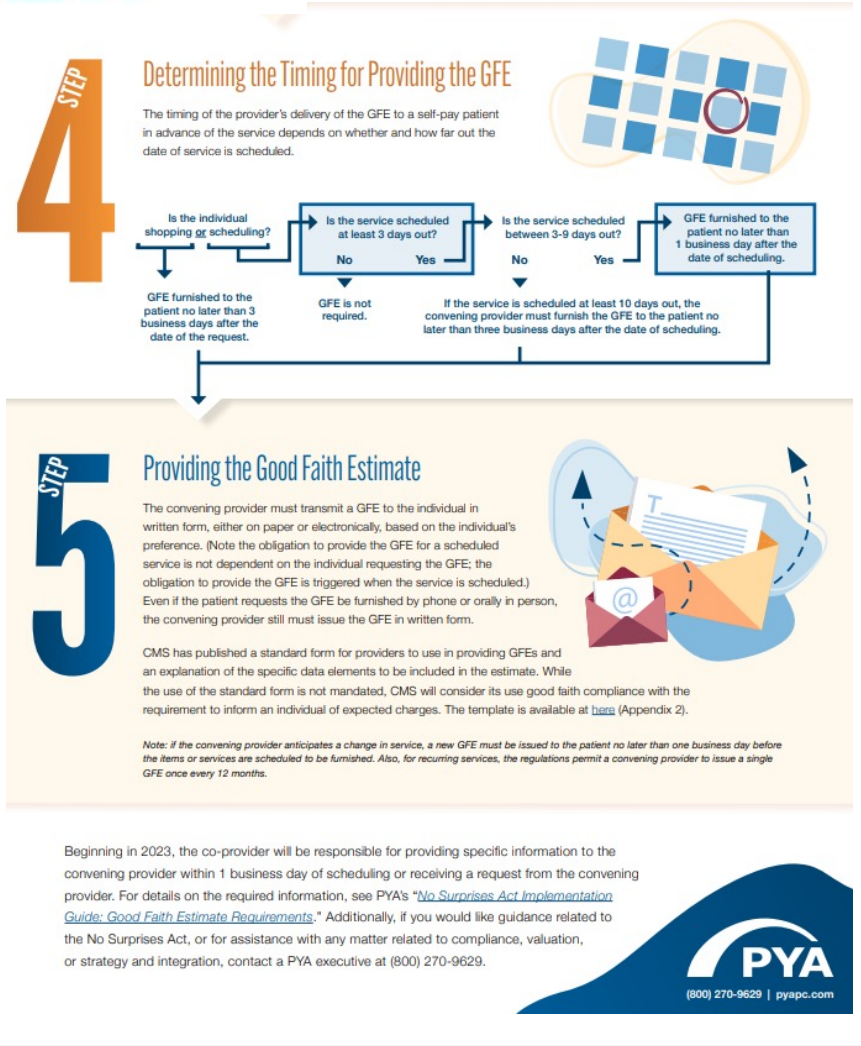
Application

- ‘Convening provider’
  - Provider responsible for scheduling primary item or service
  - Includes office visits, diagnostic testing, procedures, etc.
- Must furnish good faith estimate of total expected charges when -
  - Self-pay patient requests estimate (comparison shopping)
  - Self-pay patient schedules item/service at least 3 business days in advance
- Must include -
  - Items and services to be billed by convening provider
  - Beginning in 2023, items and services to be billed by ‘co-provider’ (i.e. furnishes care in conjunction with the primary item or services)
    - Convening provider must request and co-provider must furnish within 1 business day information required to complete GFE

No Surprises Act

Good Faith Estimate Workflow





Written GFE

- Include applicable diagnosis and expected service codes, with expected charges listed for each item or service
  - Inclusive of applicable discounts
  - Provide range of charges if specific level/type of service unknown
- Timing
  - If requested prior to scheduling – 3 days following request
  - If scheduled at least 10 but less than 4 business days in advance – 3 days before
  - If scheduled at least 3 business days in advance – 1 day before
- Special rules for recurring services

Patient-Provider Dispute Resolution

- Self-pay patient billed ≥ $400 more than amount listed on GFE may initiate process within 120 days of receiving bill
  - Administrative fee of $25 (adjusted annually)
- HHS submits matter to selected dispute resolution entity
  - SDR notifies provider, which then has 10 days to respond with credible evidence supporting higher billed charges
  - SDR makes decision within 30 days following receipt of information from provider
    - If no credible evidence, provider bound by GFE
    - If credible evidence, lesser of (i) billed charges or (ii) median payment amount paid by plan for same or similar service, by same or similar provider in geographic area reflected in independent database

Pre-NSA: Class Action Suits

- A search for [hospital /p “class action” /p (bill charge fee)] produces 520 cases.
  - Substituting “provider” for “hospital” results in 1,001 cases.
  - The number of unreported cases is unknown.
- Docket research reveals a pattern:
  - Defendants (providers) tend to win in reported cases – having particular success at the class certification stage.
  - In unreported cases, defendants tend to settle after a class is certified and interlocutory appeal is denied.

Class Counsel Motivations

- Class certification often forces settlement.
- Fee awards.

Class Certification – Legal Requirements

- Restrictive Approach:
  - Named plaintiff and absent class members must have the “same claim.”
  - Testimony and evidence from the named plaintiff must apply to all class members.
  - All class members must be injured – but there may be variation as to damages.
- Less Restrictive Approach:
  - Class will be certified when there are common issues.
  - Trend – issue classes.

Common Causes of Action & Legal Theories

- Breach of contract & breach of implied covenant of good faith and fair dealing
  - No definite price term
  - Nondisclosure
- Breach of fiduciary duty
- Unfair and deceptive trade practices
  - Arbitrary pricing; unfair billing practices as to uninsured patients

Contract Claims – Practical Observations

- Review consent form carefully.
- Ensure that consent form clearly obligates patients to pay *all* charges that the provider assesses.
  - "All charges for all services rendered" vs. "all charges assessed by the provider"
  - Language requiring payment whether or not insurance covers the charge
- Consider including (or incorporating by reference) specific billing protocols that could be challenged.
- Consider whether overly standardized procedures are helpful.

Fiduciary Duty Claims

- State law varies.
  - In some states, courts have imposed fiduciary duties on providers outside of the direct services context.
  - In other states, courts have made clear that a provider owes no duty to a patient in the context of medical billing.
  - Landscape is likely to be different for providers vs. payors.

Unfair and Deceptive Trade Practices Claims

- Again, state law varies.
  - Possible defenses:
    - Statutory exemptions:
      - “Learned profession” exemption in North Carolina
    - Limited or no application to certain entities, such as quasi-municipal entities (hospital authorities, public health organizations)
    - Limitations on class actions:
      - *E.g.*, South Carolina and Georgia

Class Action “Defenses” – Roadblocks to Certification

- Unique defenses against particular plaintiffs:
  - Accord and satisfaction (*e.g.*, payment plans)
  - Waiver and estoppel (*e.g.*, patient asks for and receives explanation of charge or bill, then pays)

Class Action "Defenses" – Roadblocks to Certification

- Individualized nature of whether amount of bill or charge is reasonable.
- No injury to certain patients:
  - Patients who are fully insured and have met deductible.
  - Patients who do not pay (and are not sent to collections).
- Inability to identify certain class members:
  - Provider may not have insurance information.
  - Provider's systems may be limited (*e.g.*, consent form records).

Class Action “Defenses” – Roadblocks to Certification

- As to nondisclosure claims:
  - Variance in oral communications
  - Inability to identify patients with prior knowledge
  - Inability to identify patients indifferent to disclosures
  - Public access to chargemasters (Hospital Transparency Act), price estimators, and payor pricing lists (Transparency in Coverage Rule)

Practical Observations

- Class certification is of utmost importance.
- Invest time in understanding processes and procedures to identify areas of risk.
- Invest time in understanding processes and procedures to understand evidence helpful for opposing class certification.

Potential Litigation in the Post-NSA World

- What we don’t know:
  - Is there private right of action under the NSA?
  - Is there a colorable preemption argument?
  - Will state UDTPAs import the NSA’s requirements?
- What we do know:
  - This is an area of significant public interest.
  - Plaintiffs’ attorneys are looking for potential lawsuits.

Potential Litigation in the Post-NSA World

- Potential for class action exposure:
  - Failure to comply with the NSA across the board
    - Billing above the in-network amount in emergency department setting
    - Failing to send good-faith estimates before scheduled procedures
    - Billing above the good-faith estimate amount – harder to frame as a class action
  - Failure to provide required NSA disclosures
  - Failure to properly obtain consent for waiver of rights under the NSA
- UDTPA litigation risk:
  - Greater transparency, greater confusion, greater visibility of variation in pricing and billing based on a variety of factors

Government Enforcement

- Which law to enforce?
- Who has enforcement power?
- How is it being enforced?

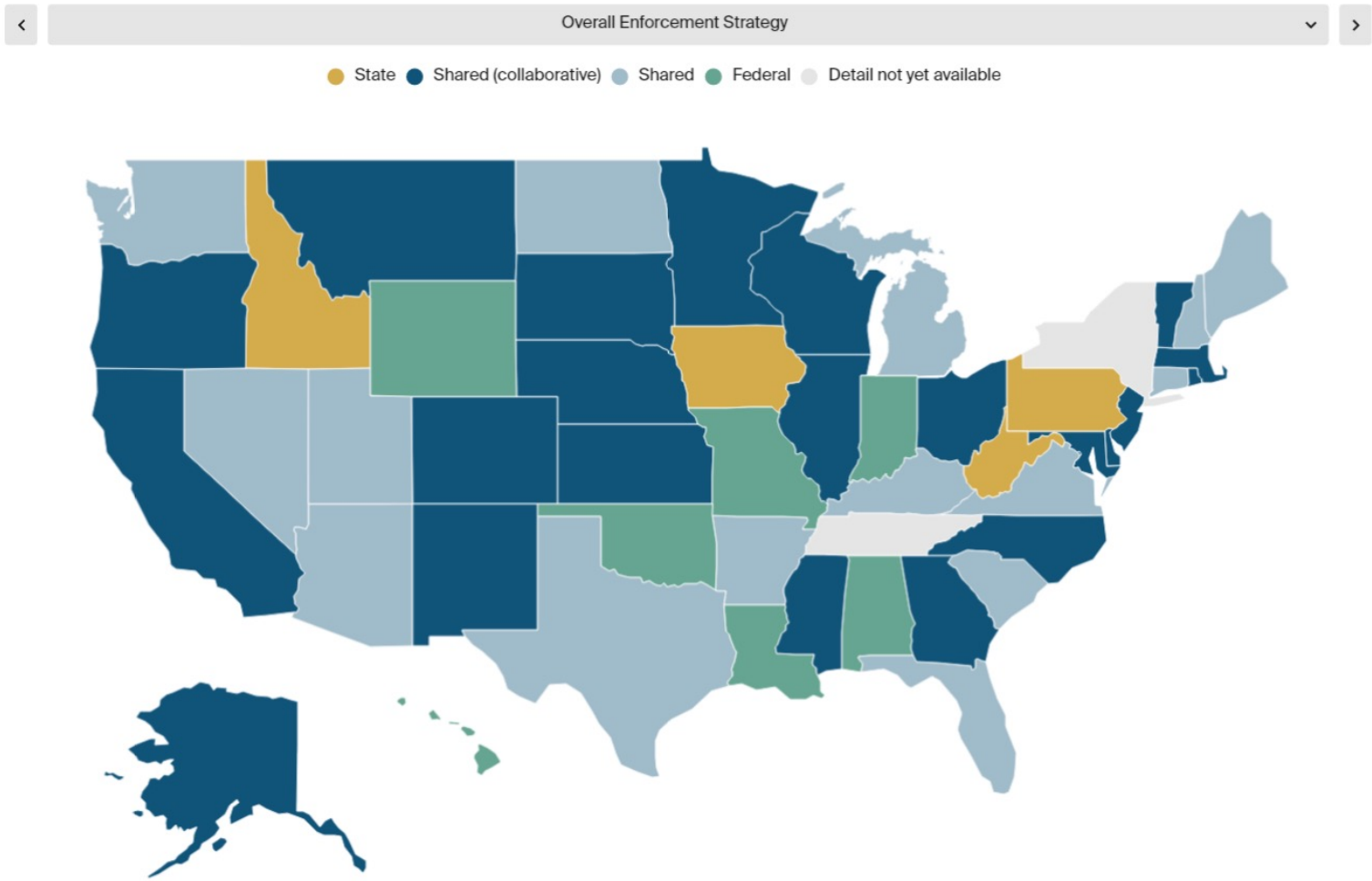
Which law to enforce? Preemption considerations

- Preemption is limited and depends on the type of health plan.
- Generally, the NSA defers to state law:
  - If more protective than the NSA.
  - If the state has methods for determining payment between insurers and out-of-network providers.
- Problems:
  - State law may not be comprehensive, and both state and federal law may apply.
  - Provision-by-provision analysis means guidance and clarity will be slow.

Who has enforcement power?

- Enforcement largely assigned to the states; federal government to fill in where states are unwilling or unable to enforce.
  - May also use collaborative enforcement agreements.
- CMS surveys and enforcement letters provide more detail.
- State enforcement:
  - Insurers – more clear.
  - Providers – less clear: department of health, attorney general, hospital commission, consumer protection, licensing board?

Who has enforcement power?



Source: https://www.commonwealthfund.org/publications/maps-and-interactives/2022/feb/map-no-surprises-act

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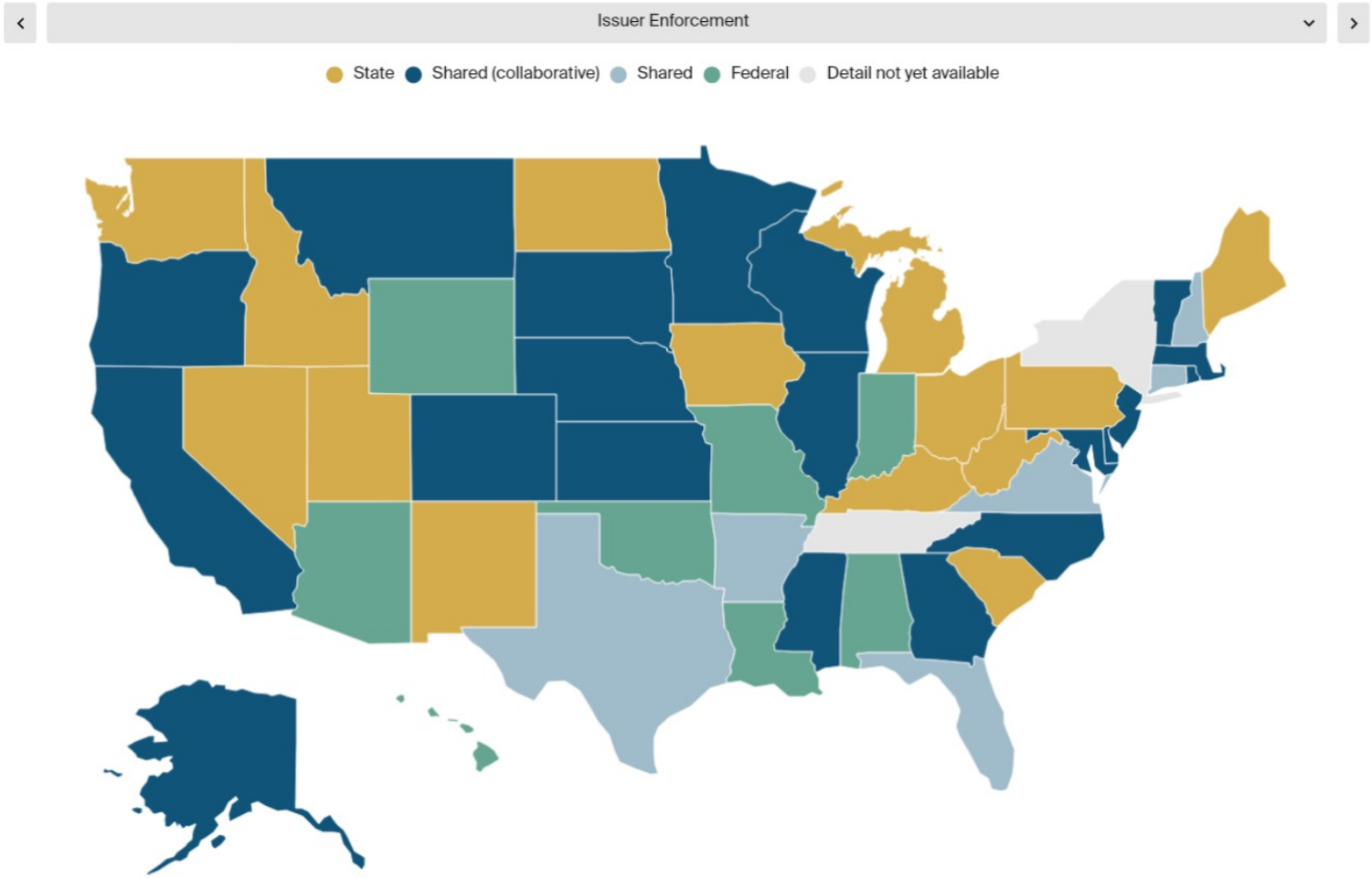

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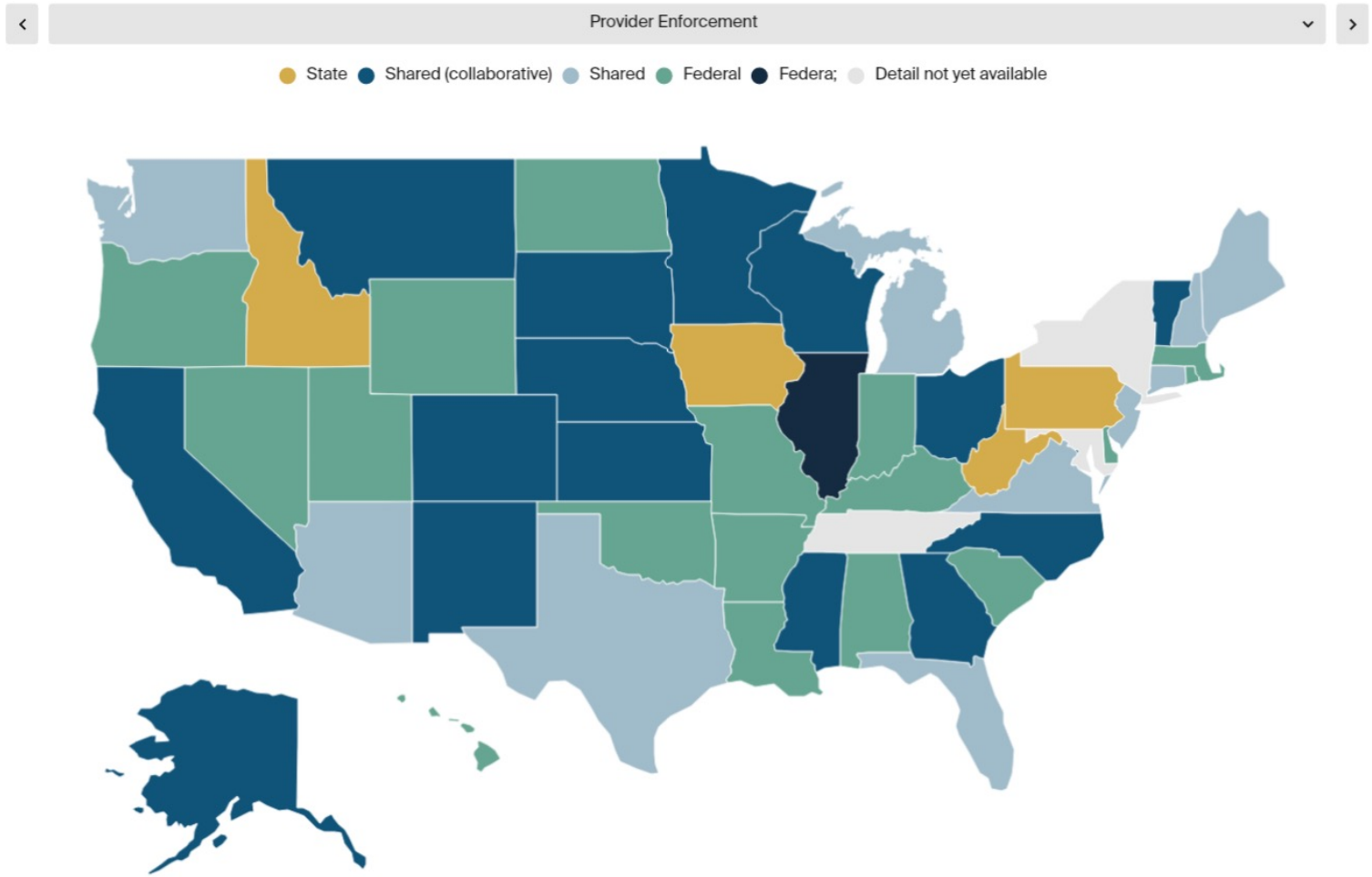

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How is it being enforced?

- Initial focus on health plans and payor compliance
- Audits and investigations
  - Health plans:
    - Required by the Act; up to 25 audits per year
    - Seemingly reactive approach
  - Providers:
    - Not required by the Act; approximately 200 per month
    - Seemingly proactive approach
- Patient complaint system for suspected violations

How is it being enforced?

- Penalties
  - Health plans: Up to $162 for each day, for each responsible entity, for each individual affected by the violation
  - Providers: Up to $10,000 for each violation
    - Waiver and exemption provisions
  - Mitigating and aggravating factors may change the penalty amount.
    - Cooperation with investigations is key.
    - CMS will give credit to those with compliance programs which focus on prevention and remediation of erroneous billing.
  - → Though health plans are the initial focus from a policy standpoint, the severity of the penalties and higher numbers of investigations appear to impact providers more.