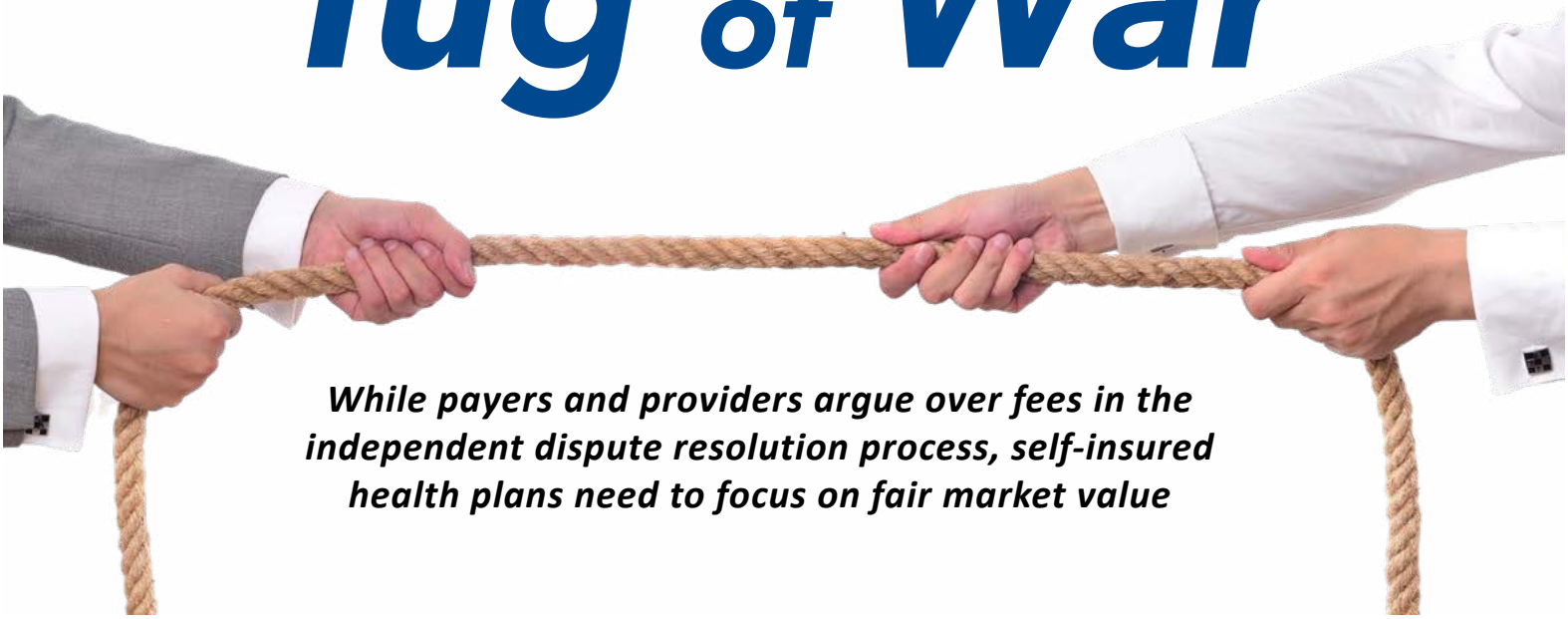
IDR's Tug of War



While payers and providers argue over fees in the independent dispute resolution process, self-insured health plans need to focus on fair market value

Written By Bruce Shutan

Faced with unintended consequences from one of the most significant U.S. healthcare reforms in recent years, the self-insured marketplace has been forced to innovate its way out of conflict.

Federal agencies vastly overestimated the ability of providers and insurers to amicably resolve payment squabbles as part of the independent dispute resolution process. IDR has generated at least $5 billion in total administrative and payment costs since being introduced in April 2022, with more than 10 times the number of disputes that were expected to be filed. This has created a heavy financial burden on group health plan sponsors.

The process was established by the No Surprises Act (NSA) to stop penalizing patients who inadvertently receive care from an out-of-network physician. While an independent, third-party arbiter is brought in to be as neutral as possible, both payers and providers have argued that the results favor the other side.

A payment formula for determining qualified payment amounts (QPAs) was introduced to capture the median of contracted rates for medical services in the same region and insurance market. But in the face of provider opposition, the IDR system was adopted when providers and insurers could not agree on payment amounts for out-of-network claims.

Scott Bennett

FOLLOWING THE MONEY

IDR intended to reduce transaction costs, improve the overall interaction between providers and payers, and protect patients who are no longer being balance billed, observes Scott Bennett, EVP of provider relations for The Phia Group. "But the process itself has created a significant number of issues," he says.

One is the sheer volume of filings from providers who are asking for open negotiations. It's easy to see why that's happening: the simplicity of pursuing these actions has now made it part of a provider's business processes. Another issue is that there's no enforcement in open negotiations to resolve payment disputes, which was supposed to be a 30-day window, while additional guidance is clearly needed.

The biggest motivator is monetary gain. "There's an incentive for the provider not to participate in open negotiations because IDR is better," he explains. "There's an incentive to initiate IDR because the win rate is so high, and then there's an incentive for IDR arbitrators to benefit providers, as providers are the initiating party most of the time and the initiating party chooses the IDR entity, and the entities want to be selected and essentially win the business."

Bennett has seen awards handed out that were actually above billed charges, noting "odd logic" in not being able to consider the provider's billed charges and award whatever amounts based on what the provider asked for.

"When NSA went into place, I was initially surprised by how much more savings there was compared to what payers were doing previously on this tranche of emergency, air ambulance and surprise billings – three different categories of claims," observes Brian Wroblewski, executive vice president of sales and marketing for ClearHealth Strategies. "So, it doesn't surprise me in the least that the providers are trying to do a grab strategy of, 'I still need to try to recuperate what I can, and I'm going to fight this tooth and nail in whatever way I can.'"

One pitfall worth noting is that QPAs are full of nuance and prone to miscalculation unless a highly skilled expert is brought in to design a proper glide path method, he explains. Look no further than various medical procedure codes, sites of service involving an inpatient vs. outpatient setting and the type of discount applied to in-network claims (percentage off vs. per diem vs. DRG-based, etc.).

Another is health plans and employers not having the ability to manage open negotiations and IDR negotiations with their respective parameters at either a claim-type or dollar-size level before getting to an actual arbitration. "If you don't have that robustness of configuration, you may run into additional problems," he says.

Brian Wroblewski

While believing the focus on IDR losses is important, Wroblewski says it's not tantamount to the issue at hand. In examining NSA claims as a whole, self-insured health plans should still end up securing a reasonable discount in the 60% to 70% range, more than they had previously. Between a proper QPA and negotiation parameters at different levels, IDR wins and losses will often be blended for superior results compared to what was in place prior to the NSA.

Whatever falls through the funnel into an actual IDR arbitration, he says, there are limits to what can and can't be used in terms of data industry or claim-specific data and no guarantee that most IDR cases will be won. "But you can still bring in important data, such as, for example, what an average allowed amount is for providers," he adds.

In addition, he notes that a "go-out" rate or initial payment amount allows plans to determine their own basis for reimbursement, such as reference-based pricing (RBP). However, they must be willing to pivot back to the QPA when a provider wants to engage further, which adds another layer of complexity.

"This is where a lot of folks in our industry will get either confused or have a limited ability to manage it from an administrative perspective, systems or otherwise," he explains.

EYEING PAYMENT INTEGRITY

The answer for avoiding IDR disputes in the first place may lie in payment integrity. At its core, this approach serves as connective tissue for price transparency, NSA compliance and a more thoughtful view of the QPA.

"It gets to how you look at payment dispute, IDR and defensibility of your methodology for the QPA process," observes Rob Gelb, CEO of Vālenz Health, who notes that no matter what methodology is used, providers can still balance-bill patients if they're not getting what they asked for.

Rob Gelb

In 2019 and 2020, he noticed RBP was causing too much friction with 12% to 15% appeal and balanced-bill rates and served as a blunt force instrument to reduce health plan costs. In short, he saw the need for a more defensible strategy with regard to a provider-reimbursement recommendation.

The tide began to turn in 2021 and 2022 when there was wider access to publicly available data around providers' charges, what they accepted as payment, published rates that were available for networks and how they reimbursed for certain procedures in and out of a hospital setting.

"We started turning that into an algorithm," he reports.

Mindful that NSA regulations created a heavy burden for TPAs and their clients, Vālenz developed a market-sensitive repricing and compliance solution to generate defensible reimbursement rates that's supported by extensive clinical data from multiple sources. Rather than use Medicare as the basis for this approach, it makes recommendations based on an analysis of provider data for specific services in a given region. The result is very low IDR appeal rates.

In responding to this trend, Bennett says self-insured employers can request that their TPA or other service providers follow meaningful benchmarks, identify service-level agreements to determine the value of services rendered, make viable good-faith offers and create a record. These steps will help lower payment amounts or influence a more favorable ruling.

"You've got to treat it as a quasi-legal function instead of an administrative function, and in doing that, No Surprises Act independent dispute resolution really should be recognized as its own standalone service, not a bolt-on to reference-based pricing or some other cost-containment piece," he suggests. "It is its own special service, and it has a significant cost per unit."

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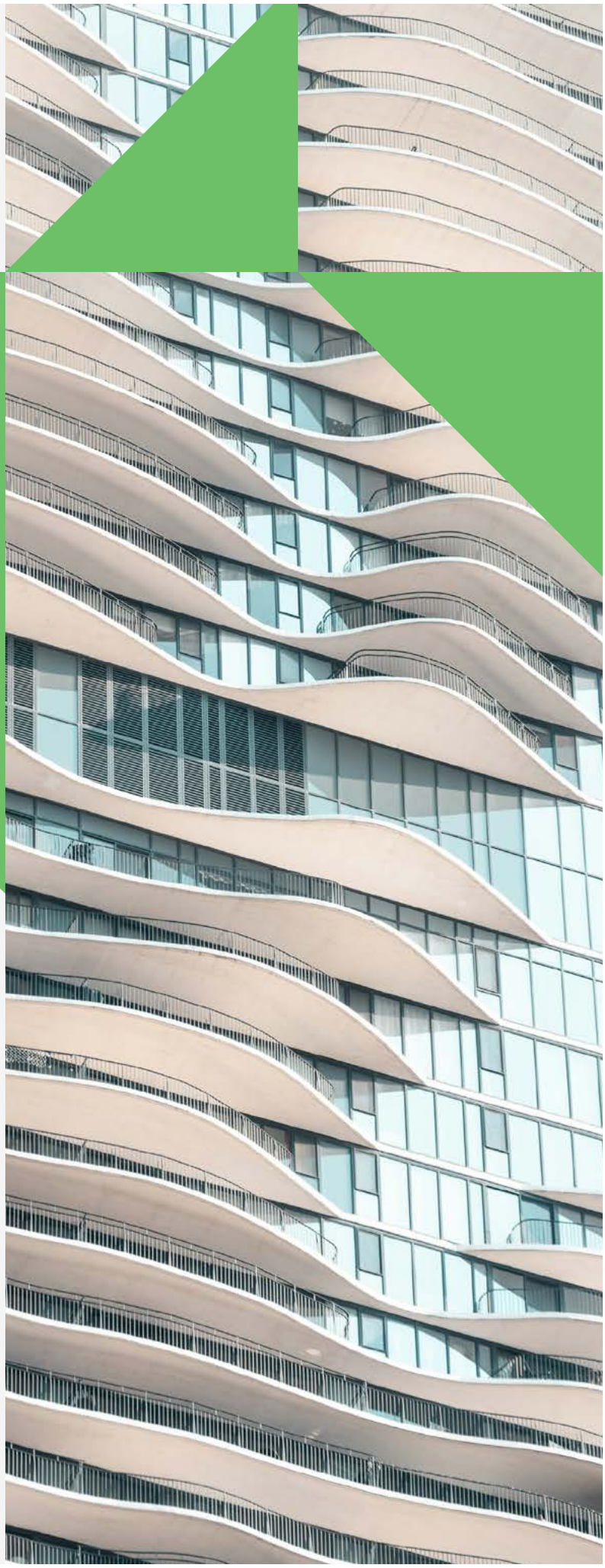
Having an ambiguous fair market value in regulations breeds disputes and seeds conflict, Bennett says, noting a need for more guidance on a direct metric – not a usual, customary and reasonable measurement. He uses California as an example of how, in the early 2000s, the state's workers' compensation system switched to the typical pricing metric used in contracts based on a multiple of Medicare, which reduced conflicts and arguments over fees.

"There's never going to be an agreement on the right value, and that's why we're seeing awards at higher than bill charges," he says.

Bennett cites studies by RAND and the Health Care Cost Institute that map Medicare multiples to contracts as the benchmark for resolving provider pay disputes. He also references workers' comp cases in Texas, pegging fees to about 200% of Medicare for facilities and more than 100% for outpatient services, with a certain multiple layered on top of that.

JUDGING THE JUDGES

Another issue to consider is that those handling the IDR process are essentially independent businesses, and there isn't enough transparency on who is making these determinations, what their qualifications are and whether those decisions are sound.



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As such, Bennett believes the selection of IDR arbitrators needs to be reformed. "The fact that the initiating party, the person who's essentially suing, chooses the judge and then you have judges whose compensations are tied to being selected more for processing these because that's how they get their fees, just seems like an odd process to me," he says.

He would like employers to advocate for more transparency and accountability for IDR arbitrators. He has seen determinations come back within less than a day when the evidence that was submitted was "an absolute dissertation on a complex medical claim," calling into question the integrity of the process and the possibility that the evidence could not have been fully reviewed in the time between submission and determination.


Christine Cooper

"There's behavioral science to this and identifying the arbitrator by name and qualifications on the determination would encourage a higher level of review and accountability; arbitrators might feel embarrassed about a cursory and copy-and-paste decision that would not withstand scrutiny," he says.

Christine Cooper, CEO of aequum, who sits on the SIIA Board of Directors, says there needs to be a substantial amount of redrafting of both the NSA and the Federal Arbitration Act to create an enforceable scenario, which has huge implications for every group health plan, regardless of whether it's fully insured or self-insured. Her takeaway: plans have options depending on their risk tolerance, including not paying the awards until there's legislative clarity on the IDR process.

"There is no private right of action to enforce any of these IDR awards," she explains, noting that the U.S. Supreme Court recently refused to hear Guardian Flight et al. v. Health Care Service Corp., which means the Fifth Circuit Court of Appeals ruling on this high-profile IDR case still stands. A similar ruling was made in the Eleventh Circuit Court of Appeals involving REACH Air Medical Services LLC v. Kaiser Foundation Health Plan Inc. On top of that, she cites a New Jersey district court case on whether the IDR process represents a fair arbitration that will likely appear before the Third Circuit Court of Appeals, where the same outcome is expected.

Given these decisions, she says the Department of Labor, Health and Human Services and Centers for Medicare & Medicaid Services do not have any right to penalize a plan or insurer for not participating in the process and not making payment if there is an award.

"The courts are, in essence, undoing the IDR part of the No Surprises Act a little at a time. If the Supreme Court doesn't take it up, then each one of these decisions are going to stay in place, and ultimately Congress is going to have to do something," she says.

WAITING ON CLARITY

Penalties under the NSA have nothing to do with the IDR process or interplay between providers and plan sponsors, according to Cooper, who says "they only have to do with whether you're providing the proper notices to plan participants and things of that nature."

She says the IDR process lacks transparency, noting that providers don't know how the QPA is being calculated. "To make the IDR process truly work and cut back on the number of claims that ultimately get filed, there has to be something more akin to a true arbitration. There has to be judicial review just like there would be for any other arbitration."

Cooper believes RBP could help minimize IDR exposure because the process doesn't apply to a pure RBP plan that cannot get to that median in-network contracted rate as defined by the statute.

"It really lifts that plan outside of the IDR process," she observes. "We are still seeing even pure RBP claims going through the process. But I think on the back end, if there's ever an enforcement that those would be grounds to overturn any decision that came out of it. Plus, the RBP experience throughout that IDR process is going to be lower in numbers because so many fewer claims will be covered."■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for nearly 40 years.

How to minimize costs and protect plan assets

Bruce Roffé, president and CEO of HHC Group and a licensed pharmacist, suggests several key strategies for self-insured employers to adopt when it comes to the independent dispute resolution (IDR) process. The following tips will help minimize out-of-network costs and protect plan assets:

Bruce Roffé

1. Strengthen network contracting. That includes expanding narrow networks for high-cost specialties and implementing tiered networks to incentivize in-network utilization.

2. Pursue pre-emptive negotiation. The thinking is to engage early during the 30-day open negotiation window and use data-driven offers based on CMS QPA methodology and historical benchmarks.

3. Leverage IDR data. Arbitration trends should be analyzed by specialty and geography, while high-risk specialties (i.e., anesthesiology, emergency medicine, radiology) should be targeted for contracting focus.

4. Adjust plan design. He suggested adopting reference-based pricing tied to Medicare or transparent benchmarks and capping out-of-network liability to limit exposure.

5. Partner with cost-containment experts. It's best to hire vendors skilled in NSA negotiations and IDR representation, as well as bundle services such as bill review, negotiation and IDR submissions.

6. Educate members. It starts with promoting steerage programs and incentives for in-network care and providing pre-service notifications for elective procedures.

7. Take action. Among the various additional steps that he recommends: audit out-of-network spending and IDR outcomes, identify high-risk providers and specialties, and engage a cost-containment partner for negotiation and IDR support.

— Bruce Shutan