COALITION AGAINST
SURPRISE MEDICAL BILLING

Policy Priorities

The **Coalition Against Surprise Medical Billing (CASMB)** is an alliance of leading employer groups, labor unions, health plans and allies committed to meaningful solutions to protect consumers from unfair, exorbitant out-of-network costs and surprise medical bills.

Congress took the first step to protect consumers from these surprise bills with passage of the *No Surprises Act*. Even with these critical consumer protections in place, certain private equity-backed providers and arbitration middlemen are systematically manipulating the law's arbitration process—known as independent dispute resolution (IDR)—to extract maximum payments from employers and patients, often exceeding the original billed charges.

In the first half of 2024, 47% of all cases originated from just four private equity-backed organizations: Team Health, SCP Health, Radiology Partners and Envision, and 45% of filed cases were challenged as ineligible, compared to 37% in all of 2023. Recent data shows that the manipulation of the arbitration process is contributing to $5 billion in excessive costs and waste in the health care system.

The *No Surprises Act*'s arbitration process was designed to be a last-resort for settling payment disputes between providers and health plans—not to serve as a routine revenue model that financially drains patients and employers. The administration and Congress must implement common-sense reforms to address current flaws with the process to protect employers, patients and families from private equity's manipulation of arbitration.

KEY RECOMMENDATIONS

Address persistent claim eligibility issues that lead to wasteful, exorbitant costs on ineligible claims.

Affirm claim eligibility for IDR: The Tri-Departments should issue guidance clarifying and affirming that only "Qualified IDR item(s) or service(s)" may be submitted and reviewed in the Federal IDR process, establishing that payment determinations on non-qualified IDR items and services are fundamental errors that are reviewable by the Departments; and further, any payment determination for a non-qualified IDR item or service is not binding. The statute does not apply to non-qualified IDR items or services (e.g., a Medicare claim), and therefore, non-initiating parties must be able to contest and confirm the eligibility determination at any point during IDR to prevent the rendering of an unlawful payment determination on a non-qualified item or service.

Discourage initiating ineligible disputes: CMS should require that a portion of the Certified IDR Entity (CIDRE) fee be charged to the initiating party upon initiation of the dispute. If the dispute is deemed eligible by the IDR Entity, the amount paid is applied to the CIDRE fee owed. If the dispute is deemed ineligible, the amount paid as a CIDRE fee is forfeited. Non-initiating parties would not remit a CIDRE fee until a dispute is deemed eligible.

Improve system transparency and oversight with enhanced information sharing and performance monitoring.

Enhance access within the IDR portal and require transparent information sharing and rationales: CMS should take steps to enhance the features of the IDR portal so that all parties can access the status, communication and details of their disputes and have the ability to reconcile disputes in the portal with their internal records. This includes confirming receipt of IDR communications and allowing for downloads and uploads of data from the IDR portal to enhance information available to the IDR Entity.

All submitted and active disputes assigned to the two respective parties should be easily accessible and transparent to each side. This includes requiring IDR Entities to post the contents of each party's submissions to the IDR portal, along with any notes or annotation by the IDR Entity, to provide transparency into contents of what the IDR Entity reviewed and how the IDR Entity interpreted the submission. Additionally, IDR Entities should be required—not just encouraged—to issue detailed reasoning or rationale as to why the offer of the prevailing party was selected, and how that aligns with the statutory considerations.

Establish a CMS quality assurance and compliance assessment: This assessment may be initiated by either party for miscellaneous procedural and award deviations that are infrequent or unexpected.

CMS should establish a quality assurance and compliance assessment process for other deviations prior to the payment determination being deemed final. Examples of such circumstances would include when an IDR Entity issues a payment determination that is neither of the two "baseball-style" amounts submitted—which is clearly non-compliant with statutory text and must be managed by CMS.

Establish IDR Entity performance metrics and audits tied to corrective action: Disputing parties and the public should have insight into how the various certified IDR Entities are performing. By establishing clear performance metrics and audits, tracking IDR Entities' performance and objectively assessing performance, CMS can identify and impose appropriately calibrated corrective actions when needed.

Monitor and correct longstanding provider misuse of the arbitration process that drives up employer and employees' costs.

Develop a series of metrics to monitor problematic provider behaviors: While the Tri-Departments have largely focused on dynamics around IDR payment amounts and timelines, CMS' own data continue to reinforce the ongoing misuse of the IDR process by certain private equity-backed providers. CMS' recent data analysis shows that in the first half of 2024, 47% of all cases originated from just four private equity-backed organizations: Team Health, SCP Health, Radiology Partners and Envision. It is these parties that have identified the Federal IDR process as a profit-maximizing opportunity, potentially misrepresenting their submissions to collect above-market rates for out-of-network services—for example, Radiology Partners' prevailing offer was over 600 percent of the QPA. These abuses are driving up costs for patients.

The Tri-Departments can better identify parties misusing the Federal IDR process by strengthening performance metrics and reporting mechanisms. Performance metrics could include the percentage of disputes found ineligible, percentage of duplicate disputes, periodic spikes in filed dispute volumes, number of new disputes initiated during the cooling off period and frequency of disputes with clearly ineligible circumstances (e.g., in-network claims).