Myths and Facts of the *No Surprises Act* Implementation

Myth 1: The *No Surprises Act* is leading to an exodus of doctors and specialists from health plans' provider networks, making it more difficult for patients to access the affordable, in-network care they need.

Fact: Since passage of the *No Surprises Act,* health plans' provider networks have grown, including increases in the number of providers participating from specialties more likely to operate outside of provider networks.

The latest data from AHIP and the Blue Cross Blue Shield Association shows that the *No Surprises Act* has led to more doctors and specialists participating in health plans' provider networks, a critical policy goal designed to increase access to affordable, in-network care. Approximately 67% of health plans indicated that they increased their provider networks since the enactment of the *No Surprises Act*. Crucially, no health plans reported decreases in provider networks, indicating that the law is succeeding in expanding access to care.

An analysis by FAIR Health also looked at national claims data during the first two years after the *No Surprises Act* took effect, reviewing the law's impact on four specialties of interest: anesthesia, emergency medicine, pathology, and radiology. The study found an increase of 2.3 percent in in-network percentages occurred nationally and in all regions, as well as across all specialties from the fourth quarter of 2021 to the first quarter of 2022.

This growth in provider networks comes despite an aggressive legal campaign launched by certain providers seeking to undermine the *No Surprise Act's* vital reforms.

Myth 2: Health care providers are not getting paid for out-of-network care and many are going bankrupt.

Fact: The *No Surprises Act* specifies that health plans must provide an initial payment to out-of-network providers for designated services within 30 days.

In nearly all circumstances, the initial payment is a market-based amount that would be paid to an in-network provider, sometimes an even higher amount in order to avoid arbitration. When government data and AHIP and Blue Cross Blue Shield data are combined, about 96% of out-of-network claims subject to the *No Surprises Act* are resolved voluntarily in qualifying payment amount-centered negotiations, consistent with congressional design. For the other 4% of the time, the provider keeps the initial payment and then the provider may initiate arbitration to make the case that a higher reimbursement is warranted.

Myth 3: Health plans' initial payment offers are below market rates, prompting out-of-network providers to rely on the independent dispute resolution process (IDR) for fair reimbursement.

Fact: Ensuring initial payments reflect fair, market-based reimbursement is a key goal for health plans, given the concerns around the costs associated with IDR, particularly given the likely impact of premium and out-of-pocket increases for consumers and employers.

After a relevant out-of-network service is delivered, the provider submits a claim, and the health plan issues an initial payment. At the conclusion of that 30-day period, either party may choose to advance to the IDR process. However, the large number of disputes initiated – nearly 14 times greater than the initial federal estimate – indicates many health care providers who were previously able to balance bill patients may now be utilizing the IDR process, presumably in the hope of collecting above-market reimbursement amounts.

According to recent data from the Centers for Medicare & Medicaid Services (CMS) and analyzed by researchers at the Brookings Institution, "investor-backed provider groups have accounted for a large and disproportionate share of IDR cases; practices affiliated with just four such companies (TeamHealth, SCP Health, Envision, and Radiology Partners) generated 74% of line items."

Myth 4: Health plans are failing to meet the payment obligations outlined in the *No Surprises Act* as part of final IDR determinations.

Fact: Relevant payments occur within the designated timeline when there is clear guidance from IDR entities about which claims in a batch should be paid at what specific amount. Improvements to the current IDR process are needed to enhance timeliness and clarity around payments and mitigate misuse of the IDR process by out-of-network providers.

A single dispute, as reported by CMS, could represent a batched dispute of many claims or a group of several claims for a single visit. The IDR entities must review each claim individually, meaning the volume of claims is even higher than the number of individual disputes, increasing the burden on IDR entities and driving health care costs higher through associated fees.

We strongly encourage policymakers to take proactive steps to improve IDR. Key recommendations include incentivizing clear and timely communications for all parties involved with IDR through a dynamic portal and requiring training for IDR entities on *No Surprises Act* guidance, including how to effectively use the final determination template and requirements for providers around claim submission. Additionally, more uniformity and specificity on how IDR entities decide payments as well as how they convey payment determinations for batched claims would help expedite final payments to providers.

Myth 5: Health plans are deflating Qualifying Payment Amounts (QPA) by including rates for services a provider does not actually furnish.

Fact: The legislative text is clear: only contracted rates for items and services provided by a provider are to be included in QPA calculations.

Congress dedicated a large section of the *No Surprises Act* to defining the QPA and detailing how it must be calculated. In summary, the QPA is calculated using median in-network rate data from 2019, before the passage of the *No Surprises Act*, and is adjusted year-over-year using the consumer price index for all urban consumers (CPI-U), a measure of the average change over time for consumer goods and services calculated by the U.S. Bureau of Labor Statistics. The Departments issued guidance reiterating that in August 2022, and the health insurance industry is on record in support of excluding $0 rates from QPA calculations.

Myth 6: IDR entities should not consider the QPA as part of final payment determinations.

Fact: The *No Surprises Act* requires that the certified IDR entity "shall consider the qualifying payment amounts" when IDR entities make final payment decisions – a critical factor in achieving the projected cost-savings for employers and employees as part of the law's protections.

To protect employees and employers from excessive costs during the IDR process, the *No Surprises Act* requires IDR entities to consider the QPA as a factor in making a final payment determination. While IDR entities must also consider additional circumstances submitted by the provider, such as patient acuity or prior contracting, the QPA is given a focal role in the law. This is intentional – both to ensure payment amounts are based on competitive, market reimbursement and that consumer cost-sharing remains affordable.

Unfortunately, the latest data on final IDR determinations show payment amounts that stray significantly from the QPA – a byproduct of ongoing litigation from private equity firms and out-of-network providers designed to intentionally undermine the cost-savings measures included in the law. As a result, the flaws in the IDR process and ongoing legal challenges are creating far greater uncertainty on how IDR entities are weighing particular factors, leading to unintended cost increases for employers and patients.