

# AMA Advocacy Insights webinar series: Implementing the No Surprises Act

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## Featured topic and speakers

The No Surprises Act (NSA) is here. During this AMA Advocacy Insights webinar, experts discuss the implementation of the NSA, including many of the issues addressed in the AMA's surprise billing toolkit. Speakers also tackle enforcement challenges and the interaction between state and federal surprise billing requirements.

### Speakers

- Joel S. Ario, managing director, Manatt Health
- Michael S. Kolber, partner, Manatt Health

### Moderator

- Bobby Mukkamala, MD, chair, AMA Board of Trustees

## Transcript

**Dr. Mukkamala:** Thank you for joining us for this webinar on the No Surprises Act. I'm Dr. Bobby Mukkamala. I'm an otolaryngologist here in Flint, Michigan, and it's my honor to serve you as chair of the board of The American Medical Association. I'm happy to be moderating today's webinar on this important issue for so many physicians and our patients. Reducing the burden of unanticipated medical bills for patients through changes in federal policy has been a priority of the AMA for many years. The AMA strongly supports protecting patients from unanticipated medical bills that can significantly raise out-of-pocket expenses and threaten access to quality care. And we supported these reforms as part of the No Surprises Act. That said, the implementation of the No Surprises Act is going to be incredibly challenging for physicians and other providers, and we are already seeing challenges arise since the law took effect on January 1.

As we will hear today, this new law brings a number of changes that are important to understand because they have the potential to significantly impact physician practices, including a ban on out-of-network billing in several situations, changes to disclosure, as well as notice and consent rules, and new price transparency requirements. And there are many questions as well, such as how existing state surprise billing laws are interacting with this new federal law and who is enforcing these requirements at the state level. Today's webinar will not focus heavily on the independent dispute resolution, or IDR process available to physicians, to challenge plans out-of-network payments, given the pressing nature of these other NSA requirements and the fact that some of that IDR process is still being finalized in many ways by the current administration. Please be on the lookout for more programming and resources on that part of the law, the IDR, in the near future.

However, I will mention the AMA's ongoing concern with the way in which the Biden administration is implementing the IDR portion of the new law and the actions we have undertaken to hopefully make that process more balanced. As many of you are aware, regulations implementing the IDR process place a thumb on the scale in favor of insurers by requiring the arbiters to consider the health plans median in network rate as the appropriate out-of-network rate in most situations and essentially predetermining the outcome of the process.

Last month, the AMA joined with the American Hospital Association in suing the federal government for stepping outside their statutory authority and implementing the independent dispute resolution process under the No Surprises Act, and for upending the careful compromise Congress deliberately chose for resolving billing disputes. To be clear, the lawsuit doesn't challenge any of the patient protections in the bill or any of the new requirements on providers. Instead, it focuses on compelling the administration to bring the regulations in line with the way the law was written in Congress and allow the arbiter in the dispute resolution process to consider all factors relevant to payments that are enumerated in the statute. This will lead to what Congress intended, a fair, more meaningful process to resolve disputes between health care providers and health plans. This challenge is a priority for the AMA and a priority for many of you. We will, of course, be keeping you updated on that effort in the coming weeks through our AMA channels.

But for the focus of today's presentation, we are lucky to have with us today two experts who are involved in the development of the AMA surprise billing toolkit and who know a great deal about both the No Surprises Act and state and federal enforcement of health care laws. First up, we have Michael Kolber. Michael is a partner at Manatt with expertise in the implementation of health coverage issues, especially the Affordable Care Act, Medicare and Medicaid managed care value-based purchasing and employment benefits. He provides legal and policy advice with a particular focus on mental health parity, medical loss ratio reporting, pharmacy benefit management, risk adjustment and health care non-discrimination rules. He also provides regulatory advice and advocacy councils clients on corporate transactions and litigates and federal court, and before administrative tribunals. Prior to joining Manatt, Michael was the lead legal advisor to the U.S. Department of Health and Human

Services on several key features of the Affordable Care Act, including essential health benefits, health insurance exchanges and risk adjustment.

Also with us is Joel Ario. Joe has over 30 years of experience shaping and implementing public health policy at the state and federal levels, and provides strategic consulting and analysis on health care policies and institutions, with an emphasis on the role of health insurers in delivering public and commercial coverage under various regulatory frameworks. Joel's experience includes two decades leading health insurance reform efforts for state and federal governments. As director of the Office of Health Insurance Exchanges at HHS, he worked closely with states and other stakeholders to develop the regulatory framework for exchanges, including the rights and responsibilities of states and federal government and expanding coverage. On the state level, Joel has served as Pennsylvania insurance commissioner and Oregon insurance commissioner. He served on the executive committee of The National Association of Insurance Commissioners and was an NAIC officer. Joel also serves and is advisor to the Robert Wood Johnson Foundation and support of its work with states. As you can tell, we are in great hands to talk more about the implementation of the No Surprises Act.

I will now turn it over to these experts for their presentation and then we'll open it up for via the Q&A function on Zoom, so please feel free to put your questions in there. Joel and Michael, the screen is yours.

**Kolber:** Thank you. So Joel and I are very happy to be here with you today. So I'm going to talk through some of the basics, the blocking and tackling about what's in the law, what's in the regulation and what you, as physicians, need to know now about implementing the law and hopefully you and your practices are beginning to, since it has been in effect for about three weeks now, since January 1. And then Joel's going to talk a little bit more about just the really complicated network of state and federal regulators and enforcement that will be overseeing all of this and how those are interacting, frankly, in one of the more complicated ways Joel and I think have seen. So next slide, please.

So the basic issue in the No Surprises Act and it's many components to the statute, some of which may have very little to do with surprise medical billing but the core protection that we're most focused on is the prohibition on surprise medical billing, really in just three circumstances. For emergencies, for emergency services that are rendered in hospital EDs or freestanding, independent EDs, out-of-network air ambulances and certain non-emergency services provided by out-of-network providers at an in-network hospital or ambulatory surgery center. I'm using a shorthand for hospital critical access hospital or a hospital outpatient department.

And in order to implement these and related provisions, there are really four things that we think that physicians need to know now, most of which are covered, as mentioned in the AMA toolkit that we worked on. First is how is patient cost sharing and provider payment determined for these out-of-network situations. Two, what obligations exist to provide good faith estimates to patients? The good faith estimates that we're talking about here actually don't tend to relate to the surprise medical bills,

because currently this is only being forced for uninsured or self-pay patients, whereas the surprise medical billing situations only arise for insured patients but it is a really substantial implementation challenge that providers are dealing with today.

So we want to spend some time focusing on that. Third, when an out-of-network provider treats a patient at an in-network facility, whether a hospital or an ASC, when can they get consent to balance bill for those non-emergency services, essentially when a patient is voluntarily chosen to get treated by an out-of-network provider. And four, when can the provider or the facility get consent to balance bill for post stabilization services in connection with an emergency visit to a hospital or a freestanding ED. This was a somewhat unique feature of the No Surprises Act that, among the emergency services protections, it includes post stabilization services and not just assessment and stabilization of emergency patients. And so the question about when can a provider bill at out-of-network rates for post stabilization services becomes newly important.

And underlining all of these is, how do the existing state surprise billing laws interact with the federal laws? And who is going to be responsible for enforcing them, which as we've said, gets pretty complicated. And we'll walk through a few cases to explain it. Next slide, please. I'm going to walk through each of these. First, and this is the overarching process for surprise medical billing, so I'll just spend a minute or two walking through this slide. First, we're principally talking about two situations for the most part. I'm not going to talk about the air ambulance situation. So the two situations we're most concerned about is if a patient is seen at out-of-network ED, including freestanding ED, or there's a charge for an out network ancillary service received in an in network facility. These tend to be out-of-network services for which the patient couldn't have consented in advance to receive treatment by an out-of-network provider—anesthesiologist, radiologist, labs, hospitalists and the like.

So in either of those two situations, one of the core protections is that the patient can only be required to pay the in-network cost sharing under the patient's health plan. And all of these, the context is this is an insured patient that either has employer sponsored coverage or has individual market commercial coverage. So a patient would be limited to only being required to pay in-network cost sharing. Of course, if that's a co-payment, it's straightforward to know what that amount is. If there's a deductible or co-insurance, increasingly common, then a determination needs to be made about how in-network deductible or co-insurance is calculated. And that's based on what's called the recognized amount, which essentially is one of these three things. It's either the amount that would come from a state all payer model agreement, that's only Maryland, whether there's a state law outside of Maryland that determines what the patient cost sharing should be and if there is a state law that applies to a particular service by a particular provider under a plan, then that would apply or the qualifying payment amount, which is essentially the median in-network rate.

So essentially, the plan will be required to determine which of these three rates applies if it is the QPA, calculating the QPA, and then reporting back to the provider what the cost sharing should be based on

that analysis. The plan then either denies coverage or makes a payment, which is supposed to be a reasonable payment amount. There's a period of potential negotiation if the provider disagrees with the planned payment. If there isn't agreement in the negotiation, the payment goes to the IDR process that you heard briefly about before I got on. I think one thing to highlight here is that there's two separate calculations, one for the patient cost sharing, which happens at the front of this process, and two for the out-of-network reimbursement, which happens at the end of the process.

So patient cost sharing should be able to be determined relatively quickly. And the patient's obligations should be resolved relatively soon in this process, even if there continues to be a dispute between the provider and the plan about what the out-of-network reimbursement should be to the provider. The result of that dispute, if it does go to arbitration, does not affect the amount that the patient ultimately pays. It's just between the plan and providers. So that's one of the core protections is taking the patient out of that dispute.

I'll mention briefly, as you heard, there is litigation about the IDR process and the rules under the IDR process in terms of what the arbitrator should consider when determining what the out-of-network reimbursement should be. There have been several cases filed about this. We should, I think, expect, we may begin to see some decisions from the various courts in February or March. And depending on the outcomes of those cases, they may be appealed. So through the spring, we may begin to get some insight into what the outcomes of those litigations may be, which would time nicely with when these IDR arbitrations will begin to occur. We don't have all the steps in here but generally the IDRs could not begin until 90 days after a service was rendered. So since this first started applying in January 1, it may be that in April at the earliest, there may be begin to be some arbitrations. Next slide.

So I want to go into a little bit more detail about the recognized amount, and this is the amount that the cost sharing is based on. And these are calculations that are going to be done by the plan and then reported to the provider about how much to be collected. Essentially, it should result in an amount that's no more than would've been charged if an in-network provider had provided the care. As I mentioned, there's these three standards, essentially the Maryland model, a state law, if it applies or this QPA, which, as indicated previously, is generally the median contracted rate. It's actually the median contract rate from 2019 that is then inflated forward. And then there are special rules when the median contracted rate doesn't apply, such as like the plan was created newer than 2019 or the service didn't exist in 2019 so there isn't a contracted rate for it. There's special rules that apply. Worth noting that for ERISA plans, private employers, self-insured plans that don't use health insurers to underwrite their costs, generally, the federal rule is going to apply about what cost sharing should apply. Next slide.

And then, as I said, there's a separate calculation of the out-of-network rate. And that amount, again, is going to be either the Maryland all payer rate setting model, if there's a specified state law that

determines it and then the federal IDR process. I talked about the federal IDR process. Just a moment more about the specified state law, because I think in many states, that may determine the reimbursement because a significant number of states already had state surprise billing laws before the No Surprises Act was enacted. And in general, in order to be a so-called specified state law, the law needs to determine the reimbursement amount for the particular service rendered by the provider type at issue and for the plan at issue.

So for example, a state law might regulate reimbursement for, for example, emergency services but not non-emergency services. A state law might regulate particular out-of-network providers. It might go by particular specialty types that it regulates and not other specialty types. So it's conceivable, in fact, it's likely, that even in states that have state laws that set out-of-network for reimbursement amounts, there will be certain types of plans, certain types of providers, certain types of claims that an out-of-network reimbursement might still be determined under the federal methodology, even if the state methodology does apply to some cases. We are seeing some states considering expanding the scope of their state laws to the extent they can, so that there's less of a Swiss cheese jigsaw puzzle and the state law applies more, more broadly. Next slide, please.

The Good Faith Estimate has been an area of enormous agita among providers because it's one of the first things that really needs to be implemented by providers. And as you see here, we have three slides on it. I think the first thing worth noting about the Good Faith Estimate as it's currently being applied is ... So first off, the Good Faith Estimate is a requirement to provide patients a good faith estimate of the charges that are expected either upon requests before a scheduled services is scheduled or at the time that the services scheduled and before it's rendered. There have been two significant relaxations of this requirement under the federal rules and guidance. First, currently it's only being enforced with respect to uninsured or self-pay patients. These are patients that don't have any form of health coverage or have commercial health coverage and they're deciding not to use that health coverage. If patients have Medicare or Medicaid, this requirement doesn't apply at all.

The second relaxation that I think is significant is the Good Faith Estimate, at least for this year, is only required to include the expected charges from the provider who's actually providing the estimate. Supposedly, because beginning next year, the departments are going to enforce a requirement that it includes the expected charges of other providers and other facilities that may be involved in the service other than the one that's scheduling the service. If a hospital is responsible for scheduling service, then the treating providers charge should also be included. That requirement for the other providers to be included supposedly is going to go into effect January 1, 2023. And then as I mentioned, it's only being enforced first for self-pay or uninsured patients. It will, supposedly, eventually, be applied to insured patients as well.

That is going to be even more complicated because the plan is that these good faith estimates would not necessarily be provided directly to the patient, but would be provided to their health plan, which

would then use that Good Faith Estimate to generate what's being called an advanced explanation of benefits, which would tell the patient how much out of pocket they would have to pay, essentially like the explanation of benefits they would get after the services are rendered. But obviously there's a lot of interconnections that will be required between providers and plans that don't currently exist and will need to be put in place somehow before that requirement is enforced to provide GFEs to insured patients. So that does not currently exist.

There's a number of regulatory requirements about what needs to be in the Good Faith Estimate. It's principally a description of the services that are expected to be provided and a listing of the charges that are expected. There is a template form that the federal government has produced that lays out how all this information should be included in the Good Faith Estimate. Next slide. There are a number of other notice and other requirements that are associated with this Good Faith Estimate requirement. First off, there needs to be a notice provider provided that explains the availability of the Good Faith Estimate. It has to be posted on the provider or facilities website, at the office and wherever scheduling or cost questions arise, it has to be clear, understandable, prominently displayed, easily searchable. There's also a template for this notice.

And then when does it need to be provided? As I said, it has to be provided when a scheduled service is scheduled but it must also be provided when requested by a patient either before they've scheduled the service. The rules have a pretty broad definition of when a GFE has been requested. Essentially, anytime that a patient asks about costs, that should be interpreted as a request for a Good Faith Estimate that complies with these requirements. Next slide, please. And then one of the really significant consequences of the Good Faith Estimate for uninsured and self-pay patients is that if the actual charges for the episode of care described in Good Faith Estimate exceed the Good Faith Estimate by more than \$400, the patient can dispute that bill for through a new patient provider dispute resolution process. This is separate from the IDR independent dispute resolution process that exists in the context of surprise medical bills.

Essentially, if any particular provider or facilities charges exceed their estimate by \$400, this process could be triggered. And once it's triggered, the provider has to provide evidence to this new dispute resolution entity. Essentially, the only reason that they can defend the higher than expected charges is if the higher charges were because of medically necessary items or services that could not have been recently anticipated when the Good Faith Estimate was provided. I think providers are thinking through a number of ways, to avoid having to participate in the dispute resolution process. One might want to give good faith estimates that err on the side of going high. That, of course, prevents problems because it may deter patients from getting medically necessary care if the estimate is artificially too high to avoid these dispute resolutions.

Another thing that providers and facilities might do is look at their bills before they go out and see if they can be essentially written down on the front end so that they don't exceed this \$400 threshold.

There may be some thoughts going through the process for early some claims and seeing how it turns out. But it seems like there's going to be a significant operational burden here to go through this process. I think I have one more slide. Yeah. One more. Yeah. So this, and then there's ...

Okay. So this is discussing two of these core issues in surprise medical bills. And generally, this applies to the two situations we're talking about where there really are protections against surprise medical billings. First, the situation of non-emergency services in an in network hospital, or ASC, and the other is emergency services at a hospital or independent ED. And in both of those cases, despite there being this new federal protection against surprise medical billing, there are situations when a provider could bill at their out-of-network rates and potentially balance bill.

For non-emergency services, if it's a service that can be actually selected by the patient and the patient actively wants to use an out-of-network provider, the provider can provide notice of the balance billing ahead of time. It has to include an estimate of the charges and then the patient can consent to be balanced billed. Now, this is for any provider type, except for ones that are specifically prohibited from balance billing under the regulations, which are things like, again, emergency medicine anesthesiology, pathology, radiology, neonatology, sometimes referred to either as ancillary services or services that a patient can't reasonably select a provider, hospitalist, intensivist.

And then in addition to all of those, there's a catch all for any urgently needed care that arises that the patient doesn't have a reasonable opportunity to select to provide for. But, say a patient wants to be treated by a particular surgeon who's out-of-network but they want to do it at an in-network hospital for a schedule procedure, the patient is permitted to do that and consent to pay the full out-of-network charges, if that's what they choose to do. There are some timing requirements about when they need to consent to be balanced billed prior to the procedure. And then for ED visits, as I said, this statute was somewhat unique in describing post stabilization care as part of these ED protections.

Despite saying that post stabilization care is generally part of an emergency visit and subject to these balanced billing protections, there are circumstances in which a provider or facility can seek to obtain consent to balance bill. It has to be for care that the provider determines the pay patient could travel to a network provider using non-emergency medical transportation or non-medical transportation, meaning taking a cab or getting on a bus and going to a different hospital. And if that is true and if the patient is in a physical condition in which he or she can actually consent, then the patient is provided notice an estimate of what the out-of-network fees would be if the patient stayed at their current out-of-network facility and the patient consents.

You would all know better than I, but I suspect this is a somewhat unusual circumstance when this would ever occur when a patient essentially can't be discharged or there's medically necessary care that the provider thinks still needs to happen in the hospital and yet the patient is well enough that the patient could travel by non-emergency medical transportation and get the care at an in-network provider. Maybe if there's new network provider in the same building or something like that, maybe a

situation where that could arise. But otherwise, it may be a rare situation when there really is even an opportunity to get that consent to balance bill. And then I think my last slide, next slide, please. Yeah. And so just to mention, as we said at the top, that we did prepare with the AMA this toolkit that goes into somewhat greater detail on, I think, all the points I bring today. And so we hope you take a look at that. And I think the link is available, both here and by email. We look forward to your questions. With that, I'll turn it over to Joel.

**Ario:** Thank you, Michael. And if we can jump a couple slides up, you see on the map here that the state's basically divided in three. A third of states don't have any kind of balanced billing or surprise billing type law. A third of the states in the lighter shade there have a law but it's a partial law. And then a third of the states have something approaching a comprehensive law and covering these sorts of issues. So the states vary a lot. And then the states also have choice under this law as to whether they want to enforce their own laws or defer to federal enforcement. So you're going to end up with a patchwork, not only among the states but also within the states with regard to different sorts of services. The basic standards that applies here is that, again, the states get to choose if they want to enforce the law. But if they don't choose to enforce it or if they choose to and then don't actually enforce it, the federal government does have authority wherever the state is not "substantially enforcing the law."

Those of you who are familiar with the ACA will recognize that standard as the ACA standard of deference to the states but ultimately federal authority behind that. If we move to the next slide, start to get into some of the details here about what may vary state by state. There are two ways that a state can choose to be the primary agent. One is that they have a law in point and they choose to enforce that law. Again, that can vary by circumstance but that would be one way the state can enforce the law. The second way is a collaborative enforcement agreement. I'm going to use the acronym here a little bit, CEA, but the collaborative enforcement agreement is a mechanism in this law where the state contracts with the federal government to essentially be the federal government's agent and enforcing the law.

It works as long as the parties comply with what the state does as the agent of the federal government. Ultimately, the federal government would have to step in under a CEA arrangement if there were disputes and parties were not complying with what the state thought was the right solution. So it's an attempt to give the state's power but it doesn't ultimately work if there's not voluntary compliance. In the boxes there, we see if it's an insurer issue, most likely the insurance departments ... Well, at every state, the insurance departments are going to have authority over fully insured plans. That's roughly half of the employer based market. The states do not have authority over self-insured plans here, as in other areas. There is a little quirk here, which is that the law does allow employers to choose state enforcement. So a self-insured plan, a large employer could elect to be subject to state enforcement but they don't have to make that election. And the state doesn't have to allow it either.

Provider enforcement is, unfortunately for you guys, a little bit more murky at the current point. The departments of insurance could have been given authority under those state laws of predated this law or under the federal law for enforcement here but they haven't been generally given that authority and most of them are reticent to exercise that authority through a cooperative agreement or some other mechanism. So in general, provider enforcement has been, in most of the situations to date, handled by delegating it back to or deferring to the federal government. There are, in some cases, we'll see as we get through here, health departments, licensing boards, consumer protection agencies at the state level who may have some authority on the provider issues. And then as Michael went through all those different circumstances, the way to think about enforcement is in each of those different circumstances, the state could make a different choice. So they could choose to enforce in emergency rooms, but not in the situation of an in-network with a non-network provider, et cetera, et cetera. They could choose to enforce against insurers but not providers, et cetera, et cetera.

Something that may start happening more in the states that already is in one of the examples I'll talk about, states could try to help consumers complaint handling, that sort of thing and help them navigate the process. And that might include working both with state and federal agencies. And then of course, on most of the new provisions, the states are going to probably defer to these GFEs, particularly to federal enforcement, till things get sorted out a little bit. Go to the next slide. Go to the next slide. Washington was the first state out of the box to issue a more detailed ... No, I'm sorry. Back to the Washington slide, because is a lag between when I say something and it gets ... Yeah. So there we go. Washington was the first state to jump out of the box and assert what it was going to do at the state level. Washington's one of these states with a pretty comprehensive law. You can stay on that Washington slide for a minute here. So back to the last slide, the Washington slide.

Again, you see there what Washington said in a bulletin and I think it was early November, that they would enforce many of the provisions of their basic, pretty comprehensive surprise billing laws, so that billing protections against balance billing, the calculation of enroll cost sharing, the provider payment, dispute resolution processes, all of that would allow Washington to essentially use its state law to enforce the whole process. But what they said was that if they got to issues with air ambulances, they didn't have authority there, so the state threw that back to CMS. Self-funded groups, Washington did take advantage of the notion that employer groups could elect to be put under the Washington law, so they will enforce the law if there's that election. But otherwise, they delegate it back to the federal government.

And then for health providers, they basically said, "Not our area, haven't been given authority." So they're going to delegate that but to the state department of health. It's unclear what the state department health is going to do in Washington still, and for facilities where there really wasn't Washington authority over providers, that would go back to CMS. And then you see this detail about provider directories. There's a bunch of other things in the law where the state might have a law. Washington thinks it has a better provider directory law than what's in the No Surprises Act, so they've

taken enforcement there as well. But you see already that it gets pretty complicated pretty quickly with the states. And again, I wouldn't rely on anything that you're hearing today as a done deal. It will probably evolve over time.

If we keep moving to the next slide, this is the big picture of how this is going to evolve. And again, Washington is one of the few states, there are a few more, Delaware's another example, that have put out things at state level so far saying what they intend to do. But most of the activities so far has been private channels with the CMS, with the federal government, talking to people in the states, oftentimes the insurance regulators but could be other state officials as well. And then through that process, they developed an understanding between the parties as to how enforcement will go. Many of us hope that what we'd see how that process was a nice, big chart that put everything together at a high level so we could just skim through and see what every state is doing.

But the way it's actually working is that CMS produces letters, pretty boiler plated letters, about six pages long, to go through the detail of what the arrangement is in each state. They've done that for 41 states so far. There's a site on our additional resources page here at the end of the deck where you can go look at each of those letters. You do have to have your statute with you because it doesn't tell you what any specific thing is. It refers to the set of the law and so forth. So they're a bit difficult to read but they do tell you, if you understand how to read them, what the state will enforce directly, what the state will enforce through a collaborative agreement and what CMS will enforce, in quite a bit of detail. The collaborative agreements in these letters so far are an intention into the future.

So to my knowledge, none have been produced yet. If I had to bet, Pennsylvania probably has the first of these because they've been more aggressive about trying to get a collaborative agreement but that's still something that's coming in the future as well. So that's what we know so far. And then the next slide, you get into just a few examples just to give you ... Again, none of this is going to be written in stone yet but it gives you an example, a flavor of what states are thinking about so far with state versus federal enforcement. So on the left there, you have Texas, which, very proud of their law, their laws work pretty well by all accounts down there in Texas or maybe not all the accounts. Maybe there's somebody on the phone who doesn't think it has. But in general, it's getting high marks and it does address the broad range of issues, balance billing, dispute resolution. In Texas, they have total federal government.

They like their system. It's got a lot of voluntary compliance on all sides. And so they want to keep the Texas Medical Board, the Texas Board of Nursing doing provider enforcement issues. They want to have the Texas Health and Human Service Commission regulate the health care facilities. And then of course, the insurance department regulates the health plans. So if you want an example of a pretty robust state enforcement, state step it up and say, "We're going to do it all," Texas is a good example of that. In the middle there, cooperative agreement, Pennsylvania, as you saw from the map, if you had a good memory, had a partial law in place. So there, the Pennsylvania insurance department has

been working with the federal government to coordinate state and federal enforcement.

Part of that is if you go up on the insurance department's website, you'd see a web-based complaint handling system there where any consumer who can't figure out where to go with the federal or state government on some complaint, they can go to the PID website, enter a few basic pieces of data and then they'll get complaint handling help to walk them through their complaint, which, again, will, most cases, probably include both state and federal enforcement agencies in the state. So that includes the Department of Health. That's going to crop up in every state where this is moving beyond the insurance department. The department of state actually in Pennsylvania has provider licensing responsibilities. And the drug and alcohol program has some provider oversight responsibilities as well. And then of course, they are coordinating with the federal government in certain areas like providers and facilities, self-funded plans, the federal employee health benefit plan, not a small thing. There are a lot of federal employees. It's another area where there needs to be coordination.

And then finally, there are going to be some states who want to just basically hand it over to the federal government, and the example here is Alabama, which is that they don't have any law under the most specific surprise billing law. And they also, even if they did, not indicated any interest in enforcing. And so in that case, the federal government enforces. And do note there that Colorado could decide in the future, these decisions are revocable, so Alabama could pick up enforcement at some point. And by the way, this could include, I haven't seen a good example yet but there are some states on the map with specified laws and comprehensive schemes that some people think may decide not to enforce those schemes may decide simply to hand it over to the federal government. So even if you have a specified law, it doesn't mean for sure you're going enforce. You still have the choice.

If we go to the next slide, I'm almost to the end here into those questions, which is now, I see you have built up to 70 questions, the future of federal and state enforcement. This is a little bit of crystal balling but I think at this point, states are generally deferring to federal enforcement for providers in their initial planning. That's particularly the case when I talk to states that they might want to be in a situation where they send a notice to provider saying, "This is what we think the right solution is." But if the provider says, "I disagree, you're going to have to enforce that," I so far know if no state that says they want to get into an enforcement fight like that. That would get delegated back to the federal government for now.

But the process could change as the rules get clarified. We've already talked about the fact that the rules ... Dr. Mukkamala and Michael mentioned the rules are still in flux and you guys have some issues with them. Let that process play out. And then again, I think a lot of it ultimately where this ends up being federal versus state will depend on the preferences of, frankly, your group and some of the other stakeholders. On one end of where it could end up is like ERISA preemption, where the states have been basically preempted from regulating self-insured plans since the 1970s. Even where states

have wanted to regulate here, and some states have tried pretty hard, they basically get pushed back to not allowed to do it because the employer groups really oppose it and they tell us to guard their exemption. So you could have a situation where some party or another is trying to make sure that states really don't have much of a role here.

On the other side of the equation, the ACA enforcement process started out with the federal government having a lot of new rules for the states and many of the states wanting to resist those rules. But as of today, 48 states do their own rate reviews. Again, they have to go get certified by the federal government. They have to follow federal rules. But 48 states, Texas being the most recent, do their own rate reviews. 21 states, so less than half, still do state exchanges, the others for the federal government. So you see a general pattern there of the stakeholders generally preferring state regulation, CMS generally deferring to that. And so it moves towards state regulation but not entirely.

One challenge in this area as this moves forward is that there's no natural home at the state level for provider enforcement. There just aren't issues on which there's a process in place to enforce things like this. There aren't laws like this for providers. So that's a hurdle. It could end up being insurance departments. I think the NESC put out something about provider responsibilities under the law of bulletin. They know they understand that the laws work. They could do more but so far, or that hasn't really been invited by any of the parties, and so it's operating in the background more.

One last slide, I think, on next steps and we'll go to the questions here. What's coming up implementation of the law? As Michael mentioned, by the clock, there won't be any independent dispute resolutions until at least April. We'll definitely see more guidance and more regulation from the federal government. Some issues going to get resolved through litigation as we've discussed. I do think you'll see a lot more action at the state level, at least on the consumer protection side and maybe on the enforcement side. And there are some additional resources in the guide that foreshadow some of where they could go. And then there'll be efforts to coordinate and harmonize. You see that these small differences between state and federal law create a lot of difficult decision making and handoffs and so forth. You're starting to hear some states talk about, maybe we'll just pass laws that make us have the exact same provisions as the federal government, at least in certain areas, just so the laws are harmonized. So there may be more of that activity as well.

**Dr. Mukkamala:** Thank you so much, Joel and Mike, for the informative presentation. I know we got a lot of questions in about 15 minutes. So I'm going to get some help from Emily Carol at the AMA who's been part of the team here working on and on the No Surprises Act implementation from the very beginning. Emily, do you want to kick off the Q&A and we'll see what we can do, maybe rapid fire to get to as many of these 70 plus questions as possible?

**Carol:** Absolutely. Thanks, Dr. Mukkamala. And I have had a lot of questions come in about this slides being available. I just want to let folks know that we will not be sending out the slides but we'll make sure this webinar recording is available and send that out. And then I've also had a couple of

questions come in about the government templates that Michael mentioned and those are all linked to in the toolkit but we'll make sure those all get out as well. I tried to group of these now 81 questions together as best I could and get as much answered as possible. So Michael, maybe I'll start off with some questions that seem to fall under your area and your presentation around the good faith estimates. Can you clarify if practices have to provide good faith estimates for patients treated in the office?

**Kolber:** Yeah. It's not limited to facility based care. It's any uninsured or self-pay patients.

**Carol:** Along those same lines, would the Good Faith Estimate requirements apply to cash-only practices? So for example, when a patient pays a physician directly and then submits the bill to insurance? Do you know?

**Kolber:** So it's an interesting question. Under the rules, the provider is supposed to inquire whether the patient has insurance and intends to use insurance. So if they say they do, then the provider, the physician doesn't have to comply with the Good Faith Estimate requirements. If they say they have insurance but they don't intend to submit it, then they're supposed to provide a Good Faith Estimate.

**Carol:** Similarly, a question came in specifically from a surgeon's office. Do physicians have to provide every self-pay patient a Good Faith Estimate? Or is it only when the patient requests one?

**Kolber:** It's every patient, whether it's requested or when the service is scheduled.

**Carol:** And do you know if a patient can opt out of a Good Faith Estimate? Is that allowed or is it...

**Kolber:** I don't think so. I don't think there really is any mechanism to opt out.

**Carol:** Great. All right. Well, I'll skip, maybe, I think, Joel, this next one probably would go to you, and it's a question on why do you think states have been reticent to pursue cooperative enforcement agreements with respect to provider enforcement?

**Ario:** I think generally, we haven't seen the details of these cooperative enforcement agreements yet, so that's number one. People will want to see one in place and then have their lawyers look at it and so forth. The second issue though, as I was saying in the presentation with provider enforcement, I know from being an insurance commissioner, we would love to work with providers and oftentimes did, on the complaint side where a provider would be helping consumers solve a complaint. But where it looked like the provider might have been the person that needed to change their behavior, maybe we try to work with some of those on complaints. But as soon as the provider said, "I don't think you're right about that," the insurance regulators get pretty reticent. So it's just an area with not a lot of experience and I don't think it's likely to be an area that the insurance regulators move into unless they're encouraged.

So I could imagine a scenario which the provider community decides, "You know what? What we want these things done locally and we'll want to work with our insurance departments or some other enforcement agents because we really don't like what's happening at the federal level," then I think it could happen. But short of that, could be the opposite too, where the providers say, "You know what? This is kind of like ERISA. We want the federal government to handle this. We like the way they do it and we don't like the states being in the middle of it." So it's just going to depend and my notion would be everybody ought to pay attention to this and look at what's happening in your state and whether ... People make different judgments on whether the state enforcement or federal enforcement is more consonant with their needs.

**Carol:** So for specialty practices who provide care following a hospital discharge, do those practices have to post documentation in their outpatient offices if similar documentation is posted in the emergency rooms or other facilities? I'm assuming this is the disclosure information.

**Kolber:** Yeah. There's two potential notices. One is this disclosure notice around balance billing protections and that only needs to be used essentially in providers or situations that are subject to the surprise billing, balance billing protections under the No Surprises Act. So if this specialty practice doesn't see patients in an in-network facility or doesn't provide emergency services, non-emergency services in an in-network facility and they only see patients in their own office, then they probably don't need to provide this disclosure. If they do, then they do need to provide this disclosure, which again is a standard disclosure, which I think is in the chat, at least in connection with transactions that could be subject to surprise billing laws. There's a separate good faith effort disclosure announcing essentially the availability of good faith estimates. And that is not limited really to any provider types. It's anyone who sees any uninsured or patients that choose not to use their insurance. So that could be essentially any provider. And so that Good Faith Estimate availability notice will always need to be provided.

**Carol:** Joel, I think maybe going back to you on this one, who should we talk to at the state level if you want to understand the enforcement options better in our states?

**Ario:** I think your insurance regulators. This is spoken by a former insurance commissioner, so consider the source. But I think insurance regulators generally do understand this law from the insurer side. That makes them necessarily understand it to some degree from the provider side. So I think they're a good place to start. They're going to be in the know about what's going on in their state. In different states, I think somebody in the governor's office, somebody in the department of health, if there is a medical board. I hear mixed things, frankly, from the community about whether who wants the medical boards involved or not involved but that's another resource. And then some states have attorneys general or other consumer protection type operations on onboards programs or whatever that may be a resource as well. So there's really no dictating exactly where this is going to be picked up on in a particular state.

**Kolber:** And I would just add to that that we've been tracking sort of what the states have been saying about no surprises and a lot of them have really just put out informative consumer facing materials but not really done much in terms of how they're regulating it. But those have, for the most part, come from the insurance regulators within the states. And in some of the states, the insurance regulators have noted that they would take comply from consumers, but then they may refer them to other, regulators at either the state or federal level if it's not something that the insurance department can oversee. So just echo Joel's point that it seems like the insurance regulators are going to be the default in some cases, even though, in many cases, we're talking about regulation providers, really not insurers.

**Ario:** Yeah. One quick other example in the resources, there is a citation to an MEIC set of materials that do include a model bulletin. It's about six pages long that's written in legalese to say, "Here's what we think providers are supposed to do under the law." That's an example of the NEIC taking a sweep at, "This is what we think the laws mean for providers." You're going to see more of that coming out of insurance, I think, than anywhere else.

**Carol:** Great. Thanks to you both. More to come. There's several questions about the scope of the balance billing protections and I'll just rattle off a few, if that's all right. You can answer these after. Do the balance billing prohibitions extend to physicians providing office-based care? And then there's another question about emergency services when the patient is self pay, are there protections there? And then another question from an employed physician of an FQHC regarding their obligations and complying with the balance billing protections. So sorry to throw those all three at you.

**Kolber:** Right. The surprise billing protections are somewhat narrow. They only apply either to emergency services at a hospital ED or freestanding ED or out-of-network services at a hospital or ASC. And all of that only applies to insured patients. So there was a question about uninsured ED services, the balance billing productions don't apply. There's a question about provider offices or an FQHC. As long as it's not regulated as an ambulatory surgery center, FQHC would be treated as other provider offices and not subject to these balanced billing protections. So there are circumstances. It's something, perhaps a gap, unless state laws fill that gap, that there are scenarios where, for example, a physician might not be aware what labs are in-network and may send labs to an out-of-network lab. And there would not be protections from that if those were generated from a physician's office and not a hospital or ASC. So the balanced billing rules wouldn't apply there, federal rules.

**Carol:** There's a question about if a state does not have a surprise billing law in place, do physicians follow the No Surprises Act rules for all of their patients?

**Kolber:** Yeah, to the extent it applies. Again, uninsured patients won't have these protections. Government programs, we're talking about commercially insured patients. There are different existing rules that exist for government programs.

**Carol:** I have a question here about the qualifying payment amount and just a clarifying question. The QPA does not function as a minimum initial payment to providers, is that correct? But rather as just the basis for the cost sharing?

**Kolber:** Technically that's true. The way the federal IDR rule has been written, I think it's reasonable to think that the QPA amount may end up being what the initial payment amount is. But technically, the way the rule is written, the QPA is the basis for the cost sharing.

**Carol:** Great. And I might try and sneak one more in. I know we're running against the hour but this one, I think, goes to some of the notice consent requirements. In some situations, notice and consent to provide added network care is required or at least available. Is that correct? And then the question goes on to ask is, am I also correct that in some situations for some providers, that option is never available?

**Kolber:** Yes. Yes. So this only comes into the picture either for post stabilization services in connection with emergency care or an out-of-network provider in an in-network hospital or ASC. But we had a slide, and there's a list of providers, there's particular specialties, hospitalists, intensivists, neonatologists, pathologists, radiologists and so forth that can never get notice and consent because the idea ... it's not something that's really shoppable. Even if you're not among one of those specialist types but it's a care that comes up urgently and that was not really shoppable, notice and consent won't apply there but the balance billing protections apply. But as I said, if it's a surgery, a procedure where you can pick the provider in advance and you just want to have it done at an in-network hospital, the patient can consent to pay the out network rate.

**Carol:** Great. And is the IDR process available in those situations where either the care or the provider is not able to obtain consent?

**Kolber:** Oh, yes. When the patient doesn't consent and the provider's not able to obtain consent, the IDR process or the state methodology would apply. Once the patient consents, the provider is just reimbursed under the out-of-network benefit of the plan and then can balance bill the patient if it chooses to.

**Carol:** Great. Well, I think we are at time. There's lots more questions and we will certainly try and follow up with additional AMA resources that attempt to answer a lot of these questions. But Dr. Mukkamala, I think I'll hand it back over to you.

**Dr. Mukkamala:** Just one more question that I saw that I think should be pretty straight. So the question is, to clarify, so if somebody's primary care internal medicine doesn't go to the hospital at all, does any of this act apply to them? They're not seeing patients in the hospital, they're not in an ASC, it's just their office based practice.

**Kolber:** Yeah. So the balance billing rules for the most part will not be an issue for them. They may still need to provide good faith estimates if they have uninsured or self-pay patients.

**Dr. Mukkamala:** Well, I want to thank Joel and Michael so much for offering this important and timely information on the No Surprises Act. You can see from the questions, there's just a lot of need for clarification and advice, and thank you for giving it. There's more where this comes from and we'll continue to work on products to the information out there. To the audience, thank you for joining us and for all these great questions. I will plan on, again, posting this webinar online and we'll be sending out a link to you shortly.

As I mentioned earlier, in the area that we didn't do a deep dive in is the independent dispute resolution process. In the coming months, this IDR process becomes available to our physicians and we recognize that the way this process is implemented is of the utmost importance to so many of us. And we're committed to both fighting for a fairer process, the one that's outlined in the regulations and providing you with the resources that you'll need as physicians and physician advocates to understand and incorporate this into your practice. So please stay tuned for that. And also, please be on the lookout for additional AMA content on the No Surprises Act, including, again, this IDR process. Thank you for joining us. Enjoy the rest of your day.

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