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Understanding the Biggest Threats to the No Surprises Act Achieving Its Full Potential

Introduction

No one should go bankrupt from receiving health care. Yet 60% of people experiencing bankruptcy in America cite medical expenses as a leading cause.[1] Thanks to the No Surprises Act (NSA) of 2020, more than 1 million surprise medical bills per month are now prevented from reaching consumers.[2] These are bills that could represent devastating medical debt that force families to make difficult decisions about whether to seek health care or pay for groceries and rent.

60% OF PEOPLE EXPERIENCING BANKRUPTCY IN AMERICA

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The NSA protects consumers in a number of important ways.

- Privately insured consumers are shielded from unexpected out-of-network bills for emergency room visits and air ambulance services as well as for non-emergency care at an in-network hospital, hospital outpatient department or ambulatory surgical center.
- People without health insurance coverage are entitled to good faith estimates from providers that outline the costs in advance of receiving certain services.[3]
- People with all types of insurance — or none at all — stand to benefit from the law's potential to reduce health care costs driven by inflated premiums that result from surprise medical billing.[4]

Major challenges, however, could prevent the NSA from realizing its full potential to protect consumers from the impact of surprise billing. Since the law went into effect on January 1, 2022, some detractors have waged a relentless campaign to undermine these protections. They have filed a series of lawsuits aimed at overturning key provisions in the law and regulations.[5]

Additionally, some health care providers and medical billing companies have inundated the Independent Dispute Resolution (IDR) process with 14 times more disputes than anticipated. This has undermined this new system before it has had the opportunity to work as designed.[6] As recently released reporting data points to, the overuse of IDR and erosion of key guardrails could lead to higher health care costs for consumers in the future.[7] Furthermore, when providers and insurers have not been not in compliance with the law, it has fallen on consumers to identify the problem and request their rightful protections.

Some consumers learn about their rights through materials from the Centers for Medicare & Medicaid Services (CMS). Others learn through outreach from consumer assistance programs, state agencies or from notices that doctors and facilities are required to post.[8] **Many people, though, remain unaware of newly enacted protections.**

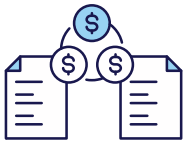
Each of these issues poses significant challenges to finally achieving a world where no patient receives a surprise medical bill. Consumers, advocates and policymakers need to monitor implementation of the law and guard against these threats to ensure that these critical consumer protections remain strong.

HOW DOES THE INDEPENDENT DISPUTE RESOLUTION PROCESS WORK UNDER THE NO SURPRISES ACT?[9]

Ensuring the IDR process results in predictable and fair payments for providers is important for providers and consumers alike — the design and implementation of this process matters.

After a patient receives out-of-network care, providers get an initial payment from insurers in the open negotiation period. A survey of major health insurers showed that both parties agree upon the full terms of payment during this period 80% of the time.[10] When there is not agreement, each can submit this dispute into the IDR process, which as initially envisioned, would ground negotiations in median prices called the "Qualifying Payment Amount" (QPA). The process is meant to keep health care costs from rising without reason and minimizes the impact of out-of-network care on insurance premiums.[11]

THREE KEYS TO IDR:



1. The provider and insurer each submit their proposed fair payment offer to the IDR entity in a "baseball style" arbitration: The third-party IDR entity is responsible for evaluating both offers and ultimately picking the most appropriate one.

2. The arbitration process as initially written in the statutes and rules begins as follows[12] *(Note: The ordering and emphasis of these IDR considerations have been challenged and altered due to various provider industry–led lawsuits. As a result, the QPA is no longer considered before other factors. See Section II below for more details)*:
    a. The arbitrator at the IDR entity considers the QPA, the median in-network rate an insurer pays for a particular service in that geographic area.
    b. The arbitrator factors in information the parties submit about: (i) the provider's training, experience and quality measures; (ii) the market share held by the provider or facility; (iii) the complexity of services needed by the patient; (iv) the provider's teaching status, case mix and scope of services; (v) the provider's efforts to join the network; and (vi) if the provider was in-network during the last four years, those rates.

3. The IDR entity picks one of the offers in a binding decision and both parties settle the payment without making changes to the patient's bill.

"Death by 1,000 cuts" litigation

The IDR system was carefully designed by Congress and implemented by the Biden-Harris administration. Its purpose is to protect patients and to ensure predictable and fair payment to providers. With guardrails in place, it should prevent inflationary impact on health system costs and removes unwitting patients from the center of payment disputes.[13] Litigation designed to disrupt that process threatens the integrity of the law.

As of February 2024, provider groups have filed a total of 26 lawsuits aimed at removing or rewriting key provisions of the NSA.[14] Each threatens to weaken current NSA guidelines and regulations, potentially undoing vital cost containment measures that have protected patients across the country from exorbitant surprise medical bills.

Most egregious was the suit brought by physician Daniel Haller against the U.S. Department of Health and Human Services (HHS), which sought to overturn the NSA altogether and bring back the practice of balance billing.[15] In January 2024, that case was dismissed by the U.S. Court of Appeals but the ruling indicated that Haller or others could modify their claims and file again.[16] At issue is whether the NSA interferes with doctors' ability to sue insurance plans for payment. Should a decision fall in favor of the plaintiffs, it would render the NSA's IDR process unenforceable and functionally unable to hold providers accountable for billing behavior that jeopardizes patients' health and generates massive medical debt for families in America.[17]

But the Haller case is not the only threat to the IDR process. Several notable cases, for example, have involved the Texas Medical Association (TMA) and the HHS. In the cases known as "TMA II" and "TMA III," the TMA contested the factors arbitrators rely on to decide how much insurers must pay for out-of-network charges.[18]

The TMA II and III cases have already been decided in favor of the plaintiffs and are on appeal. In the meantime, this decision has forced changes to key guardrails, such as the QPA, that could inflate payments to out-of-network providers. Ultimately, this could result in higher premiums and higher health care costs for patients.[19]

Buoyed by this decision, corporate provider interests continue to explore litigation strategies to further chip away at the rules governing the payer-provider IDR process. Continued erosion of these guardrails via litigation will limit the NSA's potential to deliver on a critical promise made by its bipartisan champions.

Protections against surprise billing should not increase premiums or result in higher health care costs for consumers. In fact, these protections should have the potential to reduce premiums for consumers in the commercial market.[20] In the long run, this flood of lawsuits could have a negative impact on the NSA's ability to prevent and reduce medical debt, which burdens nearly 23 million Americans today.[21]

Weakened and overburdened IDR process

Ensuring that the IDR process delivers fair payments to providers is critical to fulfilling the NSA's promise of shielding patients from out-of-network payment disputes. However, the law's effectiveness is threatened by overuse of the IDR process and by litigation. Together, these are weakening IDR guardrails and may raise costs for consumers.[22]

Consumer advocates are concerned that corporate entities might be intentionally abusing the IDR system by aggressively submitting claims with little regard to their merits. Over the first year of the IDR process (between April 2022 and March 2023), IDR entities received over 330,000 total disputes, more than 14 times the number of claims CMS had anticipated.[23] More than 100,000 cases were closed by March 2023 after being deemed ineligible for the IDR process.

These extraneous claims placed significant administrative burden on CMS and slowed the IDR process dramatically, bogging down progress on legitimate disputes.[24] While some of this heightened volume can be attributed to a learning curve by the filers, 71% of these cases were filed by the same 10 large practice management, revenue management, and physician staffing corporations.[25] This strongly suggests that some corporate interests are staying out of insurance networks and instead flooding the IDR system purely to maximize profits.

71%

OF THESE [IDR] CASES WERE FILED BY THE SAME 10 LARGE PRACTICE MANAGEMENT, REVENUE MANAGEMENT, AND PHYSICIAN STAFFING CORPORATIONS.

In addition to creating significant delays in timely processing and huge backlogs of disputes at IDR entities, these excessive claims have led to mounting administrative costs that are expected to exceed $70 million in 2024.[26] While these costs are initially covered by insurers and providers as an administrative fee within the IDR process, as they continue to grow they run the risk of ultimately getting passed on to consumers in the form of higher premiums.[27]

By March 2023, of the IDR cases with payment determinations, 71% were ruled in favor of the initiating party (the provider) in arbitration. In other words, insurers were required to pay the provider the full provider-preferred amount.[28] In the first six months of 2023, out-of-network providers received median payments between 105% and 323% of the QPA for each IDR case. This amount is expected to exceed the Congressional Budget Office's predictions for IDR process payment outcomes, which is very likely a result of eroded guardrails meant to protect the QPA's consideration within the IDR process.[29,30]

Ultimately, every patient may be at risk of higher costs and higher premiums than anticipated under this weakened and overburdened IDR process.

Predatory private equity behavior drove surprise billing practices and is now driving efforts to undermine consumer protections under the law:

- In the late 2010s, private equity firms bought into a large number of physician staffing agencies.[31] This action spurred questions about the potential for these firms to opt out of insurance networks in order to bill at higher rates and generate more profits for their investors.
- Evidence backs up initial concerns about the behavior of private equity firms: Before the NSA, private equity–backed staffing agencies engaged in extensive profiteering from surprise billing practices, including sending out-of-network bills up to 62% of the time, compared to a national average of 26%.[32] As a result, health care prices for patients with the same diagnosis averaged nearly 10 times higher at hospital-based emergency departments compared to urgent care centers.[33]
- Two of the largest private equity–owned staffing firms — TeamHealth and Envision Healthcare — formed Doctor Patient Unity, a corporate lobbying group that spent more than $57 million on advertisements opposing NSA legislation (see Figure 1).[34]
- Since passage of the NSA, out-of-network bills continue to be dominated by six staffing agencies (including TeamHealth, Envision Healthcare, and four other groups owned by private equity). These have accounted for 46% of all out-of-network emergency care disputes in 2023.[35]

Figure 1

Consumers may carry the burden of enforcing their rights under the No Surprises Act.

Though the NSA is shielding millions of patients from surprise bills each month, current enforcement procedures still depend on consumers knowing their rights and submitting formal complaints if wrongfully billed. Hospitals, hospital outpatient facilities, and ambulatory surgical centers are supposed to post notices about patient rights,[36] but in most states, there is no systemic inspection to determine if facilities are posting required information or if patients are receiving notices about their rights.[37]

The No Surprises Help Desk is an important resource providing federal support for patients submitting complaints. Some states have non-profit consumer advocacy programs that do the on-the-ground work of providing essential services like outreach, assistance and education for consumers on surprise billing rights.[38] Many states, however, lack funding for dedicated consumer advocacy or consumer assistance programs, leaving gaps in patient support.[39] Unwary recipients of surprise medical bills may unknowingly pay a bill for thousands of dollars that, under the NSA, should not have been issued in the first place.

NO SURPRISES HELP DESK
1-800-985-3059

The reality is that despite the important protections in the NSA, some loopholes and noncompliance with NSA rules still result in surprise medical bills for patients. Such loopholes could be closed with better patient education as well as corrections to provider and insurer behavior.

Evidence points to certain plans and providers failing to hold patients harmless for surprise bills. Reasons may lie in a lack of effective automated processes, gaps in provider knowledge about when the rules apply and, in some cases, misinformation that results in balance bills.[40] The burden then falls on the patient to know and report the bill as a surprise bill. However, even when patients recognize and report these surprise bills as violations of the NSA, such bills can take more than six months to appeal and resolve. In the meantime, the patient must wait to be reimbursed for any excess billed amount.[41]

One specific practice ripe for additional oversight is provider misuse of the NSA's notice and consent provision.[42] This provision was designed to give patients an option of seeing an out-of-network provider when it fits their needs, but some providers have pressured patients into waiving away surprise billing protection rights, allowing providers to legally bill them at out-of-network prices.[43]

Patients may not understand the full ramifications of signing away their rights. In some cases, going out-of-network might be the best course of action for accessing the care a patient wants and needs. But patients who are uninformed about the risks of waiving away their surprise billing rights or about alternative options available to them can be deeply harmed by out-of-network bills totaling thousands of dollars.[i]

Providers and insurers must be held accountable in fully and faithfully complying with the NSA to protect every patient in their care from a devastating surprise medical bill. And they should do so regardless of whether the patient is fully aware of their own rights under the law.

Conclusion

The NSA has already protected millions of patients from surprise medical bills. It has the potential to achieve its vital, intended purpose of holding millions more families harmless from unfair costs incurred without their knowledge and beyond their control.

The law is a critical tool to minimize the inflationary impact of provider-insurer payment disputes so that families do not face higher health care costs as a result. Key fundamentals of the NSA, such as the guardrails around the IDR process and QPA calculation, must function as intended to protect patients from egregious prices set by profiteers. Implementation must also ensure that the burden of enforcement does not rest on an individual patient's knowledge of their surprise billing rights.

While private equity–backed staffing firms and corporate health industry interests continue to call for provider-centered changes to NSA implementation,[44] policymakers should remain steadfast in centering consumers first and foremost. They should work to bring providers in-network, prevent surprise bills and stop prices from rising at unsustainable rates.

Take action today and let our public officials know how vital a strong No Surprises Act is for consumers!

[i] For example, in one recent case, a consumer whose primary language is not English was told that his varicose vein surgery would not be performed unless he signed the consent form. Because he needed the surgery and did not understand the form, he signed the form shortly before surgery and paid a $6,000 deposit (50% of the surgery's cost) out of pocket. His plan's Explanation of Benefits notice later stated that the claim was reduced and, because it was protected by the NSA, he would owe only the in-network cost-sharing of $18. But the patient had signed the consent form and was thus incorrectly required to pay the $6,000 – which will be nearly impossible to reclaim. For more information, see Endnote 38: Spicer, Testimony Before the U.S. House Committee on Ways & Means on Implementation of the No Surprises Act.

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