

Federal action on surprise medical bills: What doctors should know

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Patients will be protected from unexpected medical costs, while out-of-network physicians other clinicians and facilities will have a process available to challenge inadequate out-of-network payment from commercial health insurance companies.

These provisions, which take effect Jan.1, 2022, are part of the No Surprises Act that was folded into the Consolidated Appropriations Act, 2021, a comprehensive, \$1.4 trillion legislative package that included COVID-19 related relief for physicians and appropriations to fund government operations through the end of fiscal year 2021, which ends Sept. 30.

Early last year, surveys revealed that health care was once again at the top of voters' minds. Todd Askew, the AMA's senior vice president of advocacy, said at the time that lawmakers—eager to show they were responsive to voters' concerns—would choose to address either surprise medical billing, guaranteeing insurance coverage for patients' preexisting conditions, or high drug prices.

Surprise medical billing was “the most likely candidate for Congress to find when it goes searching for a bipartisan, popular proposal that they can enact to make people feel like they're paying attention to their fear about health care costs,” Askew told the approximately 500 physicians attending the 2020 AMA National Advocacy Conference in Washington.

At the eleventh hour of the 11-month battle, Congress appeared poised to pass an iteration of the No Surprises Act that favored commercial health plans and put financially stressed physician practices at a disadvantage.

But the AMA continued its advocacy message and, ultimately, prevailed.

“We emphasize that insurers fundamentally drive surprise billing through narrow networks, through take-it-or-leave it contracts that stem from insurer-market dominance, and as patients face unexpected cost sharing through benefit design such as high-deductible health plans,” said Marilyn J. Heine, MD,

chair of the AMA Council on Legislation, during the 2021 AMA State Advocacy Summit.

Patient protection etched into law

Patient protections included in the No Surprises Act include:

- A provision that patients may not be billed beyond the recognized in-network cost-sharing amount.
- If a patient relies on erroneous network directory information to choose a physician, the plan cannot impose a cost-sharing amount greater than in-network rates and it must count toward the patient's in-network out-of-pocket-maximum and in-network deductible.
- Unless notice and consent requirements are met in non-emergency situations, if a provider submits a bill to a patient in excess of in-network cost sharing and the patient pays, the provider must refund with interest.
- If a provider contract is terminated without cause, a “continuing patient” can continue for either 90 days or the date when no longer a continuing patient, whichever is earlier.

Provisions which help ensure fair compensation for physicians include:

- Clarification that an upfront, initial payment or notice of denial is required from health plans to the physician within 30 days of when he or she has submitted a bill.
- An increase in the time for a physician to pursue independent dispute resolution (IDR), from two to four days.
- Prohibition against the arbitrator considering public program rates like Medicare, Medicaid and Tricare during the IDR process.
- Elimination of problematic timely billing provisions.

Whole new ballgame

The IDR process calls for baseball-style arbitration—which has been successfully adopted in New York and Texas—that allows an independent third party to determine whether the plan payment amount or the provider bill represents the most appropriate resolution to the claim.

The IDR entity has 30 days to reach a decision and must consider:

- Offers by both parties.
- A qualifying payment amount for the same service in the same geographic region.

- Circumstances such as physicians' training, experience, and quality and outcomes measurements.
- The acuity of the patients and the complexity of their cases.
- The teaching status, case mix and scope of services of the facility where the service was delivered.
- Good faith efforts by parties to contract and contracting-rate history from last four years.

“The AMA strongly supports protecting patients from the financial impact of unanticipated medical bills that arise when patients reasonably believe that the care they received would be covered by their health insurer, but it was not because their insurer did not have an adequate network of contracted physicians to meet their needs,” AMA Executive Vice President and CEO James L. Madara, MD, wrote in a Dec. 15 letter to congressional leaders.

The AMA expects that state-level controversies over surprise billing will be fewer in 2021 in the wake of the federal law's passage, but states will see legislative efforts to supplement the act with laws applicable to state-regulated plans. Private health insurer practices that impact physician networks, patient out-of-pocket costs, access and comprehensive coverage will continue to be a focus in many states.

“The AMA will also be working with states to determine where state laws end and the federal law begins,” Dr. Heine said. “The AMA has a wealth of advocacy resources and extensive experience when it comes to taking on unfair insurer practices and we are well-poised to help” state medical associations and national medical specialty societies.