Independent Dispute Resolution (IDR): What's Really Working?

The heralded "No Surprises Act" (NSA) became effective in January 2022, with intentions to protect consumers from an unexpected balance bill for the difference between what a provider charged and what their insurance paid. The law prohibits 'surprise' billing for some services, and led to the creation of the independent dispute resolution (IDR) process to resolve disputes about how much insurers should pay for out-of-network care.

NSA applies to several classes of out-of-network or otherwise non-contracted medical services, including:

- Air ambulance services
- Emergency services (except for ground ambulances)
- Services provided to stabilize a patient post-trauma
- Out-of-network services at an in-network facility if the provider didn't notify the patient that the services were out-of-network and obtain patient approval of the same

Written By Laura Carabello

Administered by The Centers for Medicare & Medicaid Services (CMS), an agency within the Departments of Health and Human Services (HHS), the Federal IDR process represents a systematic way to negotiate payment amounts between providers and insurers. The parties must exhaust the 30-business-day open negotiation period before requesting payment determination through the Federal IDR Process. Both parties present their proposed payment amounts to a certified independent arbitrator, who then makes a binding decision to determine the final payment.

Nine states have adopted their own IDR processes to resolve out-of-network payments: Alaska, Georgia, Maine, Michigan, Nevada, New Jersey, New York, Virginia and Washington.

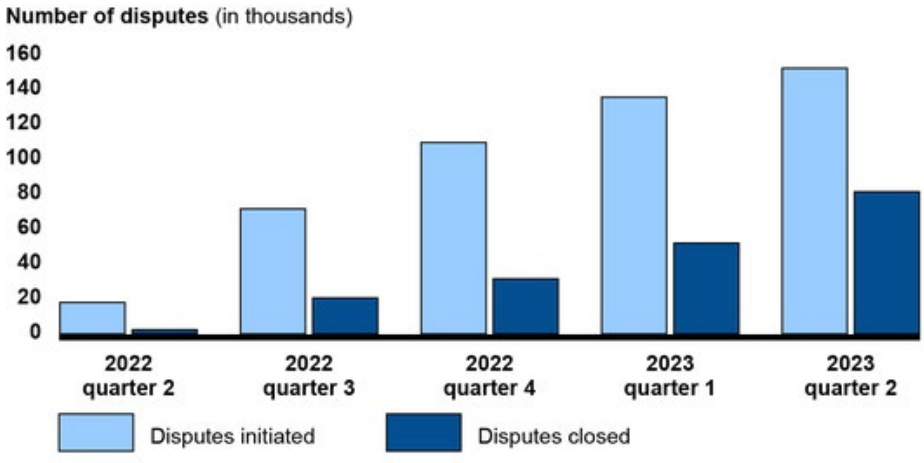
Few predicted the high demand for the federal IDR process, but it is contributing to claim delays, impacting provider cash flow and resulting in a mounting backlog of disputes. According to a December 2023 report from the U.S. Government Accountability Office, officials anticipated approximately 22,000 disputes in 2022. The volume of disputes far outpaced the estimate, with nearly 200,000 disputes initiated before the end of 2022 and another 670,000 submitted during 2023. Despite the fact that cases are getting resolved, the median time to resolve a case in the most recent reported period was 76 days — well above the statutory requirement of 30 days. By the end of 2023, the swollen backlog of disputes had left approximately 590,000 cases unresolved, resulting in delays in payment determinations.

Officials blame this bottleneck on the complexity of determining whether disputes are eligible for the process. The Commonwealth Fund reports that the IDR system continues to endure significant pressure from high caseloads, despite the fact that most claims never enter the IDR process.

Relief is on the way, contends the government agency within HHS that administers the IDR process, as well as new rules for 2025 recently announced by the Federal Hearings and Appeals Services (FHAS). These changes include: Additional Information Sharing, Open Negotiation Requirements, New Batching Provisions and Eligibility Determinations, Direct Administrative Fee Collection and Extending Time Periods Due to Extenuating Circumstances.

Many providers are now preparing for the new requirements, developing strategies and processes within their revenue cycle management to identify, track and dispute low payments from non-contracted payers. Providers feel it is inevitable that there will be lower reimbursement rates and delays in cash receipts as additional requirements and processes are established.

Number of Out-of-Network Disputes in the Federal Independent Dispute Resolution Process by Calendar Quarter, April 15, 2022—June 30, 2023



Source: Departments of Health and Human Services, Labor, and Treasury; Centers for Medicare & Medicaid Services. GAO-24-106335

UNDERSTANDING THE IDR PROCESSES

Federal and State IDR programs are very similar, with the ultimate outcome measured in terms of benefits to the member (patient) and the provider. Depending on the insurance plan type, each case may follow Federal rules and be facilitated through the Federal portal. However, the case may be required to follow a different process defined by the state in which the health services were rendered.

Industry consultants counsel that states have the primary role in enforcing NSA rules against health providers, with the Federal government providing supplemental support as necessary. Consultants advise that even in states where consumers are covered by a federally regulated health plan, states remain the primary enforcer. Most states are familiar with NSA obligations, as 33 states independently implemented their own balanced-billing laws prior to NSA. New York State serves as an example of how the process works.

Bruce Roffe, CEO, H.H.C. Group, one of five companies that has been approved by New York State as a certified Independent Dispute Resolution Entity

Bruce Roffe

(IDRE), explains, "New York's program is outside of the Federal program, although I've been told that the New York program was used as the model for the Federal program. The work that we perform for New York is fairly extensive because it involves so many different characteristics that we have to look at, including Fair Health data. It's not simply looking at the provider charges of $10 and the insurance company paid $2."

Fair Health is an independent, national nonprofit organization known for providing fair and neutral information. They base cost estimates on claims for medical and dental services paid for by private insurance plans, including the country's largest insurers. Their database includes more than 48 billion private health care claim records, and 45 billion Medicare claim records for 10,000 services in all areas of the United States, dating back to 2002. They receive about 2 billion new records each year and use powerful data to create a reliable picture of healthcare costs around the country and locally.

"There are many factors that must be taken into account when performing an independent dispute review -- it's just not a clinical or financial review conducted line-by-line," continues Roffe, noting that the IDR process in New York State is administered by the New York State Department of Financial Services (NYSDFS). "From what I've been told, the New York program was used as the model for the Federal program."

Roffe maintains that the work required for the New York program is fairly extensive because it involves so many different characteristics that need to be identified.

"Interestingly, New York is not backlogged like the Federal program," says Roffe. "If we are behind, it's just a week or two because nobody can really predict how much volume is going to come in over time."

He shares that sometimes when his team does this work, they will scratch their heads and ask themselves: How did the payer come up with their reimbursement rate? Where did they get this from anyway?

"I think the bottom line here is that it really is an objective assessment to determine if the insurance company paid enough or if the provider charged too much," adds Roffe. "I believe it's an objective assessment, and the person who really benefits from this is the patient because they can't be balanced billed."

In his experience, Roffe says that usually, about 49% of the time, the provider prevails, in 20% of the cases the payor wins and 31% are split decisions. Results in the Federal IDR process are somewhat

comparable, as federal agencies report that providers, facilities, or air ambulance providers won about 77% of resolved cases, including a substantial subset of cases where only one party submitted an offer and paid the required fees.

"The New York program allows for a split decision, enabling the arbitrator to look at the bill line by line. Ultimately, it's usually the provider who prevails with the assumption contingent upon the provider supplying all the information necessary and enabling the IDR company to perform the assessment of the charges."

DOES THE PROCESS EVER FAIL?

"No, at least not for us -- we've never failed at it, and I honestly don't intend to," says Roffe. "There's no reason for us to fail since we have so many checks and balances built into this process. In New York, we are also obligated to send the case out to a physician in the same or similar specialty as the physician providing the service that is subject to the dispute. If we're looking at an orthopedic claim, then we'll send the claim to an orthopedic surgeon who's board-certified. If we're looking at a neurosurgery claim, we'll send it to a neurosurgeon or neurologist."

He comments that when providers don't like the result, they complain.

"If they don't complain, then we're not doing our job," he remarks. "Providers might not like the result, but our determinations are evidence-based and built upon multiple factors that go into assessing a claim. Everything is in writing, including how the determination was made and why we selected one rate as opposed to another rate. It's a very labor-intensive process that requires extensive training for reviewers."

Roffe explains that gaining approval as an approved New York State IDRE required multiple layers of evaluation by the New York State Department of Financial Services,

"IDR work requires in-depth knowledge and understanding about healthcare costs, a capability that the Company developed because we deal with that every day on the cost containment side of our business," says Roffe. "We know about the clinical side of the healthcare environment because we address these issues on the Independent Review Organization side of our organization. Combined with our URAC accreditation, we were in a unique position."

LEGAL CHALLENGES

A federal appeals court states that the government overstepped its bounds when it attempted to dictate how certain factors should be weighed in an IDR process, leading the court to vacate parts of the rule. The 5th U.S. Circuit Court of Appeals ruling upholds a lower court decision in the case, Texas Medical Association et al. v. U.S. Department of Health and Human Services et al. According to reports, The TMA declined to comment on the decision or say whether it plans to appeal. Representatives for HHS and Labor departments also did not respond to requests for comment.


Christine Cooper

Christine Cooper, founder and CEO, aequum and chair of the Self-Insurance Institute of America, Inc. (SIIA) Price Transparency Committee, provides this guidance.

"The recent decision from the Fifth Circuit Court of Appeals was a big victory for self-funded health plans and insurers," advises Cooper, who handles claims on behalf of plans. "Providers attacked the methodology for the calculation of the Qualifying Payment Amount (QPA), the median rate paid to in-network physicians, hospitals and others. They did not like that the calculation could include "ghost rates" and could not include single-case agreements, bonuses, retrospective payments or adjustments, or different provider specialties. Allowing and disallowing these items in the QPA calculation will allow for plans to calculate more favorable QPAs."

Ghost rates are contracted rates that are present in contracts but are never negotiated or used. In healthcare, ghost rates can depress the QPA for a service. For example, an orthopedic surgeon's contract might include ghost rates for dermatology services that they never provide.

Cooper also expounds on the lack of compliance with the timelines set forth in the NSA, which she says has been rampant.

"One of the frustrations for plans is the failure of the IDR Entities to comply with their timelines," she says. "The Fifth Circuit Court of Appeals decision addressed compliance with decision payment timelines. If extrapolated out, all timelines should be followed and this would help alleviate the backlog and the inconsistent decisions coming from the IDR Entities. Hopefully, the Courts will continue to follow this thinking and apply the statutory timelines to all of the key parties."

One Think Tank, the Niskanen Center, comments on a concerning trend: the type of providers choosing to go to arbitration. They observe that approximately two-thirds of the initiating parties in cases going to arbitration are private equity-backed provider groups with a strong incentive to add revenue to pay down debt quickly and the resources to pay administrative fees and argue their case.

Cooper believes that a positive outcome of the NSA is the effect on some private equity-backed providers.

"Private equity's involvement in health care is generally perceived as bad for patients because of the potential for lower quality services and higher cost," she explains. "Private equity's main concern is financial returns on investment and does not seem like it should have a place in healthcare."

The subject of private equity's health care acquisitions is generating considerable attention, as Health Affairs recently examined the topic in depth. They point to discussions about their influence on the U.S. health care system and report that policy makers, especially at the state level, are exploring ways to regulate private-equity firms' involvement in physician practices, hospitals, and nursing homes. Authors continue to question whether private equity's role in health care is helpful or harmful to patients.

Cooper points to some private equity-backed providers who report taking a hit due to the NSA.

"For example, Envision Healthcare filed bankruptcy, citing the NSA as one of the reasons," says Cooper. "Envision healthcare is one of the highest utilizers of the IDR process. Prior to the NSA, Envision Healthcare used surprise billing as part of its business model and advocated heavily against NSA enactment."

"The statistics show that 82% of the decisions go in favor of providers," she adds. "But that statistic may not be very meaningful since it would include arbitrations where the plans/ insurers do not participate or do not submit the requisite information."

Eric Hanna

Eric Hanna, VP of Claim and Access Solutions at Vālenz® Health says that on the surface, the IDR process seems beneficial for members, providing protection against balance-billing and out-of-pocket costs.

"However, providers prevail in 70%+ of payment determinations with steep increases in percent-of-Medicare rates resulting from arbitration, incentivizing continued filings," says Hanna. "These increases are unsustainable for self-insured employers, ultimately forcing them to pass these costs to members.

Hanna emphasizes the importance of applying what has been learned from past IDR rulings to subsequent cases, ensuring that each decision point is addressed to increase the likelihood of favorable resolutions.

"While determinations are largely rules-based, we don't discount the human element, acknowledging with arbitrators that the patients burdened by these crippling costs are parents, children, or siblings, each with their own individual struggles," he continues. "We also encourage patients to approach healthcare decisions as consumers, with a proactive lens towards understanding their options to help reduce the impact on their wallets. With a model of health literacy and data-driven decision making, we strive to provide access to comprehensive cost and quality data, allowing members to make well-informed decisions about their care."

THE COST OF WINNING

While providers prevail in most IDR cases, yielding them nearly three times the usual in-network rates offered by payers, the cost implications of these wins are significant.

Many providers still complain about the financial hardships they endure as a result of the NSA, particularly companies providing emergency services, such as physicians groups and air medical transportation companies. Multiple health care provider organizations cite the new law, along with higher costs of debt and unfavorable payer contracts, as contributing factors in their bankruptcy filings. As of November 2023, about 30 public companies named the NSA law as a potential risk to their financial performance.

Payer associations and advocacy organizations estimate that about 80 percent of 10 million out-of-network claims in the first three quarters of 2023 saw initial

payments accepted by providers, and fewer than 7% went through IDR.

Original estimates from the Congressional Budget Office (CBO) projected that the NSA would trigger insurance premiums to fall by 0.5 to 1.0 percent. CBO's estimate was based upon the assumption that the prevailing in-network rate would be a key benchmark for both payers' initial offers to providers and arbitrators' payment determinations.

But it appears that the current pattern of payment determinations might lead to higher provider rates in future plan–provider rate negotiations for in-network services. If this trend persists, CBO's anticipated premium trend reduction may not be achieved.

As the outcomes of ongoing litigation and the reactions of stakeholders are heard, it will be interesting to gauge the cost-containment success of the NSA and IDR.

Laura Carabello holds a degree in Journalism from the Newhouse School of Communications at Syracuse University, is a recognized expert in medical travel and is a widely published writer on healthcare issues. She is a Principal at CPR Strategic Marketing Communications. www.cpronline.com