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What to Know About the No Surprises Act

Announcer:
Welcome to *Perspectives with the AMA* on ReachMD, produced in partnership with the American Medical Association. Here's your host, Dr. Charles Turck.

Dr. Turck:
This is *Perspectives with the AMA* on ReachMD. I'm Dr. Charles Turck, and joining me to discuss the No Surprises Act is Ms. Emily Carroll, a senior legislative attorney for the American Medical Association's Advocacy Resource Center. Ms. Carroll, thanks for being on the program.

Ms. Carroll:
Pleasure to be here with you.

Dr. Turck:
Let's start with a high-level overview of the No Surprises Act. Ms. Carroll, what does this act aim to do?

Ms. Carroll:
Well, among many other goals, the No Surprises Act aims to protect patients from the financial impact of so-called surprise medical billing. Surprise medical billing is when a patient receives care from an out-of- network provider in either an emergency situation or at an in-network hospital, and they weren't able to pick their provider. Because there's no contract in place between the provider and the plan, the provider sends a bill to the plan, and the plan determines how much they want to cover. And then historically, the difference between the provider's bill and what the plan pays is the balance, or surprise bill.

Under the No Surprises Act, the patient is no longer responsible for that balance, but only for cost sharing that would have been applicable if the provider and plan had a contract in place. The law requires that the plan pay the provider an amount determined by the plan, and then the provider may dispute that amount, eventually to an independent dispute resolution process. This independent dispute resolution process is set up to be a baseball style arbitration process, where each party submits their best offer and evidence supporting their offer as permitted by the statute. And the IDR entity, or independent dispute resolution entity, picks one of those offers. The process is binding on both parties.

Dr. Turck:
And are there any other steps outlined in the act to protect consumers from surprise medical bills?

Ms. Carroll:
So as I mentioned, the patient is only responsible for their in-network cost sharing based on the median contracted rate amount which is determined through a complicated and, in our opinion, slightly flawed methodology that was established by the federal regulators. The provider can't bill that patient beyond that cost sharing.

But there are also a number of other patient protections from other types of out-of-network billing, other than surprise billing including requiring that a provider offer notice to the patient if they're out of network and receive the patient's consent to treat and bill the patient at their out-of-network rates. And there's a number of transparency requirements that allow patients to understand their financial responsibilities prior to the provision of care under the act.

Dr. Turck:
Can you tell us about the current status of implementation for the No Surprises Act?

Ms. Carroll:
Sure. Most of the major components of the law are in effect as of January 1, 2022. The four departments responsible for implementing the NSA, or the No Surprises Act are the Departments of Health and Human Services, Treasure, Labor, and the Office of Personnel Management have issued three separate regulations implementing the law.

Two of those rules have been interim final rules, meaning that the rules are essentially effective without a requirement that the department's respond to public comment. Unfortunately, these two interim final rules implement some of the biggest components of the law and do so in a way that is concerning to physicians and other providers.

Dr. Turck:
For those just tuning in, you're listening to *Perspectives with the AMA* on ReachMD. I'm Dr. Charles Turck. And today I'm speaking with Ms. Emily Carroll about the No Surprises Act.

Now, Ms. Carroll, you mentioned one or two of these before, but based on the regulations that have been implemented, what are some of the challenges we've encountered?

Ms. Carroll:
Well, how much time do you have? There are a lot of challenges with implementation. Many we anticipated when the statute was passed. For example, the No Surprises Act tried to ensure that a lot of the comprehensive state laws that address the surprise medical billing are not preempted by the federal law. So while we think this is a good thing, as many states have battled out really comprehensive state laws to prevent surprise medical billing in as many as 14 states we're bound to see continued confusion as physicians and other providers attempt to navigate two different surprise medical billing systems; one for state regulated plans and one for federally regulated plans.

But an unanticipated issue and perhaps maybe the most concerning to physicians is the way in which the departments are implementing provisions around that arbitration process that I talked about. As I said, the second interim federal directs the arbiters or the independent dispute resolution entities, consider the payer-calculated median in-network rate, as the appropriate out-of-network rate barring extenuating circumstances, which they make very clear in the rule are extremely limited. This is, despite Congress outlining a series of factors beyond the median in-network rate, that should influence an appropriate out-of-network rate and should be considered by the arbiters such as the complexity of the case, the training of the provider, and so on.

We at the AMA have strongly disagreed with the department's interpretation of the statute in this aspect and creating the sort of rebuttable presumption, around the median in-network rate. And in fact, many members of Congress have written to the department stating that this is not what they intended when they wrote the law.

There's a number of reasons why this interpretation is already proving to be incredibly problematic. The biggest being the impact that this scheme will have on the ability of physicians, especially independent practices, to get insurers to even come to the negotiating table and negotiate a fair contract with them.

When Congress drafted this law, they recognized that when they were reducing the demands of patients and employers for in-network care, they were also reducing a market force that pushed health insurers to negotiate fair contracts with physicians. While incredibly important from our perspective to remove patients from the middle, there was also an understanding that that there needed to be an additional check on health plans to replace that disappearing market force. And Congress, in response, created a really meaningful arbitration process where parties could submit their offers and supporting evidence as to why their offer was appropriate and hopefully come to a fair payment rate.

We actually, at the AMA, never really anticipated a high volume of claims going all the way through that dispute resolution process when the law was enacted. But we knew that the possibility of a physician successfully making a case for a fair out-of-network payment could help influence insurers to come to the negotiating table in the first place.

Unfortunately, in implementing the IDR process in a way that essentially predetermined the outcome below or at median contracted rates, that the check in negotiating incentives established by Congress has largely been stripped away.

So we anticipate we're not only going to see insurers paying out-of-network providers much less than the coming years, but also significant and likely dramatic cuts to rates for in-network physicians as they negotiate contracts and are essentially forced to renegotiate current contracts under the sort of ceiling of the median in-network rate. We're already seeing this play out this way in several states. And there's little doubt to us that depressed rates or termination of contracts will put additional financial strain on many practices, including independent rural practices that are already working to make ends meet and pay their staff and regaining their footing over the last year two of the pandemic.

Dr. Turck:
So what are some of the ways that we can address some of the obstacles that you'd mentioned?

Ms. Carroll:
So the AMA is working really closely with state and specialty medical associations, as well as outside partners to explore every opportunity to change the structure of how the IDR process is established and make it a more balanced process.

Additionally, we are advocating, as we have for many years, for stronger network adequacy requirements that'll help ensure that the changes in the No Surprises Act don't lead to those reductions and in-network care and smaller network.

There's a lot of network regulations on the books out there, but they could be stronger, and they certainly need to be enforced. We shouldn't have situations where there are say no in-network emergency physicians or in-network anesthesiologists available at all at an in-network hospital, but plans are still being put to market with these deficiencies in place.

Dr. Turck:
So, looking ahead to the future, Ms. Carroll, does this act do enough? Or do we need to do more to protect patients from unanticipated medical bills?

Ms. Carroll:
That’s a great question. The patient protections in the No Surprises Act will do a lot of good for a lot of patients. And the AMA continues to strongly support those patient protections. But a lot of work remains to be done to ensure that patients are getting value for their premiums and they are able to access affordable in-network care.

As I mentioned earlier, the structure of the arbitration process puts a thumb on the scale of health insurers and allows them to continue to have the market power to structured networks and benefits in ways that make them more money without really increasing access.

In terms of surprise billing, the AMA has is always recognized that unanticipated out-of-network care is really a symptom of much larger problems in the way provider networks and benefits are created and then regulated.

So I think as the No Surprises Act is implemented, it's critical that regulators address issues like network adequacy, health insurer competition, and ensure created barriers to medically necessary care. Ensure that the No Surprises Act is just a component of the solution to unanticipated medical net costs, not just a Band-Aid, while some of these other contributing problems continue and continue to grow.

Dr. Turck:
Very interesting thoughts, Ms. Carroll. And as we come to the end of today's program, I want to thank you for joining me to discuss the No Surprises Act. It was great having you on the program.

Ms. Carroll:
Thanks so much for having me.

Announcer:
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