What physicians need to know about the No Surprises Act with Emily Carroll, JD & George Cox, JD [Podcast]

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Featured topic and speakers

In today's AMA Update, Emily Carroll, a senior attorney for the AMA's Advocacy Resource Center, and George Cox, the AMA's director of legislative counsel, share what physicians need to know about the No Surprises Act and how the AMA's advocacy team is working on behalf of physicians and patients as the Act evolves. AMA Chief Experience Officer Todd Unger hosts.

- Guidance for implementation of the No Surprises Act
- Summary of the August final rule (PDF)
- Toolkit for physicians on disputing out-of-network payments (PDF)

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Speakers

- Emily Carroll, senior attorney, AMA Advocacy Resource Center
- George Cox, director, legislative counsel, AMA

Transcript

Unger: Hello. This is the AMA Update video and podcast. Today's topic is what physicians need to know about the No Surprises Act. We're joined today by Emily Carroll, a senior attorney for the AMA's Advocacy Resource Center in Chicago and George Cox, the AMA's director of legislative counsel in Washington, DC. I'm Todd Unger, AMA's chief experience officer in Chicago. Emily, George, thanks for joining us today.

Carroll: Thanks for having us.
**Cox:** Glad to be here. Thank you.

**Unger:** Emily, you joined us in December to talk about the No Surprises Act. And I know a lot's happened since then but let's just kind of start with a baseline, very quick, high-level overview of the act and what it's supposed to accomplish.

**Carroll:** Great. Thanks, Todd. So the No Surprises Act was signed into law back in December of 2020 and it took effect January 1 of this year. It was intended to address unexpected gaps in insurance coverage that result in surprise medical bills when patients unknowingly obtain medical services from physicians and other providers outside of their health care network. The bill prohibits out-of-network billing by physicians, hospitals and other providers in emergency situations, and then also in certain non-emergency situations at in-network hospitals when a patient might have not typically been able to pick their provider.

The law also sets up a payment process for physicians and the plan potentially ending with arbitration. So it's really important for physicians to be aware of these changes and the new prohibitions and requirements in their out-of-network billing.

**Unger:** Well, I know the AMA supports the goal of the act to protect patients from surprise bills but there have been some concern about the independent dispute resolution process that's outlined within the act. Can you remind us of how that resolution process is supposed to work and what the concerns are, Emily?

**Carroll:** Great. Yeah, thanks, Todd. You're right. The AMA has long supported protections for patients against surprise medical billing. And we have always thought they should be kept out of the middle of those disputes between physicians and other health care providers and plans.

So when the law was being debated, we did support those protections and worked to help set up a independent dispute resolution process between the plans and the providers. The idea was that this arbitration process would be structured in a baseball-style arbitration way, where each physician or provider would submit their own offer with supporting information and the plan would do the same. And the arbiter would essentially pick one of the offers.

As the implementing rules have been released, there has been a emphasis by the administration to really focus on what is called the qualifying payment amount, which is supposed to be the in-network median rate for physicians or other providers for that service in that area. And there's been less of an emphasis on these other supporting factors, like the complexity of care or the education and experience of the physician. When the first set of rules was released, there was generally no way or very little way that some of that supporting information could be used in the decisions by the arbiter, and the qualifying payment amount sort of became the de facto payment rate for physicians.
And as the additional rules have rolled out over the last couple of years, which I'm sure we'll talk more about, unfortunately, the emphasis has continued on that qualifying payment amount, which essentially creates a de facto payment rate not only in arbitration but in the market in general for physician services. So we're very concerned about the way this arbitration process has been established.

**Unger:** And we'll return to talk more about how, then, the AMA has been advocating for a resolution around that process. George, let's ask you a question here. Back in August of this year, the HHS Labor and Treasury departments issued final rules addressing some of these issues. What were the highlights of those decisions?

**Cox:** Yes, so on August 19, the departments issued final rules addressing the provisions of the independent dispute resolution payment process. These rules and the supporting FAQs responded to several concerns directly raised by the AMA and other state and specialty federation members.

First, they clarified that the parties initiating open negotiations are always permitted to use the standard federal initiation notice. That is, a plan cannot require a physician to use the plan’s proprietary portals to initiate open negotiations. The rules also reflect the language that the AMA and other physician associations advocated for to address the lack of transparency when a plan downcodes a service and calculates a QPA based on the down service code.

Now if a plan downcodes a claim, it must provide additional information on why the claim was downcoded, including an explanation of why it was downcoded and which service codes were adjusted. This will help physicians in the open negotiation and the IDR process, primarily because without this information, physicians are disadvantaged in dispute payment processes since the QPA doesn't reflect the original claim.

The rules also address our concerns that non-negotiated contracted rates, also known as ghost rates, were being included in the QPA calculation and contributing to the artificially low QPAs. Plans must now calculate a median contracted rate separately for each specialty when the plan’s contracted rates for service codes vary based on physician specialty. One other important change I'll highlight is a direct result, also, of the successful Texas Medical Association's lawsuit on the interim final rule.

As a result of the court decision in that lawsuit, the final rules removed the rebuttable presumption requirement whereby an arbiter presumed that the qualifying payment amount is the appropriate out-of-network rate. The arbiter now must select the party's offer that best represents the value of the service after considering the QPA and information submitted by the parties. As we've considered this new language, however, we're very concerned that it falls far short of what Congress intended and still weighs the QPA to the advantage of health plans.
Unger: Well, these are all positive steps that you’ve talked about. But, obviously, as you said, still some concerns. Let’s talk a little bit more about the remaining challenges. I know that the AMA has taken legal action in response. George, how are we approaching this from a legal perspective?

Cox: Sure. So just to take a quick step back, when the interim final rule was released last fall, it included a provision that the IDR entity, or the arbiter, presumed that the QPA is the correct out-of-network payment rate, and required it to select the offer that was closest to the QPA, unless there was credible information that the QPA was materially different than what was otherwise an appropriate rate. The AMA expressed significant concern with this rebuttable presumption that was in favor of the QPA and the impact that it would have on physician’s ability to negotiate fair contracts with health plans.

So the AMA joined with the American Hospital Association in a lawsuit that we filed in the Federal District Court in the District of Columbia here in DC asking the court to vacate this rebuttable presumption that weighed in favor of health plans as contrary to the clear intent of Congress. Around the same time, the Texas Medical Association filed a similar lawsuit in the U.S. District Court for the Eastern District of Texas. In February of this year, the Texas Court found in favor of the TMA case and vacated the provision in the IFR, or the Interim Final Rule, that created the rebuttable presumption in favor of the QPA in the IDR process.

As a result, the departments had to go back and rewrite the IDR regulations, which are reflected now in the final rules. Thus, since the final rules vacate the provisions in the interim final rule that were the basis of the AMA and the AHA’s lawsuit, our lawsuit became moot. However, as I mentioned a moment ago, the final rule still, in our opinion, depart from the intent of Congress and still place a thumb on the scale in favor of health plans.

So on September 22, the Texas Medical Association filed a new lawsuit in the same federal court in Texas arguing that the final rules still suffer from the same problems as the interim final rules. And we wholeheartedly agree. And rather than file a new lawsuit of our own in the DC Federal Court, we decided, along with the American Hospital Association, that we would be a force multiplier in the Texas case and make our voice heard by filing an amicus brief.

In the latest final rule, CMS explains that the QPA presumably already factors in most other data, and that, therefore, the IDR entity, or the arbiter, is directed not to, quote, double count or consider all other data that were required to be considered by Congress unless they find that a physician demonstrates that their data was so exceptional and unusual that it wasn't already included in the QPA calculation. The final rule also requires arbiters to provide written decisions to the departments at the end of the IDR process. And if the IDRE, or the arbiter, does not choose the offer that’s closest to the QPA, it must include a detailed explanation of additional considerations relied upon, whether the information submitted by the parties was credible and the basis upon which the IDRE determined that the credible information demonstrated that the QPA is materially different from the appropriate out-of-

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network rate.

We emphasize in our amicus brief that these requirements, viewed in whole, looks more like a fist rather than a thumb on the scale in favor of the health plans. So, in other words, when all of the extra statutory requirements are viewed as a whole, we argue that the final rules elevate the QPA above the other factors that Congress requires the arbiter to consider, and that it's in violation of the plain word of the statute.

**Unger:** So still a lot of work to be done here on that dispute resolution process. Emily, from what we understand, a lot of concern about the final rule in this regard from private practices. Can you give us a little more information about the concern here about how this will impact private practices if things don't change?

**Carroll:** Absolutely. So, as you mentioned, the QPA, because of the weight that the rules give this QPA or this median in-network rate, it becomes the rate that not only out-of-network physicians are paid in just that independent dispute resolution process but it becomes the rate that enters into contract negotiations for all physicians when they're having these negotiations with plans to be in-network. We've been hearing not only that these rates have been—contract rates that are offered to physicians are lowering as a result of these final rules and the interim final rules before that but we're also hearing a lot about physician practices being cut from networks as a result of this. So the plans can take it or leave it in terms of contracts with physicians at this point and still have the benefits of having patients receive in-network rates for their care.

So without greater protections in place and without a more robust IDR process, we're going to continue to see these contracting issues. And particularly for small or independent practices, the results are going to be long-lasting. These are often plans that they've had multi-year, decades-long contracts with that they're now seeing rate cuts or removals from these networks. And the long-term impact on patients is an access issue. Some of these practices will simply not be able to keep their doors open. And we're not going to be seeing in-network access for patients in the long run.

**Unger:** Those are huge concerns. And, obviously, much more work continuing to address these. Emily, when you look into the future, do you expect more provisions as the No Surprises Act evolves?

**Carroll:** Yeah. The No Surprises Act was not actually just focused on surprise billing, although that's been the focus for many over the last year. But there were a lot of other provisions in the law that passed that are in the process are being implemented now. Several of those focus on price transparency requirements.

We saw implementation last year of a price transparency requirement, which has been sort of dubbed the good faith estimate provisions for either self-pay or uninsured patients. And this requires physicians or other health care providers who are scheduling care with a patient who is self-pay to
collect estimates from other providers involved in the care and submit that information to the patient prior to care being provided. The AMA certainly supports price transparency and providing patients with meaningful price information prior to care so they can make informed cost decisions. But it's really important that as these provisions are implemented, we're not putting unnecessary administrative burdens on already strapped physician practices to do some of these price transparency requirements, especially when lots of states have price transparency requirements such as these in place already. So some of these rules may be duplicative.

And next year, we're anticipating the implementation of what's being called the Advanced Explanation of Benefits Provision. So this is the sort of sister provision to that good faith estimate one that implements price transparency and a cost information prior to care for insured patients. So we're anticipating a lot of comment letters over the next couple of months on these provisions. And we're also really advocating for meaningful price transparency that really recognizes that all of this is happening in a much larger ecosystem of data exchange and the workflow of physician practice, and really urging the administration to keep the administrative burden that's being placed on physician practices in mind as they implement these provisions.

**Unger:** And I think that's just a really important point. You can really take away a couple of key things here. One is this is very complicated. And, two, just how important the role of organized medicine, AMA, the Federation are in being able to address some of these things, particularly in the legal front. Got to be very confusing to physicians. George, how do we help physicians navigate what are these really complicated issues?

**Cox:** Well, we've put together a number of documents and guidance materials that help physicians understand the implementation of the No Surprises Act. This includes a summary of the August final rule that we've been talking about, as well as the toolkit that walks through the steps that physicians or their practice managers need to take when disputing out-of-network payment. And we're currently in the process of updating our toolkit and other resources to reflect the changes that were made in the final rule. And we're going to be posting these revised resources on our website when they're finalized.

Also, I should point out that the Centers for Medicare and Medicaid Services, as well as the Department of Labor, also has resources for physicians on their websites. And the link to those resources are in our toolkit. And we've also held two national webinars on the No Surprises Act implementation. The first is on the implementation itself and the second one focuses on the out-of-network payment process under the law. Those are currently on our website.

We also continue to revise our resources and create new ones as developments arise. And that will include the changes, if there are any, to the final rule that relate to the independent dispute resolution process as a result of the outcome of the current lawsuit in Texas.
Unger: Thank you so much, George. All the links for the resources that George talked about, you can find them in the description of this episode. And, again, what a great example of the power of organized medicine and just how important it is to support the AMA and your state societies. That wraps up today's episode. Again, thank you, Emily, George, for all the work that you and the advocacy team at the AMA are doing on this important concern for physicians and patients. We'll be back with another AMA video and podcast soon. You can find all our videos and podcasts at ama-assn.org/podcasts. Thanks for joining us today. Please take care.

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