

AMA Advocacy Insights webinar series: Out-of-network payment process

Featured topic and speakers

Out-of-network payment process under the No Surprises Act

As a follow-up to the AMA's January webinar on the No Surprises Act (NSA), this AMA Advocacy Insights webinar focuses on the payment process for physicians and other providers in surprise medical billing situations, as addressed in the AMA's toolkit (PDF). Joel Ario and Michael Kolber from Manatt Health join the chair of the AMA Board of Trustees Bobby Mukkamala, MD, to discuss provisions of the NSA, such as the initial payment, open negotiations period and Independent Dispute Resolution (IDR) process.

The speakers also discuss the different ways that state regulators are choosing to enforce the NSA's surprise billing provisions, including in those states with existing surprise medical billing laws.

Meeting documents

- Webinar slides from Manatt Health (PDF)

Speakers

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

Moderator

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

Transcript

April 21, 2022

Dr. Mukkamala: Thank you for joining us today for our second 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 trustees of the American Medical Association. Today, we'll focus on the provider payment process under the NSA or the No Surprises Act and how physicians and insurers can settle claims for certain out-of-network care. We'll look at the enforcement of the NSA, not the National Security Agency but the No Surprises Act, including the role that states play in enforcing federal law and state law. These issues were recently addressed in a second NSA toolkit that the AMA released two weeks ago and we're going to drop that link into the chat for you. As a background for today's discussion, the No Surprises Act took effect on January 1 of this year, 2022, and over the past year the Biden administration has been working to implement the law through a series of regulations and guidance.

One of the most challenging aspects of this implementation has been the provider-payor dispute resolution process. As you likely know, the AMA strongly supports protecting patients from unanticipated medical bills that can significantly raise out-of-pocket expenses and threaten access to quality care. We support these reforms as part of the No Surprises Act. The AMA advocated for a fair and balanced process to determine payment to physicians for out-of-network care. This included a required initial payment, an open negotiations process and an independent dispute resolution or IDR process, where an independent arbiter could consider all the relevant factors used to determine fair payment to the physician. Litigation over the weight given to certain factors by the IDR is impacting the way the payment process will be implemented, including recently updated and improved guidance provided to the arbiters that coincided with the opening of the IDR initiation portal.

As many of you are aware, regulations implementing the IDR process placed a thumb on the scale in favor of insurers by requiring arbiters to consider the health plans median in network rate or QPA, the qualified payment amount, as the appropriate out-of-network rate in most situations, essentially predetermining the outcome of the process. So therefore, multiple lawsuits, including one on behalf of the AMA and the American Hospital Association and one on behalf of the Texas Medical Association were filed soon after that IDR regulation was issued. The associations argued that the text, the context and purpose, as well as history of the No Surprises Act, made clear that the statutory IDR process leaves no room for the agencies to create a rebuttable presumption that the QPA is the correct out-of-network rate. In other words, the Texas medical association, the AMA, the AHA argue that the administration stepped outside of their statutory authority in implementing this IDR process under the

No Surprises Act and essentially upended the careful compromise for resolving these billing disputes.

To be clear, the lawsuit doesn't challenge any of the patient protections in the bill or any of the new requirements for providers. In February, the U.S. Federal District Court for the Eastern District of Texas found in favor of the Texas Medical Association and vacated the provisions that weighted the IDR process in favor of health plans. As a result, CMS recently issued new guidance to IDR entities that reflect the court's ruling. In the coming days, we'll find out if the federal government will appeal this decision. And we're also awaiting a decision on the AMA, AHA lawsuit in the U.S. District Court of D.C. We'll drop a link into the chat for more information on the lawsuit and the AMA advocacy efforts in this regard. So, yes, there are still a number of new and moving parts regarding the implementation of the NSA. We're thankful to have back with us two experts on the No Surprises Act who helped develop our AMA surprise billing toolkits. Today's presenters will also share their expert opinions on state and federal enforcement of health care laws.

First up, we have Michael Kolber. Michael is a partner at Manatt Health 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, counsels clients on corporate transactions, and litigates in federal court and before administrative tribunals. Prior to serving at 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. Joel has over 30 years of experience shaping and implementing public health policy at the state and federal levels. He provides strategic consulting and analysis of 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 of leading health insurance reform efforts for state and federal governments.

As director of the office of health insurance exchanges of the U.S. Department of Health and Human Services, 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 in 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, as well as an NAIC officer. Joel also serves as an advisor to the Robert Wood Johnson Foundation in support of its work with states. As you can tell, we are in great hands as we talk about the implementation of the No Surprises Act. Now I'll turn it over to these experts for their presentations, then we'll open it up for questions via the Q&A function on Zoom. So please feel free to post your questions in there as they occur to you and we'll get to those when we're done with the presentations. So, for now I will turn your screens over first to Michael. Mike, it's all yours.

Kolber: Great. Thanks very much, Dr. Mukkamala. Well, we'll have to give you some shorter bios next time. So, as you've heard, this is the second of a two-part series of webinars we've done for the AMA on the No Surprises Act. The first addressed some of the initial implementation issues for the No Surprises Act that U.S. physicians and your practices would need to deal with. Today, we're really going to focus on the Federal Independent Dispute Resolution process, which will determine, in many cases, the out-of-network reimbursement from health plans to physicians and other providers, as well as interaction with state law in cases where state law applies and the federal law does not apply. So, we'll talk to you both about the federal process and state examples of understanding whether state or federal law applies and how the enforcement will work thereof. And, we'll have plenty of time for questions.

So, the core protections—I'll just provide a brief overview of the law before we get into some of the details. The core protection that we're talking about under the No Surprises Act is a prohibition on surprise medical billing. While that is a broad protection, it is limited to a few particular scenarios as relevant for today's purposes. First, emergency services provided at out-of-network facilities and those out-of-network facilities either have to be hospital emergency departments or independent freestanding emergency departments. The second broad area is non-emergency services provided by out-of-network physicians or other providers at an in-network hospital or ambulatory surgery center. Has to be one of those, those types of facilities. There's also some protections for air ambulances; we're not going to cover that today. In this context, emergency services includes post stabilization services. We talked a bit about that last time and the complexities there.

The law establishes a federal process to determine the patient cost sharing and to determine the out-of-network reimbursement rate as we discussed, when the state law does not apply. The provider-payor obligations often serve two sides of the same coin, although there are some differences focusing on the provider obligations. There are consumer notices and disclosures, requirements that the notices be provided in particular forms, particular times. We discussed that a bit last time. There are requirements to figure out whether a patient is insured or whether we'll be covered by insurance because for self-pay and uninsured patients, there's a requirement to provide a good faith estimate. As we discussed last time, there's an opportunity to provide notice and an estimate and consent in order to be able to balance bill in certain circumstances where a patient is permitted to leave the balance billing protections.

There are requirements around continuity of care and continuity of coverage, and there's both payor and provider requirements around that. There's a new patient-provider dispute resolution process for uninsured or self-pay patients. And there are some of the core provider obligations and some of the payor obligations that are novel and include a new federal prompt pay requirement requiring prompt payment of claims that are subject to the surprise billing requirements within 30 days. A requirement that initial payment be made on these surprise medical bill situations, that's intended to be reasonably a complete payment as mentioned in the continuity of coverage requirements. There's some

requirements about what needs to be on ID cards, there's requirements to update provider directories regularly and that imposes obligations both on the payors and on providers to provide information regularly to their payors to make sure that provider directories information is up to date. And then there's certain requirements around advanced EOBs, price comparison tools that have been deferred at least temporarily.

So, as I said, the main focus today is going to be on the Federal IDR process which determines out-of-network reimbursement under these surprise medical billing situations.

As we discussed on the previous slide, this Federal IDR process, these out-of-network reimbursement requirements, only apply in these three situations, out-of-network emergency services, non-emergency services provided by an out-of-network provider in an in-network facility and then the air ambulances. Air ambulances are almost always going to be covered by federal law but we're not going to focus on that today, of course, because air ambulances are a different issue entirely. And then as we mentioned, there is the ability to waive these balance billing protections and for a patient to agree to pay the full out-of-network amount in certain cases. Generally, that won't apply to emergency services, at least pre-stabilization but can apply in other situations when a patient really does have a free choice of providers.

The out-of-network rate, the determination of how much the plan is going to pay the provider, relies on this Federal IDR process that we're discussing in cases when a state law doesn't apply. So first, is there a state all-payor rate setting model that currently is only in the state of Maryland? If not, is there another specified state law that applies, and we're going to discuss in more detail, what qualifies. And if neither of those are true then the federal process applies to determine out-of-network reimbursement for these surprise medical billing situations.

So, as we discussed, the Federal IDR process applies when the state process doesn't apply. There's some complexity beyond just determining out-of-network reimbursement which we'll discuss throughout because, as you saw on that first slide, there are a lot of consumer protections that are a part of the No Surprises Act and many of these overlap with existing state consumer protection laws. And the whole question of preemption here is pretty complicated. In general, the federal law provides a baseline and state law can continue to apply as long as it is more stringent, provides better consumer protections, better patient protections than one that applies under federal law. And the only difference is with actually the out-of-network reimbursement amount, where there isn't this question of, "Which is more stringent for out-of-network reimbursement?"

If there is a specified state law that applies to a particular situation, that law will continue to apply and the Federal IDR process won't apply. So, it's possible that you have a Federal IDR process and state law applies to other patient protections, whether it's about notice, waiver issues like that. Or the reverse, you might have a specified state law that determines out-of-network reimbursement but doesn't cover all the things that federal law covers in terms of patient protections and so there may still

be federal patient protections that apply.

So, we've been talking a lot about the concept of a specified state law and a specified state law is defined as a law that provides a method for determining the total amount payable to the provider for the surprise medical billing situation. The key questions there for figuring out whether a specified state law applies is, does the state law apply to the particular plan at issue? Does it apply to the particular provider or facility at issue and does it apply to the item or service? The reason you need to look at all three things is that some state laws have a limited scope. For example, most state laws are not designed to apply to self-insured private employer health plans, so called ERISA plans, because generally those laws would be preempted under federal law.

So, under the NSA there's now some flexibility for state law to apply to ERISA plans but generally hasn't applied in the past. The type of provider or facility and the item or service, some states had state laws that only applied to emergency services, some only applied to non-emergency services, some only applied to particular provider types or to particular specialties, some of them only applied to anesthesiology, radiology and other types of specialties where a patient going in say for a surgery isn't necessarily going to be able to select those provider types and some states define their surprise medical billing laws in that way. The point is that a specified state law will apply to the extent that it does apply and then when it doesn't apply to particular specialties, particular provider types, particular plans, the federal law applies. So, it's entirely possible, and indeed likely, that in almost every state, that there will be both state and federal processes applying that may differ by what plan is involved, what provider is involved, what item or service is involved.

The state law can be relevant both for determining what the patient cost sharing is if the state law determines what the patient cost sharing is and the out-of-network rate that's paid to the provider. And the state law can really take any number of different forms. It could be a fee schedule that sets the prices or sets prices by reference to some other publicly available fee schedule. It could be a mathematical formula for determining an out-of-network rate, it could be a process like the Federal IDR process where there's an opportunity to negotiate and then engage in some form of binding arbitration to determine the out-of-network rate. Any of those could be a specified state law which the NSA would defer to.

So just getting to the nuts and bolts of it, how do you figure out whether the state law applies or federal law applies? First thing to do, is in the past couple of weeks CMS has put this chart on their website, and so I would start with that chart and we have the link here in the materials. I would say that this chart is not as helpful as it appears to be. The category where it's most helpful is going to be the Federal IDR process states in the middle because you know in those states that essentially any claim will be subject to the federal process because there is not a specified state law in those states that applies. In the other states, the four states where CMS says there's a state process, or in the many states where there's a bifurcated process, you do need to then look at the state law and understand

the scope of it and understand which claims it applies to.

CMS has put out letters also on its website to the states where it provides some information about each state, about what types of claims each state law applies to but those will ultimately be questions for the states and for lawyers in those states. Even in the four states where it says it's state process, as we're discussing, for the most part ERISA plans, self-insured private employer plans, will still be subject to federal law unless the state has a mechanism to allow the plan to opt into the state law and the plan actually does opt in. So, in many of these states there will still be a lot of analysis to be done. Practically, the way you may get some guidance is that if the plan believes that the Federal IDR process applies, it should send the QPA with the remittance advice when it makes initial payment. It will send the QPA with the remittance advice; it may be an indication that the plans are required to do that if the federal law applies.

It's still possible that you may disagree about whether the state or federal law applies. As we're going to discuss, the providers are really in the driver's seat about initiating the QPA process. And so, when a Federal IDR request is submitted, the first thing the IDR entity will do is determine whether or not the federal process applies; there is an opportunity to get the arbitrator themselves to determine.

We're going to go through in some detail how the Federal IDR process works, again, assuming you're in it. This is how you get there in a state that the law applies to. For one of these services that are covered by the surprise medical billing law, there'll be an EOB as there typically is. It determines patient cost sharing based on the recognized amount and, as we said, this could be determined under state law. Or if a state law doesn't apply, then it's based on the qualifying payment amount which, as Dr. Mukkamala said, is essentially the plan's median in-network rate and that's how patient cost sharing is determined.

And the plan will make initial payment within 30 days on a clean claim or send a denial notice. And if the provider is not happy with the payment amount, the provider has 30 days to invoke the negotiation period, which is itself a 30-day period. And so, there is a form notice that needs to be submitted to trigger the negotiation period in which the payor and the provider can try to negotiate a better amount. If no agreement is made, then the IDR process can be initiated.

So, starting here now a third of the way through this slide which overlaps a little bit with the previous one, after the 30-day negotiation period typically it's going to be the provider that will want to invoke the IDR process. We'll have up to four days to initiate the formal IDR process, which is done on the Federal IDR portal website which we'll discuss in more in a moment. Then there's a process of deciding who will be the IDR entity, which is an arbitration firm essentially that will decide it. It's part of the selection. The parties can either agree on an IDR entity or if they don't come to agreement, the federal government will select one on their behalf. Within 10 days of the IDR entity being selected, the parties can submit their offers, the amount that they think the out-of-network reimbursement should be for the amount that is being contested and then any additional information that they want the IDR

entity to consider. The IDR entity will issue its final determination within 30 days of being selected and then payment must be made within 30 days.

For each time that there's a claim that goes to arbitration, there's a cooling off period so that the same provider and same plan can't arbitrate the same item or service for 90 days but anything that arises during that 90-day period gets batched together and then can be arbitrated as a batch after the 90-day cooling off period. Important point: the Federal IDR portal wasn't open until April 15. It may not be that there were many items that came to arbitration before that because you still had to go through these, wait 30 days through the open negotiation period and so forth. But anything that was ready for IDR before April 15, the initiation notice must be filed by May 6.

So, in order to fill out this form on the web after you determine that the federal process does apply, there's a number of pieces of information that should be gathered before entering this information because it all has to be done at once and there's a 15-minute timeout period. So, it's essentially information about identifying the qualified IDR items or services falls into one of those categories of surprise medical bills that are subject to the NSA, date and location, the types of the service, the service codes and the provider. Assuming you're the one initiating the process, your preferred certified IDR entity, this is the initiating party's, the provider's opportunity to designate which IDR entity it wants.

So how does the IDR process actually work in terms of how does the IDR entity make its selection here? So, first of all, the IDR entity is not making up its own out-of-network rate, it has to select one of the offers submitted by either the provider or the plan. This is so-called baseball style arbitration. It can't split the difference and it creates incentives, hopefully, for each party to come up with a realistic and reasonable number, knowing that it isn't likely the plan. It isn't like the arbitrator can split the difference. The statute says that the IDR entity is supposed to consider both the QPA, the qualifying payment amount, which is again generally the median in-network rate for that service and the geographic area for the plan, as well as these additional factors, the level of provider expertise, training, quality, the market share held by the non-participating provider/facility, the acuity of the patient, complexity of the services, teaching status case mix and then demonstrations of good faith efforts to enter into a network agreement during the previous four years. We'll discuss these in a little bit more detail in a minute.

The NSA does not allow the IDR entity to consider the provider's billed charges, the rates paid by government payors, including Medicare or Medicaid, or the usual and customary charges including payments or reimbursement rates expressed as a proportion of usual and customer charges. These are things that might be considered under certain state laws but under the Federal IDR process, as dictated by Congress, those are not factors that can be considered or presented to the IDR entity.

As you heard, there were several lawsuits filed over the regulation, establishing the IDR process. All of those lawsuits, including the AMA's lawsuit and the Texas Medical Association lawsuit, challenged an aspect of the federal regulation that, in the view of the litigation, differed from the process outlined in

the statute by specifying that the IDR entity has to begin with the presumption that the QPA is the appropriate out-of-network rate and the IDR entity must select the offer closest to the QPA unless the certified IDR entity determines that credible information submitted by either party clearly demonstrates the QPA is materially different from the appropriate out-of-network rate. So, as you heard, this regulation gave significant deference to the QPA, the plan's contracted median rates. One of these cases has been decided already, almost two months ago. The Texas Medical Association case was decided and the Texas Medical Association won. The rules were vacated on a nationwide basis and the court ruled that this regulation was inconsistent with the statute.

The following week, CMS and the Department of Labor issued a memorandum stating that the invalidated portion of the rules would not be enforced but that the rest of the NSA and the rest of the IDR process would continue to apply. The government has a few more days to decide whether they're going to appeal the Texas Medical Association case so we'll learn soon what it intends to do. It has also said that it intends to issue a final rule. These were interim final rules in which the government issued a final rule and took comments at the same time. So, the government has said it's going to issue a final rule, I believe, in May, next month and so that may further alter these standards or it could alter the course of the litigation.

But currently the government is proceeding and the IDR process is proceeding under the rule established by Texas Medical Association, which is that this rule of the deference to the QPA is not on the books anymore, that the IDR process will be determined based solely on the factors outlined in the statute.

So, in light of that, the government has issued new guidance to IDR entities. So, in light of the decision Texas Medical Association, in light of the fact the government has not appealed, at least has not yet appealed, the federal government issued new guidance to the IDR entities about how they should decide cases. First, in terms of credible information that parties can submit, the government said that the IDR entity can only consider credible information and then that means, upon critical analysis, the information is worthy of belief and is trustworthy.

It can consider only information that relates to an offer of either party and it cannot consider any prohibited factors. So, it provided a little bit more information about how to think about these additional factors. Essentially, the parties will still be submitting the QPA and the QPA amount will still be an amount, that's before the IDR entities. But then they'll consider each of these factors to determine whether they had an impact on the care that was provided and should ultimately impact the out-of-network rate. So the factors, the QPA, still being considered but there's, I'd say, somewhat more flexibility that the IDR entities will have in weighing the factors.

So, because the QPA will still be part of the determination, it will be sort of the one factor that is actually a dollar figure where many of the others will be a little bit more vague. It is still very important. The plans will still be responsible for calculating the QPA, as we said. That will be disclosed to the

provider when they receive the initial payment and it will be before the IDR entity. The government has said that the certified IDR entity is not responsible for ensuring that the QPA is calculated correctly. If the certified IDR entity or the provider believes the QPA has not calculated it correctly, they should report that to the government. But the certified IDR entity is not going to be re-adjudicating the QPA through this process. With that, I think I'm going to toss it to Joel.

Ario: Thank you, Michael. So that's a pretty deep dive into the Federal IDR process. We're now going to turn to some state examples. Michael teed up most of the issues that we'll talk about here between state and federal regulation and spend maybe 10 minutes just giving you a sense of the different flavors of state involvement in this process and then we'll turn to questions for the last 15 minutes. So, I see a number of questions already in the chat. If others have questions, feel free to put them, I guess, not into the chat, into the Q&A function there and Emily will, and Dr. Mukkamala, will help us with those questions.

So again, reinforcing some of what Michael has said, the starting point for this law is that states have primary authority to enforce the law if they have state law authorization to do so. There's also another process where a state can enter into a collaborative enforcement agreement, a so-called CEA, that allows them to voluntarily seek enforcement of the law. With CEAs, if the parties end up not agreeing to what's happening, they then can turn that matter over to the federal authorities. The line with state enforcement is more clear on the payor side than it is on the provider side. States have, since long before the ACA, primary enforcement authority over state regulated health plans but just like under the ACA, if the state chooses not to exercise its enforcement powers over state plans under this law, then HHS must enforce the law. So, the federal government is in the position of having to be the default enforcer of the law if either the state chooses not to enforce, or if the state tries to enforce and somehow doesn't substantially implement the law, that would be a federal law judgment as well.

And then finally, as Michael mentioned a couple times, the Department of Labor has primary authority over self-funded plans, although there is ... process under this law for those parties, the self-insured plans to agree to be subject to state enforcement. On the provider side, there's been talk for a number of years as states have developed these No Surprises Act laws about who would be the enforcer on provider issues. Lots of times the departments of insurance come up in that a conversation. In general, the state legislatures have not gone there, they have not given departments of insurance enforcement authority over providers. As a former insurance commissioner, I think most of my colleagues didn't really want that kind of enforcement power and so that could be something that happens over time but it hasn't really happened yet.

So you kind of have a smattering of different agencies in states that may have some authority over provider issues that are related to the No Surprises Act, health departments, licensing boards, consumer protection agencies. Texas, as you will see in a couple minutes, is a good example of a state that has that kind of smattering of authorities in other agencies. And again, the default position is

that CMS, the federal government will enforce the law if there's not state enforcement or a CEA.

This is a pre-NSA implementation slide. It shows you what the state of play was in the states. It gives you a flavor for why there is this series of complicated questions about federal/state enforcement. Because if you look at this, it's roughly a third, a third, a third; 18 states have comprehensive laws around balanced billing before the No Surprises Act. Another 15 states had some partial protections around balanced billing and then 17 states in white here had no laws at the time. So, again, this is a moving target. I don't think anything's changed on this map since it was put together by Commonwealth in 2021 but if we look at it in five years, there'd probably be significant changes in response to the federal law. Now we're going to turn to looking at four different examples of the kinds of things that states might do or will end up doing over time.

So if we go to the next slide, Texas stands out there as one of the states where the legislature took a comprehensive approach. In the 2019 laws, a big deal in Texas, reached across most of the areas here. Again, like Michael said, hardly any states that do all of the enforcement under the NSA but Texas is one that reaches pretty far into these issues. They had a 2019 law that set up an arbitration process, roughly similar to the federal process for provider-related disputes and they had a mediation process for facility-related disputes. One illustration of where the federal government heads on this would be that under that mediation process, it's not binding so the parties go to mediation but they don't have to honor the mediator's decision.

But still the federal government held that that was a state-specific law that would be enforceable by Texas rather than having the federal dispute. So you could have somebody in Texas in a facility dispute, it goes through mediation, wins and then the other party says, "Okay, it's not mandatory on me so I'm not going to comply," but still the federal government considers that a state-specified law so that's the end of the process from the perspective of the law. That could generate some issues over time but it illustrates the federal government being relatively generous to the states in terms of what is the state-specified law. Then the state's IDR process in Texas does involve multiple state agencies, the Texas Board and the Medical Board and the Board of Nursing for provider issues, Health and Human Services for certain facilities and then, of course, the Texas Department of Insurance for health plans. Where Texas doesn't have clear enforcement authority, they have not entered into a CEA to pursue voluntary enforcement. So, in Texas, it's either all Texas or all the federal government under the current status of things.

If we go to the next slide, see the opposite of the spectrum here. Pennsylvania is one of the states that does not have a specified state law but it's a consumer protection-oriented state, at least in the insurance department side of things so the Pennsylvania Insurance Department has been named by the lead state agency to coordinate state and federal enforcement. And if you were to go on the PID's website, you'd see a web-based complaint handling process there where a consumer who's in one of these disputes could initiate a state involvement in the case. Of course, the first step would probably

be to get the consumer out of the case and leave it to the provider and the insured to decide what the payments are going to be between them.

But the consumer can start the process with the PID. And I spoke recently with the commissioner who said, "If a provider or a payor were to try to invoke their process, they would try to be helpful to them too, particularly and if there's issues coming up with the Department of Health or the Department of State, or the Drug and Alcohol Program, maybe help those parties navigate." But he did say that when it came down to what's the right number in terms of who owes who what, that they probably would not get involved in that, would defer that to the federal government. But he did also say their first case was a self-insured plan where the state was invoked to help with the process and they think they're going to help solve that particular case with the provider and the self-insured plan.

So again, on all of these issues, if the parties go to the state and the state can voluntarily resolve the issue and the parties agree, then the federal government doesn't become involved. But I think for a while, until the IDR process sorts out, you'll probably see most of the cases going through the federal IDR process where there isn't clear state authority. For the next slide, got two more flavor of the state issues here. This is the California enforcement situation. I think we may have talked about this on the prior webinar and we had a different result at that time. California does have statutory authority to resolve certain disputes and they also have case law that applies to another set of disputes. Originally, the fed CMS said that obviously the statutory law is a specified state law but that case law did not fit the definition of specified state law and so it would not be in enforceable, it wouldn't be considered a specified state law.

Subsequently, they reconsidered that, apparently. And it hasn't been announced yet by CMS but it has been announced by the state that their case law is now considered a specified state law. And so, the CEA that they entered into to cover the cases where they didn't have specific authorities now narrow to a smaller number of cases and the California regulators started two of them over the insurance industry, both have broader state authority. So that's, again, an example of the trend being towards federal deference to the states where the state wants to take it on and has either statutory or case law authority. Final state to talk about here is Washington, the most recent action in a state. That was last week, Washington became the first state to formerly harmonize state and federal law through state legislation and I think this starts a trend that you will see potentially in several other states.

Colorado may have passed their law already. They're close to passing a similar law and this reflects the thinking, I think, of a number of states who look at this and say, "These laws are pretty complicated to set up. We had a particular take on it when we set up our state law. Federal government's now made a national take and that will apply where we don't legislate, so let's just defer to the federal law on most of the details." But then as Michael said, if you have things in your law that are stronger in consumer protections than the federal government has in the federal law, then you can keep those consumer protections in your state law as you harmonize.

So that's what I think you'll see just if you look at that second bullet. The way they harmonized was basically to say, "Federal law applies but we've got some stronger consumer protections." One example here is their crises triage centers that are for behavioral health emergencies and they extend a lot to those, and potentially states could have any number of consumer enhancements. As long as they provide stronger consumer protection, they're not preempted by the federal law. And again, we think maybe some additional states followed that. Michael, I think you want talk through that first set of bullets, I'll come back and talk through the other bullets.

Kolber: Sure. So, there probably will be more rules and more guidance from the federal government likely this year and perhaps into future years as well. There are a number of issues that have been teed up in either proposed rules or guidance that are going to be resolved. There are reporting requirements around air ambulance services that haven't been finalized yet. There are issues around the price comparison tool for health plans and how that will interact with the existing price comparison rules, then the transparency and coverage rule. There are rules around how the advanced explanation of benefits requirement will work and this will affect providers in that they will need to provide a good faith estimate to insured policy holders that can then be given to their insurers to calculate this advanced explanation of benefits. And there's a lot of complicated technical requirements that will need to be worked out in order for that actually to happen.

And then, as I mentioned, there will probably be a rule perhaps in May that may update and respond to the Texas Medical Association case in some way. So, there will still be a lot of movement in this area to be watching over the next year.

Ario: And in terms of states continuing to adjust their laws like costs, just a couple issues there, again, following Washington State's, may want to harmonize their laws with the federal law. That, by the way, could include a state that doesn't have a law yet and essentially enacting the federal law as state law and then they'd have the authority to enforce that. But you may see that in number of states that are ... path for states, maybe Pennsylvania path where maybe the legislature for various reasons doesn't want to take on full responsibility for these issues but the state regulators want to help consumers in particular. That's a trademark of state insurance departments, consumer protection, so they may see more state centered into CEAs as well.

But of course, all that depends on what's called out in that last bullet, what's going to happen with these early IDR cases? Depending on how they're decided, they may expand or narrow the number of IDR cases and that mostly will depend on whether there's a fairly predictable set of outcomes there that look like maybe they're all slanting towards the in-network rate of the provider, despite there not being a rebuttable perception anymore. Maybe they're all fighting the other way towards the provider's billable rates.

As these things get more predictable, really isn't a good incentive for parties to go to the IDR process. But if it goes the other way and there's a lot of variation between different arbitrators and so forth, and

it's an ongoing skirmish over, where is this going to settle out, then you might see quite a few cases in the near term here as the law shakes out. I see there are a number of questions related to that, so I'll stop with that. Turn it back to Dr. Mukkamala for the question-and-answer portion.

Dr. Mukkamala: Thanks, Joe, thanks, Michael, for a very informative presentation. I know there's a lot of questions here. We've got about 13 minutes and so we're going to jump right in. I'm going to ask for the help of Emily Carol, senior legislative attorney here at the AMA, part of the team working on the NSA implementation. So, Emily, let's do some Q&A.

Carol: Great. Thanks, Dr. Mukkamala. We've had a bunch of questions come in and then several that were submitted when folks registered, so I'll get started. I think the first couple are probably Michael but anyone jump in. So, there's been a couple questions about different scenarios for which the payment process might apply. So how does payment process differ for specialties or where care is provided, for example, emergency physicians or anesthesiologists providing emergency care versus a surgeon at an in-network hospital versus a specialist at an out-of-network hospital providing scheduled care? Are there different payment processes? Can you answer some of that?

Kolber: Yeah, so unlike some of the state laws that do specify by specialty type or by site of care, the NSA provides this out-of-network reimbursement methodology, the IDR process, that applies to all the scenarios that the NSA applies to. So, it will apply, I think, to most of the scenarios that you just mentioned, Emily, and it will essentially be the same. If we're talking about emergency care at a hospital or a freestanding ED, then to the extent the federal process applies the same, the federal process applies to all the providers and the facility. And if we're talking about an out-of-network provider at an in-network hospital, or ASC, then this process applies and it doesn't matter which specialty we're talking about or anything like that.

One, I guess, distinction is that certain providers who are out-of-network but in an in-network facility may be able to get consent from the patient to charge their full amount and opt out of this process. And those are only providers where the patient actually has a choice of providers. So, if a surgeon is scheduling a surgery at an in-network facility but the surgeon's out-of-network, they can get the patient's consent to balance bill. But if there are ancillary providers, ancillary physicians who don't have that opportunity, then their bills are going to be subject to this process if they're out-of-network and in an in-network facility.

Carol: Great. Thanks. And I'll say a lot of that information was provided in the first toolkit we put out and a link to that is in the chat. And also, just to clarify, these rules and protections don't apply in a situation where the provider is out-of-network but the facility is also out-of-network. Is that correct?

Kolber: Right. That's right. There are still a lot of situations where these rules don't apply. If it's an out-of-network provider at an out-of-network facility. Also, if it's not a service that's taking place at a hospital or an ambulatory surgery center. So, most services being provided at a physician's office are

not going to be subject to these rules at all.

Carol: Great. And that was actually the next question. Is there an opportunity for an out-of-network physician providing care outside of hospital to negotiate payment through the IDR process? And it sounds like no, there's not.

Kolber: No. Yeah.

Carol: Great.

Kolber: Unless it's an ASC or freestanding ED.

Carol: Got it. And can you summarize how the payment process might apply to transparent out-of-network practices? So, where information is provided up front to the patient about out-of-network care and where their balance billing might apply?

Kolber: Yeah. I think the law is really set up to recognize the existence of those sorts of practices and generally would permit them to continue to exist. First of all, if the practice is not a hospital-based practice and not an ASC, then these rules don't apply at all. But if they are seeing patients for non-emergency services in a in-network hospital or in-network ASC, they do have the opportunity to provide an estimate and get the patient's consent upfront to pay that estimate or whatever their bill charges are. And that remains possible if that's their current business model.

Carol: Great. Thanks, Michael. I think this next one goes to Joel. And you talked about this a little but maybe there might be anything more you want to say about this. Do you anticipate more states changing or altering their out-of-network laws in the coming months? It sounds like you do.

Ario: Well. I think they're separate and apart from the NSA, there are a number of proposals out there about price regulation, tend to perform more in hospitals than at other providers. I think maybe none of those laws have tended to be ... they're not very popular yet in the states and I think because of the NSA now, people will probably be in a waiting mode to see how the IDR process settles out what the results of that process are. And depending on what those are, you may see more states move forward or not. But I think if they move forward in the short term, much more likely within the structure, something like Washington harmonizing the laws or getting involved in a voluntary way, learning more about the situation. States are more like laboratories experimenting with stuff, so I don't think you'll see some broad proposals in this area, but more like watching NSA and tinkering with their involvement in NSA.

Carol: Thanks, Joel. I think another one for you. If a state has a specified state law but it doesn't otherwise apply to ERISA plans, so there's no opt-in option, does the state have any enforcement authority over ERISA plan disputes? And we got into this a bit in the presentation but maybe we could

...

Ario: Yeah. The short answer is no, but again, if the parties come and say, "We'd rather try to resolve this issue under your authority to resolve consumer complaints," or whatever, states have that authority, then it all can happen voluntarily but there would be no legal authority over either party if they wanted to invoke the federal process.

Carol: Thanks, Joel. Similarly, also applying to a specified state law situation, can physicians choose whether to pursue claims under the specified state law or the federal law?

Ario: Michael and I were talking about this a little bit; I think the answer is no. There's an answer and the IDR process determines it but we're saying, Michael, maybe you want to speak to it, what happens if the IDR determines the federal process and then the physician says, "Well, I want to try to invoke the state process," how that dispute might get reconciled? That goes out of my turf and into Michael's turf.

Kolber: Yeah. Yeah, I would say that it's entirely possible that there is going to be some confusion when these processes start, which is now essentially. And because of the complexity between state and federal law, that there may be a different answer even within the same state, depending on which plan is involved, what provider type, what service. So, I think the answer is yes, there should be one process that applies to any given claim, even the state or the federal process. And the parties generally won't have a choice but it may be confusing. And I would note, as was clear in the federal process, there are fairly rigid timelines and fairly short timelines for invoking the IDR process and moving forward, so it's possible if the parties are somehow waylaid interacting with the state, they may miss an opportunity to go through the federal process.

Carol: That's really helpful. And there was a question in here about if the state has a voluntary arbitration process, does that count as a specified state law or does the arbitration have to be binding?

Kolber: So, it's interesting. You would think that a voluntary process would not count because if it's voluntary in the sense that the parties don't need to adhere to the result of it. But my understanding is that Texas has a so-called voluntary mediation process but that has been determined to be a specified state law. So, I think you really just need to look at the state law and also look at these letters that CMS has published for each state where it says whether particular state statutes are in fact specified state laws under the law.

Carol: Got it. A couple questions came in about auditing and tracking of some of the information, including tracking of the IDR outcomes to see if there are patterns and who is prevailing and who's not. Is there any mechanism in the statute to track auditing for those outcomes? I'm not sure if we can answer that now.

Kolber: There is going to be reporting from the IDR entities to HHS and I assume there will eventually be some public accounting from those reports, although we haven't seen it yet.

Ario: I would add to that that almost certainly some private parties will take it upon themselves to track this closely, and to the extent, it's going to be an issue of how quickly CMS gets the information out. But say with the transparency laws, there are parties that make it their business to collect that information and share it, so I do think a lot of people would be very interested in what are the trends here in terms of what the likelihood is of wanting to be involved in the process is? So, you'll see a lot of focus on that as we go forward.

Carol: Yeah, that's a great point, Joel. And similarly, how to track and determine the accuracy of the QPA. I believe that the IDR entity is not in a position to make that determination in the IDR process. Are there any mechanisms for ensuring the QPA is calculated correctly?

Kolber: I think this goes to some of the issues that Joel was talking about, in terms of who is enforcing with respect to these rules because it could be both state or federal enforcement. As Joel was indicating, in a state like Pennsylvania where it's going to be relying on the federal process because they don't have their own surprise billing law but the regulator is very active. They may look into it as part of their just general enforcement of the insurance laws. So, there is not a mechanism as part of the IDR process to challenge the QPA amounts but I think the plans will be subject to oversight by the regulators.

Ario: Ten years ago, it would've definitely been the states that would be doing that sort of thing, but as the ACA has developed and the federal government's doing more and more oversight of commercial insurers, I think they start developing their expertise. So, I think Michael's right that it's probably more like a state insurance department responsibility but over time I wouldn't be surprised to see the federal government get more involved in that too.

Carol: Yeah. And I know that there is an email that CMS has set up so that if you do believe the QPA was incorrect when you're entering the IDR process, you can certainly report that to CMS for follow-up. So, we have lots more good questions but we are running up right against the hour. So, I want to turn it back over to Dr. Mukkamala for closing remarks.

Dr. Mukkamala: Sounds good. Joel, Michael, Emily, thank you very much for this important, insightful and timely information on the No Surprises Act. Thank you for your help in developing the toolkits that were linked to earlier. Thank you to the audience for joining us and sharing your questions. I will note, I put a link in the answer section here about the question about IDR outcomes, where do we stand so far? And this is just a link to Michigan data just so you get a sense about who is filing for this. The Michigan data suggests most of it is anesthesiology and emergency medicine, 13 out of 31 cases. Be on the lookout for additional AMA content on the No Surprises Act as well as other webinars from our AMA advocacy group that will keep you informed and engaged on today's most pressing issues.



Thank you again to our panelists and to you, our AMA audience, fellow providers, physicians and friends for joining us in the discussion. Enjoy the rest of your Thursday.

Disclaimer: The viewpoints expressed in this video are those of the participants and/or do not necessarily reflect the views and policies of the AMA.