



CMS-9883-F (2027 Notice of Benefit and Payment Parameters) – Kansas Hospital Impact Summary

This final rule is primarily focused on the ACA Marketplace (Exchange) and the individual insurance market. While it does not directly regulate hospital payment rates, several provisions could affect Kansas hospitals by changing network design, patient coverage, uncompensated care, and provider contracting.

Key Takeaways for Kansas Hospitals

1. CMS Will Allow Certification of "Non-Network" Marketplace Plans

One of the most significant provisions for hospitals is CMS's decision to permit Qualified Health Plans (QHPs) on the Marketplace to operate without traditional contracted provider networks, provided they meet certain access standards.

Historically, Marketplace plans were required to maintain provider networks and demonstrate network adequacy. Under this rule, insurers may offer plans that do not rely on formal contracts with hospitals and physicians. Instead, the insurer establishes a "benefit amount" and seeks providers willing to accept that amount as payment in full.

Non-Network Insurance Plans: What They Are

A non-network plan:

- Does not maintain a traditional contracted provider network.
- Pays a predetermined benefit amount for covered services.
- Relies on providers voluntarily accepting the insurer's payment amount as payment in full.
- May require enrollees to locate providers willing to accept those payment amounts.
- Must demonstrate access to providers and Essential Community Providers (ECPs) that accept the plan's payment methodology.

CMS will require these plans to:

- Report the percentage of providers willing to accept the plan's benefit amount as payment in full.
- Demonstrate access to Essential Community Providers.
- Maintain consumer support resources.
- Explain methodologies for setting payment amounts.
- Maintain processes for addressing provider access complaints.

Potential Hospital Impacts of Non-Network Plans

1. Increased Pressure on Hospital Reimbursement

Hospitals could face situations where:

- Patients present with a non-network Marketplace plan.
- The hospital has no contract with the insurer.
- The insurer pays only its predetermined benefit amount.
- The hospital must decide whether to:
 - Accept the payment as payment in full, or
 - Pursue additional patient responsibility consistent with applicable laws and plan design.

CMS notes that insurers may establish benefit amounts based on Medicare rates, commercial rates, regional factors, or other methodologies.

Kansas Hospital Concern

If benefit amounts are set at prevailing commercial rates, hospitals may experience:

- Lower reimbursement.
- Greater revenue uncertainty.
- Increased administrative burden in determining patient liability.
- Additional disputes over payment adequacy.

2. Increased Patient Confusion and Collection Challenges

Unlike traditional PPO or HMO products, patients may not clearly understand:

- Which hospitals will accept the insurer's benefit amount?
- Whether they will face additional out-of-pocket costs.
- Whether a provider will consider the insurer's payment sufficient.

CMS specifically acknowledged concerns regarding consumer understanding of balance billing and out-of-pocket exposure and requires plans to provide consumer education.

Kansas Hospital Concern

Hospitals could see:

- More patient billing disputes.
- More financial counseling requirements.
- Increase bad debt and charity care if patients underestimate their financial exposure.

3. Rural Hospital Implications

Kansas has many rural hospitals with limited competition among providers.

Potential effects include:

Possible Advantage

- Some rural hospitals may gain access to patients enrolled in plans that otherwise would not have contracted with them.

Possible Risk

- Rural hospitals may feel pressure to accept lower payment amounts because patients have few alternatives.
- Smaller facilities may have less negotiating leverage than large health systems.

This could be particularly important in frontier and rural counties where provider availability is already limited.

4. Essential Community Provider (ECP) Considerations

CMS requires non-network plans to demonstrate access to Essential Community Providers and report which ECPs accept the plan's payment amounts.

Kansas Hospital Concern

Safety-net hospitals and other ECP-designated providers may receive increased outreach from insurers seeking to satisfy certification requirements.

Hospitals should evaluate:

- Whether accepting these arrangements supports community access goals.
- Whether reimbursement levels are sustainable.

5. Administrative Burden

Hospitals may need new workflows to:

- Identify non-network Marketplace plans.
- Verify payment methodologies.
- Determine whether insurer payment will be accepted.
- Educate patients regarding potential financial responsibility.

This could create operational complexity similar to challenges seen with some indemnity-style or reference-based pricing arrangements.

Other Rule Provisions Relevant to Kansas Hospitals

Changes That May Reduce Marketplace Enrollment

The rule includes several eligibility and enrollment restrictions, including:

- Elimination of the 150% FPL Special Enrollment Period.
- More stringent income verification.
- Stricter premium tax credit eligibility requirements.
- Additional limitations affecting certain non-citizen populations.

Potential Hospital Impact

These changes could:

- Reduce Marketplace enrollment.
- Increase the number of uninsured individuals.
- Increase uncompensated care and charity care burdens.
- Increase bad debt for hospitals, particularly safety-net and rural facilities.

Provider Access Standards

CMS is shifting greater responsibility to states for provider access review and non-network plan oversight. States may conduct reviews of both traditional network plans and non-network plans if they demonstrate sufficient oversight capability.

For Kansas, this means future implementation and enforcement decisions could become increasingly influenced by state-level insurance regulatory approaches.

Suggested KHA Policy Concerns

For KHA members, the most significant issues likely include:

1. Adequacy of non-network plan reimbursement levels
 - Will benefit amounts cover the cost of care?
2. Patient financial exposure
 - Increased confusion and potential unpaid balances.

3. Rural hospital negotiating leverage
 - Potential pressure to accept below-market payment rates.
4. Marketplace enrollment reductions
 - Potential increase in uninsured patients.
5. Administrative burden
 - New processes for hospitals to manage non-network products.
6. Transparency requirements
 - Need for clear disclosure of provider payment methodologies and patient liability.

Bottom Line

The most consequential provision for Kansas hospitals is CMS's approval of non-network insurance plans on the Marketplace. While these plans may create additional coverage options for consumers, they introduce significant uncertainty regarding provider reimbursement, patient cost-sharing, and hospital revenue cycle operations. Rural hospitals, safety-net providers, and hospitals with a high share of individual-market patients could be particularly affected if insurers use low benefit amounts or if Marketplace enrollment declines due to the rule's eligibility changes.

This is likely an area where KHA may want to consider future monitoring and advocacy around reimbursement adequacy, consumer protection, and rural access implications.