Project Report

PETRA W. RASMUSSEN, ERIN LINDSEY DUFFY, ISHA YARDI, JESSICA RICHARD, MONIQUE MARTINEAU, CHERYL L. DAMBERG, AND M. SUSAN RIDGELY

The Implications of the No Surprises Act on Contract Dynamics, Negotiations, and Finances

Perspectives from Key Stakeholders

RAND Health Care

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About This Project Report

The No Surprises Act (NSA) went into effect on January 1, 2022, with the goal of protecting commercially insured patients from receiving surprise medical bills in certain circumstances. Under the NSA, patients cannot be charged more than the in-network cost-sharing amount when they receive emergency care at an out-of-network facility or from an out-of-network provider (including post-stabilization services), non-emergency care from an out-of-network provider at an in-network facility, or emergency transports by an air ambulance provider.

Under Section 109 of the NSA, the Secretary of Health and Human Services, in consultation with the Federal Trade Commission and the Attorney General, must annually report on the effects of the NSA on patterns of vertical or horizontal integration of health care facilities, providers, group health plans, or health insurance issuers; overall health care costs; and access to health care. To support this requirement and build on prior work that RAND has conducted on the NSA, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) asked RAND to hold discussions with stakeholders to explore whether and how the NSA has affected insurer-provider dynamics, contract negotiations, and payment rates, and to gain stakeholders' perspectives on the law moving forward. ASPE also wanted to understand the work underway to respond to the advanced explanation of benefits (AEOB) provisions included in the NSA and stakeholders' thoughts on the opportunities and challenges brought on by AEOBs. This report summarizes themes that emerged from our discussions.

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RAND Health Care Communications
1776 Main Street
P.O. Box 2138
Santa Monica, CA 90407-2138
(310) 393-0411, ext. 7775
RAND_Health-Care@rand.org

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Summary

Surprise medical billing occurs when an insured patient is unexpectedly billed for the difference between an out-of-network health care provider's charges and the amount their insurer paid for the service (i.e., the remaining balance). The No Surprises Act (NSA) was passed as part of the Consolidated Appropriations Act, 2021, and went into effect on January 1, 2022, with the goal of protecting commercially insured patients from receiving surprise medical bills in several key instances (Pub. L. 116-260, 134 Stat. 1182, Division BB, Title I, 2020). Under the NSA, patients cannot be surprise billed (i.e., *balance billed*) when they receive emergency care at an out-of-network facility or from an out-of-network provider (including post-stabilization services), non-emergency care from an out-of-network provider at an in-network facility, or emergency transports by an air ambulance provider. The law also specified the Federal Independent Dispute Resolution (IDR) process for insurers and providers to handle disagreements about payment without involving patients in the dispute.

Issue

The NSA has changed dynamics between insurers and providers by prohibiting the use of surprise billing by out-of-network providers and establishing an IDR process to arbitrate payment disputes for services subject to the NSA. However, questions remain as to how these changes, and the NSA more broadly, affect insurer-provider contract negotiations.

Negotiations are influenced by each party's best alternative to a negotiated agreement (Fisher, Ury, and Patton, 2011). Before the NSA, providers' alternative to negotiating a contract was to bill as an out-of-network provider, which could include surprise billing and trying to collect payments directly from patients. Insurers' alternatives to contracting were to pay out-of-network providers' billed charges or to put enrollees at risk of surprise billing (Murphy, 2019; Cooper, Morton, and Shekita, 2020; Duffy et al., 2020). However, the NSA has changed the alternatives to negotiating by prohibiting the practice of surprise billing, creating a reference point for out-of-network payment amounts in the qualifying payment amount (QPA)[1], and establishing the IDR process to handle payment disputes between insurers and out-of-network providers.

To explore whether and how the NSA has affected insurer-provider dynamics, contract negotiations, and payment rates, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) asked RAND to conduct discussions with stakeholders. In addition, ASPE

[1] The QPA is the inflation-adjusted median 2019 contracted rate of the service provided for a defined geographic area and insurer market (Centers for Medicare & Medicaid Services, 2021).

was interested in learning about the work underway to implement the advanced explanation of benefits (AEOB) provisions of the NSA and stakeholders' views on the opportunities and challenges AEOBs provide. Under the NSA, insurers are required to provide AEOBs to patients to give them information about their expected cost-sharing requirements in advance of planned procedures or services. The final rules around AEOBs have not yet been released, therefore delaying implementation of this provision of the NSA. In this report, we summarize the approach we took to exploring these topics, the themes that emerged from our discussions, and areas for additional inquiry.

Approach

From January to March 2024, we held 35 semi-structured discussions with representatives of provider and insurer organizations, including anesthesiology groups, emergency medicine groups, radiology groups, air ambulance organizations, provider coalitions, provider partners (i.e., firms that participate in revenue management and negotiations on behalf of providers), insurers, insurer coalitions, benefits consultants, and insurer partners (i.e., firms that participate in claims processing and negotiations on behalf of insurers). These key stakeholder groups were selected based on the expectation that they were most likely to be affected by the NSA and were the most knowledgeable about the topics of interest. Discussion topics included the out-of-network payments before and after the NSA, the typical structure of a contract and the negotiation process before and after the NSA, network and payment changes under the NSA, organizational staffing changes, overall view of the NSA, and expectations for insurer-provider dynamics moving forward. We also asked insurers and relevant provider groups about their perspectives on the AEOB provisions of the NSA, including what work is underway to prepare for implementation and stakeholder views on the challenges and opportunities that AEOBs provide.

Discussions were led by two experienced researchers and conducted virtually via Zoom for Government. The discussions were recorded and transcribed. After the transcripts were coded using Dedoose software, the researchers reviewed the codes to identify key themes that emerged across discussions, met to discuss the identified themes, came to consensus, and developed a consolidated set of themes to be reported. These findings represent a snapshot in time, as perspectives can shift over time in such a rapidly evolving policy and rulemaking environment. Additionally, participants were selected non-randomly, and their perspectives cannot be assumed to accurately represent those of all providers, facilities, and insurers impacted by the NSA.

Key Findings

We organized our major themes under the following topics: out-of-network payments; contracting process and outcomes; insurer staffing, operations, and revenue changes; provider staffing, operations, and revenue changes; overall thoughts on the NSA; and AEOBs.

Out-of-Network Payments Pre- and Post-NSA

- Although the NSA only applies to out-of-network items and services, it also has the potential to influence contract negotiations and networking dynamics between insurers and providers, including the payment rates at which the parties are willing to contract at and their overall willingness to contract.
- Stakeholders (both insurers and providers) described lower out-of-network payments under the NSA, largely driven by lower initial payments to providers.
- Providers who challenged initial out-of-network payments through the IDR process described long delays in processing disputes, extended timelines from the time of service to receiving the final adjudicated payment, and situations in which insurers did not pay providers even after an arbiter (known as an IDR entity [IDRE]) decided in the provider's favor.
- Insurers corroborated these payment delays and explained that insufficient information in payment determinations from IDREs and payment determinations being made on claims that are ineligible for the Federal IDR process contributed to delays in payment after an IDR determination.
- The QPA is a particularly contentious issue for providers and insurers, with the two groups expressing drastically different views on its accuracy and utility.
- Stakeholders also expressed uncertainty about NSA process and oversight responsibility, including confusion around jurisdiction and claim eligibility between state and Federal IDR systems.
- Providers described their views on how delays to and denials of out-of-network payments benefit insurers and hurt providers because they allow insurers to keep payments they would otherwise be making to providers for a longer period of time and potentially invest or otherwise use that money.

Contracting Process and Outcomes

- We spoke with participants about their negotiating experiences both before and after the passage of the NSA to gain an understanding of how the law has affected insurer-provider relationships and the contracting landscape.
- Stakeholders explained that, before the NSA, the ability to balance bill gave providers substantial negotiating leverage. Under the NSA, however, stakeholders discussed observing a loss in provider leverage in negotiating contract terms and payment rates.
- Since implementation of the NSA, providers reported a more confrontational tone in negotiations. Several providers reported contract terminations, payers presenting take-it-or-leave-it offers, and a downward pressure on in-network payment rates.
- Insurers also reported having contracts terminated by providers and cited providers' high IDR win rate and Texas Medical Association wins in court cases as shifting some leverage back to providers.
- Some providers have moved in network and are accepting lower negotiated prices than before the NSA.
- Stakeholders say that insurers and providers are still far apart on desired price points.

Insurer Staffing, Operations, and Revenue Changes

- We asked stakeholders about administrative and procedural changes that insurers have made in response to the law to explore the impact of the NSA on insurer operations.
- Insurers and their partners have made substantial administrative changes to accommodate the IDR process and to take on the work of computing QPAs.
- Although some insurers handle IDR work themselves, others outsource it, which some providers characterized as a missed opportunity for provider-insurer relationship-building that could lead toward contracting discussions.
- The NSA has expanded the potential for increasing revenue for third-party administrators and supplementary cost-management firms through shared savings arrangements and discounts. These revenue mechanisms may be a disincentive for insurers to seek in-network contracts for services subject to the NSA.

Provider Staffing, Operations, and Revenue Changes

- We asked providers about their administrative and operational changes under the NSA to better understand how those pressures affect their financial position, which can play a role in contract negotiations.
- Providers have used different tactics in engaging with the IDR process. Large provider groups have predominantly built the capacity to navigate the IDR process internally. While some smaller provider groups have looked to partner with external firms, the expense and administrative burden of the IDR process is a barrier to participation for others.
- Several provider organizations described realized or anticipated changes in their operations, structure, or ownership that were due, at least in part if not predominantly, to the NSA. Operational changes discussed include diversifying their services, laying off or hiring new staff, taking out loans, changing the facilities and areas they service, or adjusting clinical staffing mix.
- When facing financial constraints, providers sought to cut administrative costs first before considering modifying clinical staffing.
- Providers also expressed concern about the viability of small practices, including the potential for many to close or consolidate, and described struggles to maintain access to care in rural and underserved communities.
- Some providers look to hospitals to help stabilize their financial position, both through direct subsidies and by asking for their support in negotiations with insurers.

Overall Thoughts on the NSA

- Overall, stakeholders reported that the NSA has largely eliminated surprise billing for services subject to the law.
- While stakeholders described a challenging implementation process that has put pressure on them financially, they continue to support the law.
- Importantly, we heard about instances of patients being erroneously balance billed due to challenges that providers and insurers faced getting billing and claims processing systems updated.

- Both insurers and providers expressed a need for more predictability and stability under the law and concern that, in the absence of improvements, tensions could grow.
- In the face of continued uncertainty, few said that the effect of the NSA on a variety of important outcomes was knowable in the near term.

AEOBs

- We also spoke with stakeholders about their experience preparing for the AEOB provision of the NSA. Under the AEOB provision, insurers will use the information given to them by providers to issue AEOBs in advance of patients receiving care. The AEOB will include details on patients' expected cost-sharing requirements for a specified service or item.
- Work is underway among insurers and providers to establish processes for producing AEOBs.
- Stakeholders saw potential for AEOBs to help patients but expressed concerns over multiple and competing cost estimates across existing and new tools.
- Stakeholders emphasized that coordination between insurers and providers will be needed for AEOBs to represent an improvement over the status quo.

Conclusions

The goal of this study was to explore how the NSA has affected insurer-provider dynamics, negotiations, and payment rates. Prior to the NSA, providers gained leverage in negotiations with insurers from their ability to balance bill patients when out of network. In our conversations, we heard from stakeholders about changes to negotiation processes and dynamics between insurers and providers under the law and how that has affected their operations, staffing, and finances. Many stakeholders reported decreases in out-of-network payments under the NSA. This was largely a result of lower initial payments made to out-of-network providers, which, according to both providers and insurers, were often at or below the QPA. Because the vast majority of these payments are accepted by providers without further dispute, average out-of-network payments are likely lower than they were before the NSA despite large wins to date in the IDR process among some providers.

Most discussants described shifts in negotiating leverage and contracting under the NSA. Both providers and insurers reported experiencing or initiating contract terminations after the implementation of the law. Providers said that the NSA has shifted leverage to payers because payers could use the QPA and the threat of the administrative burden and hassle of the IDR in negotiations. Although many providers reported winning IDR cases, they explained that they experienced cash flow difficulties because of the extended time period between when care was provided and when a post-IDR payment was made. On the other hand, insurers raised the provider-initiated litigation surrounding the NSA as a factor that has countervailed the shift in leverage toward insurers, though not to the point of restoring leverage to pre-NSA positions.

Both providers and insurers reported, however, that some providers are coming in network, sometimes at negotiated prices that are lower than they would have agreed to prior to the NSA.

The changing environment of negotiations and payment disputes under the NSA has also led to operational adjustments among both insurers and providers. All stakeholders mentioned ways in which the law has increased administrative burden. Insurers described how much of the administrative costs of navigating the NSA for self-insured plans were passed on to employers through a range of fee structures, such as a straight pass-through of IDR fees and shared savings arrangements. Providers described how the NSA is putting more pressure on them to find additional revenue from other sources. Several providers described turning to hospitals for financial stability, asking for stipend payments or support in their negotiations with payers. Some providers also reported having to take out loans, lay off staff, or reduce pay. Providers described making changes to clinical staffing as the least preferred option and generally approached changing provider staffing levels or composition with caution.

In discussing the law overall, stakeholders reported that the NSA has been largely successful at eliminating surprise billing of patients in the situations covered by the law. They generally said that they support the NSA and offered suggestions for ways it could be improved, largely focusing on improved transparency and enforcement of the IDR process and QPAs. Still, insurers and providers expressed concerns about future negotiations. Both voiced a need for more predictability and stability under the law and concern that, in the absence of improvements in transparency and enforcement, tensions could grow between insurers and providers and further stress their negotiating relationships. They also raised concerns about how the law could affect patients' costs and access to care, particularly in rural and underserved communities. Some providers reported examples of service lines that had closed and indicated that there may be more at risk of closing or consolidating.

Areas for Additional Inquiry

The inaugural years of the NSA have been complicated by implementation challenges and litigation. From the conversations we held with a wide range of stakeholders, several areas of inquiry emerged for policymakers and researchers to consider in the coming years.

First, as the federal government ramps up efforts to audit the QPA process and as rulemaking around the QPA calculation methodology stabilizes, it will be important to assess how stakeholders' perceptions of the QPA evolve. As the QPA continues to be audited by the federal departments responsible for enforcing the NSA (the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury), and if it becomes more widely accepted as valid by providers and IDREs, there is potential for insurers and providers to arrive at greater consensus around the QPA's utility in benchmarking payment rates for both in-network and out-of-network claims. Tracking how stakeholders perceive the QPA and whether

and how this affects contract negotiations over time will be critical for understanding the broader market impact of the NSA.

Second, further investigation is needed to better understand the impacts of the NSA on employer-insurer relationships and the financial implications for employers as health care purchasers. This is also an integral part of understanding whether and how the NSA is affecting the overall costs of health care.

Third, we heard from providers about their reliance on hospital subsidies when payment rates are cut. The relationship between hospitals and hospital-based provider groups is an important area to watch moving forward. Notably, claims data do not capture the cost of hospital subsidies, so other sources of data are needed to fully understand cost of the NSA to the health care system. Additionally, how the relationship between hospitals and ancillary providers plays out in rural and underserved areas is of particular importance in terms of understanding how the NSA affects access to care.

Fourth, provider discussants also emphasized how the financial pressures of the NSA could lead to greater consolidation—a key area for policymakers and researchers to monitor. This could come in the form of more providers joining hospitals as employees rather than independent groups or as smaller provider groups being acquired by larger groups. The challenges that smaller groups face in navigating the IDR process and the downward pressure on both in-network and out-of-network payment rates may encourage more providers to consolidate. Similarly, future research should examine the extent to which private equity investment in the specialties providing services subject to the NSA grows or cools.

Finally, because of the evolving nature of the NSA implementation, it will be important to continue to hear from stakeholders about their experience with the IDR process, contract negotiations, and managing changing payment rates. This can be achieved through future qualitative (e.g., discussions and focus groups) and quantitative (e.g., surveys) research.

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Chapter 1. Background

Overview of the No Surprises Act

Surprise medical billing occurs when an insured patient is unexpectedly billed directly for the difference between an out-of-network health care providers' charges and the amount their insurer paid for the service (i.e., the remaining balance). Patients who receive emergency care from an out-of-network facility or provider are particularly vulnerable to surprise billing because they are less likely to be able to choose to go in network for care; however, patients who seek care at an in-network facility may also incur a surprise bill if one or more of their providers is out of network. Surprise billing, also known as *balance billing*, gained national attention in recent years (Cooper and Morton, 2016). A 2020 study on surprise billing found that, in the prior two years, 41 percent of insured adults had received an unexpected medical bill, 19 percent of which were from an out-of-network provider, a finding that is consistent with earlier estimates of surprise billing rates using claims data (Pollitz et al., 2020; Garmon and Chartock, 2017). Surprise billing is especially prevalent in emergency medicine and other hospital-based specialties, such as anesthesiology, radiology, and pathology, as well as for air ambulance transports. In 2020, approximately 18 percent of emergency department visits in the country resulted in at least one surprise bill (Pollitz et al., 2020; Garmon and Chartock, 2017; Duffy et al., 2020). These bills can be devastating for patients and their families, many of whom are not financially prepared to pay large out-of-pocket bills (Chhabra et al., 2020; Cooper and Morton, 2016). The Federal Reserve's 2018 report on economic well-being found that 27 percent of insured Americans reported that they could not immediately resolve a $400 surprise medical bill without selling something or borrowing money (Chen et al., 2019).

In an effort to curb surprise billing, states passed surprise billing protections that varied in their approach (Kona, 2021). By 2020, 33 states had enacted surprise billing laws (Hoadley and Lucia, 2021). At the end of 2020, Congress passed the first federal protections against surprise billing in the No Surprises Act (NSA) as part of the Consolidated Appropriations Act (CAA), 2021 (Pub. L. 116-260, 134 Stat. 1182, Division BB, Title I, 2020). The NSA went into effect at the beginning of 2022 and protects commercially insured patients from incurring a surprise bill if they receive care under any of the following circumstances:

- emergency care at an out-of-network facility or by an out-of-network provider, including post-stabilization services
- non-emergency care from an out-of-network provider at an in-network facility
- transports by an air ambulance organization.

In these situations, patients generally cannot be charged more than what they would have paid had they seen an in-network provider.[2]

Independent Dispute Resolution

The NSA established the Federal Independent Dispute Resolution (IDR) process to settle payment disputes between out-of-network providers and insurers. Together, three federal departments—the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury (referred to as "the Departments" in this report)—released in October 2021 the interim final rules on the IDR process, "Requirements Related to Surprise Billing: Part II," establishing the IDR process (Department of Health and Human Services, Department of Labor, and Department of the Treasury, 2021b). Figure 1.1 outlines the IDR process and timeline as it is intended to work.

As laid out in the NSA regulations, the IDR timeline begins when the provider submits a claim to the insurer. Within 30 calendar days of the claim submission, the insurer must make an initial payment or deny payment. Should the provider be unsatisfied with the initial payment or the payment denial, they have 30 business days to initiate a 30-business-day open negotiation period, during which the provider and insurer must engage in good faith negotiations and attempt to settle the payment dispute. If the dispute is not adequately resolved during open negotiation, the provider or insurer can choose to initiate the IDR process by submitting the claim to the Federal IDR portal and selecting an IDRE to independently arbitrate and resolve the payment dispute. IDREs are organizations that have been certified by the Departments to serve as independent arbiters for payment disputes over the services subject to the NSA (Centers for Medicare & Medicaid Services [CMS], 2024b). After the selection of an IDRE, both disputing parties are then required to pay a nonrefundable administrative fee and a refundable certified IDR entity fee.[3] Within ten days, both parties must submit an offer of reasonable payment for the disputed items or services to the IDRE. Parties must also submit information about the qualifying payment amount (QPA) for the disputed service, the size of the provider practice or facility, the practice specialty or type, the coverage area of the plan or issuer, the coverage type, and the geographic region used to calculate the QPA.[4] Parties may also submit additional information to

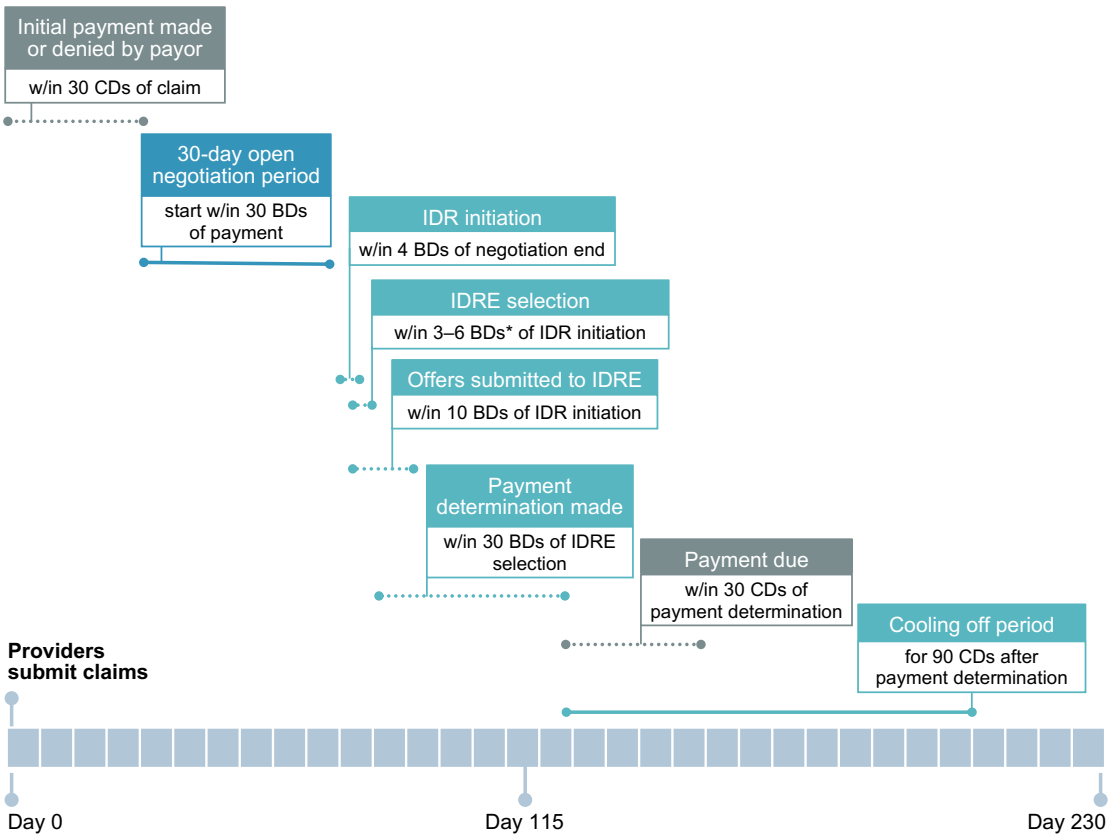
[2] In limited circumstances, some out-of-network providers or facilities can seek written consent from individual patients to voluntarily waive their surprise billing protections (Department of Health and Human Services, Department of Labor, and Department of the Treasury, 2023c).

[3] The administrative fee was initially set at $50 per party but was increased to $350 per party starting January 1, 2023. Following litigation, the administrative fee was reduced back to $50 in August 2023, until the Departments issued updated guidance setting the administrative fee at $115 as of January 2024 (Department of Health and Human Services, Department of Labor, and Department of the Treasury, 2023d). The IDR entity fee ranges are based on whether the dispute is a single or batched dispute and have similarly gone through changes over time. Initially, the IDR entity fee could range from $200 to $670. Starting in 2023, the IDR entity fees could range from $200 to $938. As of 2024, the IDR entity fees can range from $200 to $1,173 (Department of Health and Human Services, Department of Labor, and Department of the Treasury, 2023d).

[4] Code of Federal Regulations, Title 45, Section 149.510(c)(4)(i)(A).

support their offer, including information on provider training, experience, and outcomes; market share of the parties; patient acuity; provider teaching status; prior contracted rates; and good faith efforts made to enter into network agreements.[5]

Figure 1.1. IDR Process and Timeline



NOTE: CD = calendar day; BD = business day; w/in = within. * If parties do not agree on an independent dispute resolution entity (IDRE) within three business days, HHS selects an IDRE within six business days of IDR initiation. Horizontal lines represent approximate lengths of time; dotted lines represent a length of time that could be shorter than shown, and solid lines represent fixed lengths of time. Each blue-gray block in the scale at bottom represents seven calendar days.

The QPA is the inflation-adjusted median 2019 contracted rate of the service provided for a defined geographic area and insurer market (CMS, 2021). The QPA is calculated by the insurer and is one component to be considered by the arbiter when issuing a final determination on a disputed claim through the IDR process. Both payment offers and any additional information about the claim and dispute provided by the parties are then reviewed by the independent arbiter, who is to issue a final decision ("payment determination") within 30 business days.

The arbitration decision is "baseball style" or "final offer arbitration," such that one of the two submitted offers is chosen rather than the arbiter finding a compromise between the offers.

[5] Code of Federal Regulations, Title 45, Section 149.510(c)(4)(iii)(B).

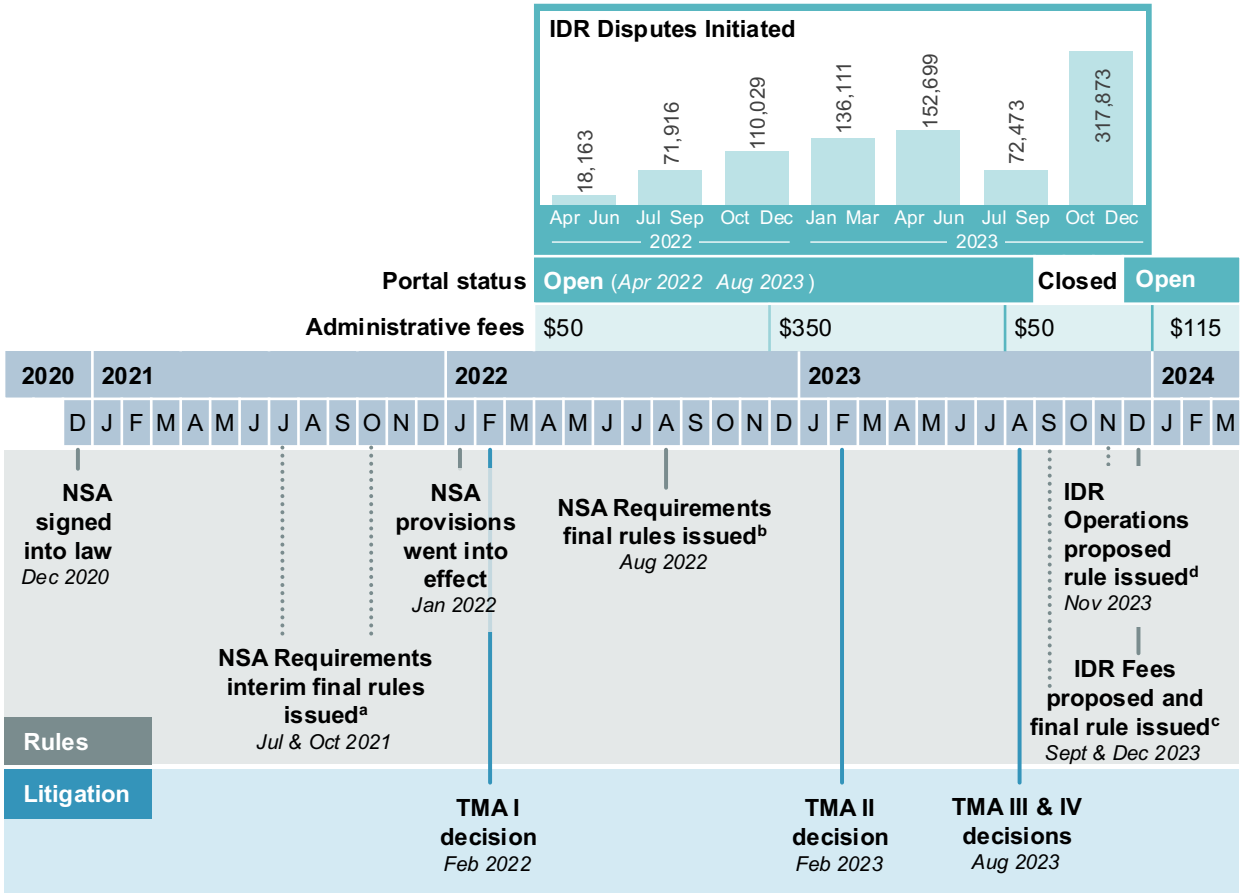
The losing party is responsible for paying the IDR entity fee, while the winning party is refunded their IDR entity fee but not their administrative fee (Department of Health and Human Services, Department of Labor, and Department of the Treasury, 2023d). When the offer selected by the IDRE is higher than the initial payment made by the insurer, the insurer is also required to pay the provider the difference between the initial payment and the IDRE's payment determination.

After an IDRE payment determination is rendered, the two parties enter into a 90-calendar-day cooling-off period. During this period, the initiating party for the prior dispute cannot submit a subsequent dispute with the same opposing party to the IDR process for the same or similar item or service. However, the initiating party may hold on to claims for the service or item covered by the cooling-off period and submit them to the IDR process within 30 business days of the end of the cooling-off period.

Implementation of the NSA

Since the provisions of the NSA went into effect in January 2022, provider and insurer responses to the law's implementation have been mixed. (Figure 1.2 describes the major milestones in the implementation of the NSA.) Overall, many have expressed support for the law and have reported that it has largely benefited patients. However, several reports have identified significant challenges that both providers and insurers have faced under the new law (Government Accountability Office, 2023; Hoadley et al., 2023; unpublished 2023 RAND research by Rasmussen and colleagues). One of the main challenges for both providers and insurers is the IDR process. Initial government estimates on the number of expected disputes in the first year of the NSA were between 17,000 and 22,000. In reality, however, more than 200,000 disputes were submitted in the first eight months that the Federal IDR portal was open (Department of Health and Human Services, Department of Labor, and Department of the Treasury, 2022a; Department of Health and Human Services, Department of Labor, and Department of the Treasury, 2023b). Although this represents just a small portion of the estimated 10 million out-of-network claims, this higher-than-expected volume has led to major delays in the IDR timeline and a need for more IDREs to be certified (AHIP and Blue Cross Blue Shield Association, 2024). In addition, stakeholders reported having to make significant changes to their own administrative staffing and procedures to handle the IDR process in part because they viewed the Federal IDR portal as too rudimentary (Government Accountability Office, 2023; Hoadley et al., 2023; unpublished 2023 RAND research by Rasmussen and colleagues). Both providers and insurers also reported that IDRE decisions lacked transparency and were inconsistent, making it difficult for both parties to understand why specific determinations were made (Government Accountability Office, 2023; unpublished 2023 RAND research by Rasmussen and colleagues). Insurers reported receiving decisions on claims that were ineligible for the Federal IDR process, making it difficult or impossible for them to process the required payments. This manifested in delayed payments to providers (Government Accountability Office, 2023; unpublished 2023 RAND research by Rasmussen and colleagues).

Figure 1.2. Major Milestones in NSA Implementation



NOTE: The Federal IDR process was temporarily paused in response to the Texas Medical Association (TMA) I, III, and IV decisions. Data on IDR disputes initiated were only available through the fourth quarter of 2023 at the time of this writing (fall 2024).
[a] Department of Health and Human Services, Department of Labor, and Department of the Treasury, 2021a; Department of Health and Human Services, Department of Labor, and Department of the Treasury, 2021b.
[b] Department of Health and Human Services, Department of Labor, and Department of the Treasury, 2022b.
[c] Department of Health and Human Services, Department of Labor, and Department of the Treasury, 2023d.
[d] Department of Health and Human Services, Department of Labor, and Department of the Treasury, 2023a.

In addition, the QPA has been a point of contention between providers and insurers. Under the law, insurers are charged with the task of calculating the QPA per the methodology outlined in rulemaking. However, providers claimed that the QPA calculations are a "black box" and expressed concern over the alleged inclusion of "ghost rates" in the calculation (according to unpublished 2023 RAND research by Rasmussen and colleagues). *Ghost rates* are rates that are included in a provider's contract with an insurer but were not actively negotiated or used. For example, a primary care physician's contract with an insurer may include anesthesia payment rates even though that physician would never provide that service. Although regulations require that insurers calculate specialty-specific QPAs if reimbursement rates differ across specialties, which should prevent the inclusion of ghost rates, providers are skeptical that insurers are

complying with this requirement. Without widespread auditing of the QPA, and with some QPAs coming in at what providers see as unreasonably low amounts (e.g., at or below Medicare rates), there has been hesitation within the provider community to accept the validity of QPA estimates.

There also have been lawsuits that have challenged the constitutionality of the NSA and specific sections of the implementing regulations (Ranganathan, 2023). Some have described the lawsuits challenging the implementing regulations as a "litigation campaign" being "waged by providers," which has created obstacles for the Departments' implementation of the law and uncertainty for insurers, providers, and the IDREs who must implement the IDR system (Ranganathan and Baron, 2024). Specifically, a series of lawsuits filed in federal court in Texas between October 2021 and January 2023 by the TMA—known colloquially as TMA I, II, III, and IV—have focused on the QPA and the arbitration process itself, including how IDREs should weigh the relevant statutory factors in making their determinations (Freer, 2023). Although some of these cases are ongoing, at the time of this writing the providers have prevailed in these cases at the district court level, resulting in changes in NSA regulations over time. However, most of the rulings in TMA III were overturned on appeal in October 2024.

Some of the specific provisions that have been challenged and invalidated by the district court judge in Texas include (1) a requirement that the arbiter accept the offer closest to the QPA as the presumptive appropriate out-of-network payment rate (TMA I), (2) a requirement that the arbiter give the QPA more weight than other factors in the determination of the appropriate out-of-network payment rate (TMA II), and (3) an allowance for the inclusion of rates for a service that a provider never rendered in QPA calculations (TMA III).[6] In addition, in TMA IV, plaintiffs challenged the Departments' implementation of a 600-percent hike in IDR administrative fees, which they argued violated the federal Administrative Procedures Act.

In August 2022, the Departments issued "Requirements Related to Surprise Billing: Final Rules," which included information that insurers are required to disclose about the QPA (Department of Health and Human Services, Department of Labor, and Department of the Treasury, 2022b). The final rules also included revisions to the Interim Final Rules that address how arbiters should consider information when issuing a final IDR determination.

[6] The original decision on TMA III invalidated the rulemaking that defined contracted rates eligible for inclusion in the calculation of the QPA as "the rate negotiated under a contract constitutes a . . . contracted rate regardless of the number of claims paid at that contracted rate," which could be interpreted to allow for the inclusion of ghost rates in the calculation of the QPA (Department of Health and Human Services, Department of Labor, and Department of the Treasury, 2021a, p. 36889). However, on appeal, the Fifth Circuit Court of Appeals overturned the district court judge's opinion and ruled that there is "no requirement that a service must previously have been performed by a provider for that rate to be included in the QPA calculation" (*Texas Medical Association et al. v. United States Department of Health and Human Services et al.*, Appeal from the United States District Court for the Eastern District of Texas, USDC Nos. 6:22-CV-450, 6:22-CV-453). The Court of Appeals stated in its opinion that the NSA addresses the issue of ghost rates by requiring that the QPA is "the median of the contracted rates recognized by the plan or issuer . . . for the same or a similar service that is provided in the same or similar specialty and provided in the geographic region in which the item is furnished" (U.S. Code, Title 42, Section 300gg-111(a)(3)(E)(i)(I)).

In further response to court rulings and ongoing stakeholder concerns, the Departments issued another set of updated rules, including setting out some new requirements. In November 2023, the "Federal Independent Dispute Operations" proposed rule was promulgated (Department of Health and Human Services, Department of Labor, and Department of the Treasury, 2023a), which proposed changes to all phases of the IDR process, including

- requiring insurers to communicate to providers in written or electronic form using Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) when providing remittance advice
- amending certain requirements regarding the open negotiation period, the initiation of the Federal IDR process, and the IDR dispute eligibility review
- amending requirements related to batching claims
- changing the collection and payment of administrative and IDR entity fees.

Final action on this proposed rule is pending, following the required comment periods. Providers and insurers who have been participating in the IDR process have complained about "moving goal posts" as the litigation and regulation processes continue to clarify how provisions of the NSA ultimately will be operationalized.

Good Faith Estimates and Advanced Explanations of Benefits

To further bolster consumer information and protections, the NSA also includes provisions establishing requirements around good faith estimates (GFEs) and advanced explanations of benefits (AEOBs). GFEs are estimates of expected charges for scheduled care. Under the NSA, providers are required to provide patients with GFEs within one to three business days of a patient either scheduling an item or service or requesting the estimate. A convening provider is the provider responsible for putting together the GFE, including getting cost estimates from other providers (referred to as co-providers) who will participate in the scheduled item or service. Currently, the GFE requirements only apply for services a convening provider anticipates providing to self-pay and uninsured patients. However, pending additional regulations, providers will eventually need to coordinate with co-providers to supply comprehensive GFEs to both uninsured/self-pay patients and the insurers of commercially insured patients to allow the insurers to issue AEOBs before patients receive care. The AEOB will include details on patients' expected cost-sharing requirements for a specified service or item. While explanations of benefits (EOBs) are currently provided to patients after they receive care and describe what the insurer is willing to pay for a specific service or item rendered by a specific provider, AEOBs will provide this information to patients before the service is rendered, allowing the patient to engage in price comparisons between different providers and to better understand expected out-of-pocket payment requirements. The final rules regarding AEOBs have not yet been released, and therefore implementation of this provision of the NSA is delayed.

Insurer-Provider Contract Negotiations

The NSA has changed dynamics between insurers and out-of-network providers by prohibiting the use of surprise billing and establishing the IDR process. There is interest on the part of lawmakers, regulators, and market participants in how these changes—and the NSA more broadly—may affect insurer-provider contract negotiations. Negotiations are influenced by each party's best alternative to a negotiated agreement, and staying out of network is the primary alternative to a contract between a provider and insurer (Fisher, Ury, and Patton, 2011). Before the NSA, providers' alternative to contracting was billing as an out-of-network provider, which could include balance billing and trying to collect payments directly from patients. Insurers' alternative to contracting prior to the NSA was to pay providers' billed charges or put enrollees at risk of surprise billing. Prior research has shown that out-of-network payments generally are higher than in-network payments and that these higher out-of-network payments may impact negotiations over in-network payment rates (Biener et al., 2021; Duffy et al., 2020).

An unpublished 2023 RAND report, commissioned by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), engaged stakeholders in qualitative discussions to explore the effects of the NSA on health care market dynamics and found that insurers and providers reported a palpable shift in insurer-provider negotiations post-NSA. Providers described the NSA as unfairly skewing negotiating power in favor of insurers: In their view, insurers have no incentive to engage in good-faith negotiations because they can rely on the QPA as a payment benchmark to define payment amounts both in contract negotiations and for out-of-network providers. Insurers voiced concerns about providers "weaponizing" the NSA and gaming the IDR process by flooding it with disputes and overwhelming IDREs. These concerns regarding leverage positions were seen as potential barriers to productive future negotiations, according to the unpublished 2023 RAND research by Rasmussen and colleagues.

Project Report Road Map

To explore whether and how the NSA has affected insurer-provider dynamics, contract negotiations, and payment rates, ASPE asked RAND to conduct further discussions with stakeholders. In this report, we summarize the approach we took to explore these topics (Chapter 2), describe the themes that emerged from our discussions (Chapter 3), and identify overall themes and areas for additional inquiry (Chapter 4).

Chapter 2. Approach

To explore how the NSA has affected contract negotiations and the relationships of key parties covered by the law, we held semi-structured discussions with representatives from the following types of organizations:

- anesthesiology groups
- emergency medicine groups
- radiology groups
- air ambulance organizations
- provider coalitions
- provider partners who participate in revenue management and negotiations (hereafter referred to as "provider partners")
- insurers
- insurer coalitions
- benefit consultants
- insurer partners who participate in claims processing, cost management, and negotiations (hereafter referred to as "insurer partners").

These groups were selected based on the expectation that they are the most likely to be affected by the NSA. Insurers that act as both fully insured health plans and as third-party administrators (TPAs) for self-insured employers provided information on both sides of their business. Because of restrictions imposed by the federal Paperwork Reduction Act of 1995 (Pub. L. 104-13, 1995), we were limited to no more than nine discussions per stakeholder group. We identified organizations within these categories by reaching out to related national and regional organizations (for example, business coalitions and professional associations), organizations identified through web searches, and organizations identified through contacts of contacts ("snowball sampling").

After identifying potential organizations, we sent emails to organizational leaders to request participation in the study. In the recruitment emails, we included an informational sheet about the study and an example list of discussion questions so that organizations would have an opportunity to identify who would best be suited to participate in the conversation. Participants included both policy and strategic decisionmakers (e.g., senior executives), as well as operational staff (e.g., the director of contracting for a provider group or a health plan). The discussion guides for each stakeholder group covered the same basic topics but were tailored for each stakeholder type. Topics included out-of-network payments before and after the NSA, the typical structure of a contract and the negotiation process before and after the NSA, network and payment changes under the NSA, administrative and structural changes, overall views of the NSA, and expectations for insurer-provider dynamics moving forward. We also asked insurers and relevant provider groups about their perspectives on the AEOB provisions of the NSA,

including what work is underway to prepare for their implementation and their view on the challenges and opportunities AEOBs provide. The appendix includes a list of discussion topics.

From January to March 2024, we conducted 35 discussions with the representatives of the organizations described in Table 2.1. Discussions were conducted virtually via Zoom for Government, were led by one of two experienced researchers on the project team (Petra Rasmussen and Erin Duffy), and were scheduled for approximately 90 minutes each. We did not offer an incentive for participation. Table 2.1 lists the participating organizations by stakeholder group, as well as their geography, ownership type, and the average length of the discussion. All discussions were voluntary and conducted in accordance with the requirements of the RAND Human Subjects Protection Committee.

Table 2.1. Description of Participants and Average Length of Discussions

Stakeholder Group (Number of Participants)	Geography			Ownership Type				Average Length of Discussion (minutes)
	National	Multi-state	Single State	Not-for-Profit or Non-profit	Privately Owned	Private Equity Invest-ment	Publicly Traded	
Anesthesiology groups (4)	0	3	1	0	1	3	0	79.5
Emergency medicine groups (5)	2	2	1	0	3	2	0	85.6
Radiology groups (3)	1	0	2	0	2	1	0	68.0
Air ambulance organizations (4)	2	2	0	1	0	3	0	73.0
Provider partners[a] (3)	0	3	0	0	3	0	0	79.3
Provider coalitions (3)	2	1	0	N/A	N/A	N/A	N/A	81.3
Insurers (7)	4	2	1	3	0	0	4	81.3[c]
Benefit consultants and other insurer partners[b] (4)	2	2	0	0	2	2	0	60.3
Insurer coalitions (2)	1	0	1	N/A	N/A	N/A	N/A	54.0

NOTE: N/A = not applicable.
[a] Provider partners include external organizations that participate in revenue management and negotiations.
[b] Insurer partners include external organizations that participate in claims processing and negotiations.
[c] One insurer did not agree to be recorded, and therefore the estimate for the average length of discussion for insurers excluded that conversation. The length of the discussions was calculated based on the recordings, which excluded the introductory and consent process.

In addition to the discussion leader, at minimum a second project team member listened to the discussion and took notes. The discussions were recorded and transcribed, and then the transcripts were deidentified and cleaned for analysis. The research team used Dedoose software to code the transcripts. An initial codebook was created by the project lead. This version of the codebook was used by the entire four-person team to code two separate transcripts (one from a provider group and one from an insurer) to ensure consistency in coding. The full team then met and discussed how each person coded the transcripts, reconciled differences, and added additional codes to the codebook as needed. The remaining transcripts were then split across the

four team members for coding, with spot checks performed by the project lead. After the transcripts were coded, two researchers reviewed the codes to identify key themes that emerged across discussions, met to discuss the identified themes, came to consensus, and developed a consolidated set of themes to be reported.

Study Limitations

This study has limitations. First, we spoke with only a small number of organizations from each stakeholder group, and thus we are limited in our ability to assess how representative the perspectives they provided are of their larger group. In addition, while we attempted to speak with organizations from a range of geographies and ownership types, our limited sample size hindered our ability to cover all types of organizations. Second, we were only able to speak with organizations that responded to our outreach. Those organizations more affected by the law may have been more willing to speak with us. While these organizations may have deeper insights into the challenges or benefits many are experiencing under the NSA, the generalizability of our study may be limited. Third, we did not speak directly with any hospitals, employers, or IDREs, all of which are stakeholders that could provide useful perspectives on how they are affected by the NSA or participate in the IDR process. Finally, these conversations represent a snapshot in time. NSA regulations have changed over time, and there currently are pending final rules that respond to some of the issues highlighted by stakeholders. In such a rapidly evolving policy and rulemaking landscape, perspectives can shift over short periods of time.

Chapter 3. Key Themes from Discussions

Through our discussions with stakeholders, many key themes emerged that are worthy of consideration by ASPE and other policymakers. In this chapter we have organized these themes into six categories: out-of-network payments pre- and post-NSA; contracting process and outcomes; insurer staffing, operations, and revenue changes; provider staffing, operations, and revenue changes; overall thoughts on the NSA; and AEOBs. We begin each of the following sections with a brief overview of the themes included in each category before detailing the findings with substantiating quotes.

Out-of-Network Payments Pre- and Post-NSA

Overview: While the NSA only applies to out-of-network items and services, it also has the potential to influence contract negotiations and networking dynamics between insurers and providers, including both the payment rates at which the parties are willing to contract and their overall willingness to contract. For each entity, their leverage position and willingness to accept certain contract terms is dependent on the out-of-network alternative. Thus, to understand the impact of the NSA on contracting, we explored through our discussions with stakeholders differences in the amounts paid, timing of payment, administrative cost, and related revenue for out-of-network services before and after implementation of the NSA.

Stakeholders on both the payer and provider sides described lower out-of-network payments under the NSA, largely driven by lower initial payments to providers. Providers who challenged initial out-of-network payments through the IDR process described long delays in processing disputes, extended timelines from the time of service to receiving the final adjudicated payment, and situations in which insurers did not pay providers even after an IDRE decided in the provider's favor. Insurers corroborated these payment delays and explained that insufficient information in payment determinations from IDREs and payment determinations being made on claims that are ineligible for the Federal IDR process contributed to delays in payment. Stakeholders also expressed uncertainty about process and oversight responsibility, which has made it challenging for stakeholders to seek resolution of their concerns about IDR processes. Providers described how the delays and denials of out-of-network payment can benefit insurers and hurt providers because they allow insurers to keep payments they would otherwise be making to providers for a longer period of time and potentially invest or otherwise use that money. These differing financial pressures, in turn, can affect each party's willingness to engage in contract negotiations.

Out-of-Network Payments Prior to the NSA Varied by Types of Health Plan, Leading to Larger Post-NSA Decreases in Payments for Self-Insured Plans Than for Fully Insured Plans

Insurers described the pre-NSA contracting landscape with out-of-network providers whose services are subject to the NSA as challenging. In determining their payments to out-of-network providers, insurers described a range of techniques. Some insurers described paying for emergency care based on the "Greatest of Three Rule" under the Patient Protection and Affordable Care Act (ACA), which specified that insurers should pay the highest value among (1) in-network rates; (2) usual, customary, and reasonable charges; or (3) Medicare rates. As explained by one insurer:

> Generally, it's always been challenging to bring hospital-based providers in network. They haven't wanted to come in, their reimbursements are high, they often work for not a hospital but a large national entity with a lot of leverage. It's hard to contract at a reasonable rate. Prior to NSA, we followed the ACA greatest of three requirement for reimbursement.

However, the "usual, customary, and reasonable charges" language of the ACA has been interpreted in different ways, leading to variation in out-of-network reimbursement methodologies.

Prior to the NSA, self-insured plans and fully insured plans approached out-of-network payments differently. Employers often chose the payment design for their self-insured plans and leaned toward paying a high share of billed charges to avoid employees bearing the cost of a balance bill. In contrast, fully insured plans where the insurance company designs the payment structure typically paid out-of-network providers closer to average in-network rates, with less concern about balance bills. In the words of one insurer:

> I think you have to draw a distinction here to some extent between the fully insured and self-insured business. For the fully insured business, we typically pay to the contract. However, with the self-insured business, we're acting on behalf of the employer, and sometimes the employers, pre-NSA, had specific requests for us as to how we should handle some of these situations. We would get requests from them to just pay billed charges or whatever is necessary to get the member out of the middle.

An insurer coalition representative also explained this practice:

> Employers prior to the NSA were covering 100 percent of billed charges for out-of-network services. . . . The plans would try to convince the employers to not do that, and they would say "No, no, no, I don't care what it is. I don't want a patient to be balance billed. I don't want one of my employees to be balance billed."

However, the insurer coalition representative went on to explain that "after the NSA happened, the large employers stopped doing 100 percent of billed charges."

Because self-insured plans (also referred to as administrative services only [ASO] plans) typically paid more for out-of-network services prior to the NSA, several participants described seeing a more notable decrease in the out-of-network payments from these plans. One insurer estimated a 16-percent reduction in out-of-network payments on behalf of their self-insured clients:

> Prior to the NSA, you had ASO customers [employers] who were adopting out-of-network programs and having us implement them on their behalf, and they were a blend of things. Sometimes you had very generous programs. They wanted to take the member completely out of the mix and reimburse very high out-of-network programs. Another would be ones where they want to get a little bit closer to [in-network] rates. And so they would adopt schedules or approaches that would be a lot more aggressive, but it was a blend, and then when the NSA came in, it moved to median levels. And so the ASO side had a significant drop in reimbursement in that first year [of] about 16 percent.

By contrast, this same insurer estimated a smaller (4 percent) decrease in out-of-network reimbursement for their fully insured plans.

Under the NSA, Initial Out-of-Network Payments Vary but Are the Final Payment in Most Cases; Only a Small Share of Claims Go to IDR

Many insurers and participants with information on payer activities reported that initial payments to out-of-network providers were generally the QPA. Several participants explained that this was primarily due to the NSA requirement that cost-sharing be benchmarked to the QPA and the way that claims are processed by insurers. Multiple insurers explained that they produce the EOB statements that go to patients and the payments that go to providers through a shared process. It is not feasible for those insurers to delink those processes, so it would be impossible to base patient cost-sharing on one amount and pay the provider a different amount. Therefore, for those insurers, the initial payment to the provider has to be the QPA.

However, this claims processing constraint was not a barrier for all insurers, and initial payment at the QPA level was not uniform. For example, one insurer described heterogeneity in initial out-of-network payments across fully insured plans and different employers:

> It depends because your fully insured or individual market might be different. It might be lower, at the QPA, but then you might have self-[insured] groups that are paying multiples of the QPA right out the door. So, it's very different, and it just depends on the line of business or the employer.

Additionally, another insurer reported that they initially decided to take a different tactic and "set our payment amount at half the QPA."

Most providers reported that they did not receive sufficient information at the time of initial payment to know how the initial payment they received from insurers compared to the QPA. However, we heard from many providers that initial out-of-network payments were lower than before the NSA. As an example, one provider partner reported, "We see a precipitous drop in the

reimbursement rate from pre–No Surprises Act. I mean, reimbursements that may be 10 percent of billed charges where they were 85 [percent] before the law." One emergency medicine group representative estimated that out-of-network payments had been cut by 50 percent among some insurers, saying, "I have not seen a payer keep payments [at pre-NSA levels]. I have not seen that. That would be abnormal. We have not seen any payer remain status quo."

The initial payment amount made by an insurer to a provider is the final out-of-network payment for the majority of cases; only a small share of claims go to open negotiation and then on to the IDR process (AHIP and Blue Cross Blue Shield Association, 2024). One emergency medicine group representative explained that the majority of out-of-network claims are not brought to IDR and are paid at or below the QPA, which means lower out-of-network payment than pre-NSA overall:

> If the insurer takes that approach [of making an initial payment at or below QPA] on 100 percent of out-of-network claims . . . and only 10 percent of the claims go through the arbitration process, they are automatically winning 90 percent of the time if nobody challenges the underpayment.

This is particularly concerning for smaller provider groups that have not been able to participate in the IDR process because of the resources required to go through arbitration. An anesthesiology group representative reported:

> There are plenty of examples where groups of the smaller size don't [use the IDR process]. It's cost prohibitive. Some of these things are so cost prohibitive and administratively complex for them to be able to play on an even playing field. It's not possible for them to do that.

Providers also reported that going through the IDR process often was not to their advantage because the costs associated with it were higher than what they could recoup from payers. The radiology group representatives we spoke with described this, saying:

> Our average patient balance is 30 bucks. So in many cases, it's just not worth it. I'm paying more to go through the process than I would collect.

> Our average claim was $51 and just from the administrative fee, we were going to be shut out completely. The whole process was so broken. . . . I would say we're a pretty savvy practice. We're not like the eight-person practice. . . . We're an 85-person group. . . . It was very difficult for us to use. Then when we did win IDR, the payer ignored it. They still didn't pay us.

Notably, ongoing rulemaking proposals could adjust the rules around batching claims for submission to the IDR and changing the IDR entity fees with the intention of addressing provider concern that the fees are prohibitively high for smaller-dollar claims.

A provider partner explained that insurers do not have an incentive to negotiate higher prices with providers because they are able to pay only the QPA in the majority of cases: "90 percent of the time the carriers are getting away with paying the QPA, and there are so few arbitration resolutions that there's no pain being imposed on the carrier community for the low payments."

The QPA Is a Particularly Contentious Issue for Providers and Insurers, with the Two Groups Expressing Drastically Different Views on Its Utility

Prior to the implementation of the NSA, many believed that the QPA would act as an important lever for putting downward pressure on out-of-network costs, as well as in-network payment rates. Since the law's passage and implementation, the QPA has been a particularly contentious point for providers and insurers, with the two groups having drastically different points of view on its utility. Across specialties, providers expressed concern over the methodologies being used to calculate the QPA and the lack of transparency regarding the estimates. As one radiology group representative stated, "It's not transparent. Nobody can say, 'Hey, show me your QPA calculations.' They're like, 'No, it's all proprietary, but trust us, this is the right QPA.'"[7] An anesthesiology group representative described similar frustration that "there's no auditing or validation of those [QPA] rates. We have a lot of doubts."[8]

Providers cited particularly low QPA rates, such as those at or below Medicare, as one of the reasons they struggled to believe that QPAs were being calculated correctly. An emergency medicine group representative explained this, saying:

> We think there are some pretty significant problems with the way that QPAs are being calculated. . . . The payers [are] claiming that this is their QPA for the service, which candidly doesn't pass the smell test. . . . QPA is meant to be the median in-network rate. I have a very hard time believing that you're paying any meaningful portion of your in-network clinicians below Medicare for a high-acuity [emergency department] service.

Similarly, a radiology group representative stated, "It makes us question when the QPA or initial payment is below Medicare because it's all opaque. There is no transparency around the QPA. And for our practice, 16 percent of all of the NSA-eligible charges are paid below Medicare, which for us is kind of unbelievable." A provider partner echoed this, saying, "Some of them [QPAs] are comparable to Medicare payments, which nobody expects to get a Medicare payment from [a commercial insurer]."

With QPAs at or below Medicare rates, several providers brought up the inclusion of ghost rates in the calculation of QPAs as a possible explanation. While the Fifth Circuit Court of Appeals ruling on the TMA III case affirmed the Departments' stance that the NSA prohibits the use of ghost rates in QPA calculations by requiring rates to be from the same or similar specialty, the practice continues to resonate strongly with providers' sense of unfairness in the law's implementation:

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[7] While some providers reported not being able to learn more about the QPA calculations from insurers, they are entitled to request additional information on QPA calculations, and payers must provide that information if asked (Code of Federal Regulations, Title 45, Section 149.140(d)(2)).

[8] At the time of our discussions, no audit reports had been released. In May 2024, the first audit report was publicly released (see CMS, 2024c).

> They can include rates from providers that don't even provide air ambulance services as long as there's an air ambulance rate in there. In the contract, they said all services are 100 percent of Medicare [rates]. Well, that includes air ambulance, even though they're not even air ambulance provider. So, it's called ghost rates. The courts have said now that you can't use those. But when they started, they used them.

In addition, some providers said that the QPA methodology of giving each in-network contract equal weighting regardless of providers' capabilities and intensity of services was unfair and did not capture some of the meaningful differences between providers. As one air ambulance organization representative described:

> I think another thing that irritates me is that the QPA is assuming that all providers are equal. . . . And the reality is that there is a large difference between level of service, level of quality, safety, clinical excellence amongst our industry. . . . [But] the insurer is like, "Well, this is what everyone else is accepting, so you should just accept it as well. It's the QPA."

A radiology group representative agreed, saying, "Are they comparing my group to the outpatient group that never works holidays or weekends and saying, 'Okay, here you go, take their rate.'?"

Because of the lack of transparency and their incredulity about the QPA, providers were vocal in calling for auditing and oversight and highlighted how the QPA plays a role in contract negotiations:

> I think, honestly, if there was one thing that I could get, it would be the government to corroborate the QPA. I know it's not the only part of [IDR considerations], there's seven items that go through it, but the arbitrator has to accept that the QPA that's given to them is accurate. . . . Nobody sees or knows if that number is true. . . . Define the QPA very clearly, put the number out there for everybody to see. It really creates a tremendous imbalance when we negotiate when they know what they think their top number is and I have no idea. . . . And so that balance is completely out of whack.

On the other hand, insurers expressed support for the QPA, seeing it as a well-defined measure that should be relied upon during the dispute resolution process:

> What was so important to us about the NSA is that it solidified the debate in a benchmark that everybody can get their heads around because the vast majority of providers in the country are accepting this amount for the same or similar service. It's not like we're making this up. This is the market rate. So it was helpful to us that we had not just a third party, not just one judge in one jurisdiction, we had Congress getting around this idea that it's a benchmark that's worthwhile.

Some insurers also saw the QPA as a useful tool for negotiations, including acting as a strong benchmark for in-network payment negotiations. As one insurer said, "There were carriers out there initially when the law first came out that wouldn't move off of the QPA. That if they were going to contract, they were going to contract at no more than the QPA."

However, insurers said that they were concerned that, in IDR arbitrations, there was a lack of understanding around medical billing[9] that led arbiters to side more with providers because of the differences between billed charges and the QPA. As one insurer described it:

> Many of them [providers], their offer is their billed charges, which can be five times, ten times the QPA. . . . You look at [the] two rates, they're so vastly different. And if you don't have the clinical knowledge . . . you look at that and you say, "Golly, how can they be charging $20,000 when they're only paying $1,000?" And then we lose.

Providers Expressed Frustration About Low Initial Insurer Payments, Long IDR Timelines, and Lack of Enforcement on Post-IDR Payments

Providers who challenged initial out-of-network payments through the IDR process described long delays in processing cases, extended timelines from the time of service to receiving the final adjudicated payment, and situations in which payers did not pay providers after an IDRE decided in the provider's favor. Insurers corroborated these payment delays and explained that IDREs provided insufficient information about applicable claims in their payment determinations and made payment determinations on disputes that are ineligible for the Federal IDR process (e.g., Medicare claims, claims subject to a state surprise billing law), which contributed to this issue. Stakeholders also expressed uncertainty about process and oversight responsibility, which has made it challenging for stakeholders to seek resolution to their concerns about IDR processes. Because insurers are holding money that providers believe is owed to them, providers described their views that the delays and denials in out-of-network payment benefit insurers and hurt providers. These different financial pressures, in turn, can affect each party's willingness to engage in contract negotiations.

Many provider groups expressed a high level of frustration with insurers' initial payment practices, long IDR timelines, and delayed or denied payments after IDR determinations. In the words of one ambulance organization representative: "The frustrating part for us is, we see there's not good faith [on behalf of the insurer]. [They're] providing [very low] payments or not paying after the IDR prevailed in our favor. Yet, there's no enforcement, there's no regulation, there's no oversight of that."[10] A representative from this organization also described the change in time from service to fully adjudicated payment under the NSA:

> Prior to the NSA, we were able to close the claim within 62 to 65 days. If we follow the NSA process, that timeline increases to about 200, 204 days or

[9] Although some stakeholders expressed concern over the experience of IDREs, it is important to note that IDREs go through a certification process that requires them to demonstrate experience and expertise in medical billing as well as arbitration and claims administration, managed care, and health care law.

[10] CMS does release enforcement reports that show the number of complaints it has received regarding NSA compliance. These reports include counts of complaints against providers for surprise billing and counts of complaints against insurers for noncompliance with QPA requirements, late payments after an IDR determination, and noncompliance with 30-day initial payment or notice of denial of payment requirements. Reports are available at CMS, 2024c.

> so. What we're currently experiencing is around 325 days from the transport to where we're receiving reimbursement.

We also heard from providers that the IDREs were not meeting the payment determination timelines outlined in the law. There were long delays in processing cases that were due to high volume and insufficient IDRE capacity, as described by a radiology group representative:

> It takes us 253 days. But we've only had 33 percent of the disputes heard, and the new ones that are coming out are even longer because what's happening is this backlog is growing and growing because there have been so many filings. . . . It takes a long time before you get heard and before you get the arbitrator to rule on you.

Providers also said that while IDREs were not being held to the timeline standards set in the law for making determinations, and insurers were not meeting payment deadlines, providers had to keep to their deadlines or risk losing money. Providers said that insurers did not seem to face these same consequences for not adhering to the 30-day post-IDR payment timeline prescribed under the law.[11] An emergency medicine group representative described the repercussions they faced for missing an IDR deadline compared to what they viewed as the insurers' experience, saying:

> The provider, if we miss a day, we calculate five business days versus four business days because of a holiday, you're out of the process, you're just out of the process. You have to be so careful, so specific, and a procedural error is fatal. And these payers are just like, "We don't have to pay because we don't have to pay." They actually have to pay based on the law. But because there's no teeth, they're emboldened to not pay.

Providers explained that the delays in IDRE decisions allowed insurers to withhold payments longer and that this was beneficial to insurers' cash flow and harmful to providers' cash flow. A radiology practice representative described their experiences with extended timelines for receiving post-IDR determination payments, saying:

> Then once they rule, then you['ve] got to actually get your money because the ruling is great. But we need the cash because we're paying rads and tech and other people. Once they rule, only 40 percent of the time when we've won have we actually received cash. The other 60 percent they haven't paid us for one reason. Sometimes they tell us that they don't think it's right even though there's no legal precedent for them to do that. And they haven't done that. And the average amount of time it has taken for us to get our money is 118 days. They're supposed to pay within 30. So, that's another four months essentially on top of the 250 that we are [waiting for a payment determination]. So, we're over a year now where they're holding our cash compared to what we would have gotten before.

[11] Providers have the right to sue insurers to collect on IDRE determination payments. In addition, the Departments have the power to take enforcement action and impose civil monetary penalties against parties who violate any of the NSA requirements, including timely payment requirements. However, to our knowledge, no penalties have been issued to date.

Similarly, one anesthesiology group representative said:

> It's favoring the payers at this point. They're looking at the short game because the short game favors them because they're keeping their money in their pocket. They're keeping the money in the self-[insured] employer group's pocket until it can all get pushed through the system.

Providers also said that the 90-day cooling-off period after a payment determination benefited insurers' cash flow and was detrimental to providers. As one anesthesiology group representative explained, "This whole cooling-off period is a problem as well because it artificially lengthens your revenue cycle, which is already prolonged as it is."

Several providers said that penalties should be implemented for insurers that do not make reasonable initial payments, that do not negotiate in good faith during open negotiation periods, and that do not meet the required IDR timelines for payment post-determinations. In the words of one anesthesiology group representative:

> Enforcement is probably the biggest thing that I think that the payers would respond to. I have to submit all of my documents by X amount of days, then you technically should have to pay me by a certain amount of time. And I think there is, like, you have to pay within a certain amount of time, but if there's no penalty for not doing that, then why bother? So, until there's enforcement like that, where the payer has to pay, and they have to pay by a certain time, and if they don't pay it by a certain time, there's a penalty associated with it, nothing is going to change.

Providers said that when insurers get to hold onto funds longer for out-of-network claims, it disincentivizes them from wanting to create an in-network agreement. Representatives from an air ambulance organization and a provider partner both described how enforcing the law could help improve the landscape of contract negotiations, saying:

> Interest and penalties for failing to pay timely. I mean, interest should be paid no matter what. If we get awarded an amount later that's more than the initial payment, you pay us interest on the amount that we are not getting paid, because you now had an independent third party say this is the amount that you should have paid. And so, you need to pay us interest on that. Don't keep our money for free. . . . Number two, you have penalties for systematic underpayments of claims. You need to have a financial incentive because . . . until there's a financial incentive for them to go in network, they will not do it.

> Enforce these timelines on the IDREs and the carriers. And once these decisions start getting rendered, the system is going to fix itself. They just have to get these arbitrations decided and then enforce the payment for the lost arbitrations and then the system's going to start to function, then it's going to become a market in and of itself, and then the carriers are going to be making decisions based on the realities of that market. . . . But short of that, I think the law says everything. Now, it's just a matter of it being implemented.

Insurers Reported That Issues with IDRE Decisions Contributed to the Delay in Processing Payments to Providers After Payment Determination

When asked about the payment delays for claims that go through the IDR process, insurers described challenges with IDRE decisions, including receiving decisions on ineligible claims (such as Medicare claims), inadequate information about the claim, and decisions that had insurers paying more than the provider's billed charges. An insurer explained the challenges they face in processing payment determinations when there is inadequate information about the claim, saying:

> Some of the time it's because the determination itself is lacking information that we need to properly adjudicate the claims so that we're required to go back [to the] IDR entity and do a back and forth. And there's no pause. So, our time is being eaten up by that. The lack of requisite information to pay the claim or to adjust the claim is really eating into our ability to make that 30-day time frame.

Another insurer reported receiving payment determinations on claims that, for a number of reasons, are ineligible for the IDR process, including Medicare claims, claims that fall under state regulations, or disputes not going through a period of open negotiation.

> We still see a lot of ineligible claims. . . . And so that's still a major challenge that has to be handled individually and within a batch. . . . The eligibility determination for those batches is very, very challenging. . . . We see Medicare claims, that a lot of claims that did not go through negotiation. . . . We do also see a lot of claims that are submitted after the period of eligibility for IDR has ended. We see services that aren't eligible. It really runs the gamut.

An insurer coalition representative described how some insurers have handled the issue of determinations being made on ineligible claims, saying:

> They've had compliance lawyers look at the No Surprises Act and say we're only legally obligated to pay for claims that are subject to the No Surprises Act. So if it's not subject to the No Surprises Act, we're not going to make a payment just because this IDR entity said you have to make a payment. They only have the authority under the law to issue a payment determination on claims that are subject to the Act. And who gets to resolve that? I think that's yet to be determined.

One insurer explained that they were refusing to make payment on these cases:

> I have actually pushed back on a couple of providers' attorneys and said, "We're not going to pay you regardless of whether you have an IDR because it's not eligible. It was never eligible, and here are all of the reasons why, and here's all the times that we told you it wasn't." So far, it's only happened in a couple of situations, and I've been successful, at least to date.

Additionally, insurers expressed a desire for IDREs to face repercussions in order to legitimize their decisions. One insurer urged CMS to consider this when contracting with IDREs, saying:

> I think there should be some consequences—it would be great for CMS to be disciplining or ending contracts with IDREs that put out bad decisions. I

> think there are probably gray areas where the decision was made, whether it was right or wrong or fair or not as one thing, but like where they're clearly not following guidance, there should be some repercussions. I think you need to send a signal to both the payer and the provider that the IDRE decision is a valid decision.

In order to get IDREs to meet the IDR timeline outlined in the law, providers also called for penalties for IDREs, saying:

> There's no teeth to it because when you talk to the IDREs and we say, "Okay, well, you're supposed to have the decisions within 30 days." They're like, "Wow, it doesn't really say what happens if we don't."

The Existence of Both State and Federal IDR Systems Creates Confusion over Jurisdiction and Claim Eligibility

Participants with experience in states with their own surprise billing laws also said that there were challenges navigating the dual state and federal systems. For instance, in a number of states, fully insured plans' claims are subject to the state law and most self-insured plans' claims are handled through the Federal IDR system (Stovicek, 2024). A frequent sentiment was that "it's very confusing to have two systems."

Providers explained that it was sometimes unclear which agency (state or federal) was responsible for oversight and addressing complaints and that they were referred around to agencies without having their problem addressed. One air ambulance group described circular referrals:

> For example, we submit a complaint to HHS. HHS tells us or CMS tells us to reach out to the [state insurance regulator]; we reach out to the [state insurance regulator] and they say, "CMS is supposed to resolve that issue. Go, report the complaint to CMS." We respond stating, "CMS told us to reach out to you." They say, "Well, this is outside of our purview, this is a CMS issue. They're the ones who need to respond to it." So, we're kind of stuck in this area where people are pointing fingers, yet, once we get back to the beginning of that circle, it stops.

Many participants stated that there has been confusion about which claims are for state-regulated and which are for federally regulated plans because the information has not been communicated in a standardized way through the existing claims processing workflow. Although specific codes have been created and should be added to remittances to indicate whether a claim is subject to the NSA or a state surprise billing law, some stakeholders reported that implementation of these codes onto existing forms has been challenging. As one insurer coalition representative described, for providers receiving payments and EOBs, "You can't tell which ones are which, and so then it creates a huge dump of claims" into the Federal IDR system, some of which may not be eligible.

Contracting Process and Outcomes

Overview: We spoke with participants about their negotiating experiences both before and after the passage of the NSA to gain an understanding of how the law has affected insurer-provider relationships and the contracting landscape. Stakeholders described palpable changes in the communication and negotiation tenor between insurers and providers brought on by the NSA and some of its implementation challenges. Overall, stakeholders observed a loss in provider leverage in negotiating contract terms and payment rates. Several providers reported contract terminations, payers presenting take-it-or-leave-it offers, and a downward pressure on in-network payment rates. Meanwhile, insurers also reported having contracts terminated by providers and cited providers' high IDR win rate and TMA decisions as shifting some leverage back to providers.

Stakeholders Explained That, Before the NSA, the Ability to Balance Bill Gave Providers Substantial Negotiating Leverage

Prior to the NSA, for many providers, the ability to balance bill was used as a leveraging tool. As one anesthesiology group representative explained:

> One of the things that we did here is in the past, if a practice could not get a contract and the insurer had them out of network, you could leverage the patient, right? The patient got a balance bill; they would complain to their employer; they'd complain to the hospital; ultimately, they'd complain to the payer. And around all the muckety-muck that someone would finally say, "All right, let's work with the anesthesia group to get them in network so we don't have to hear complaints." But that doesn't happen anymore.

Although providers could legally balance bill prior to the NSA, a provider partner explained that, in practice, different provider groups took a range of approaches to out-of-network payment collections:

> I think it really ran the gamut because some providers, they would not balance bill; they would collect the co-insurances and the co-pays and deductibles, but they might not balance bill. Or they could balance bill part of it, or they would get into a negotiation with the patient for some portion of the balance bill.

A provider that did not engage in balance billing could still benefit financially from the pre-NSA landscape when payers paid the billed charges in full, as described by an anesthesiology group representative:

> I would say, so before, we were probably one of the very few groups that didn't really actually balance bill. We never really chased before NSA, because, like I said, you'd have enough patients where the insurer would pay the [full billed charge] versus those that didn't pay at all.

Insurers said that prior to the NSA, it was hard to get emergency, air ambulance, and other hospital-based providers in network or get them to accept discounts on out-of-network services, in part because the ability to balance bill was such a strong source of negotiating leverage.

> These are providers who typically don't accept discounts and who don't like to participate in networks primarily because they've always been paid at a high percentage of billed charges. Because when push came to shove, payers would just pay it to avoid putting the member in a situation that was obviously unavoidable.

Since the Implementation of the NSA, Providers Reported a More Confrontational Tone in Negotiations

Several providers characterized the pre-NSA contracting landscape as one that was fair and operated in good faith. In the words of one anesthesiology group representative:

> Prior to [the NSA], we had a relationship with our health plans that we would enter into a good-faith negotiation environment where both parties had benefits to reaching a mutual agreement to remain in network and have our relationship governed through contractual terms and legal terms, as well as solidified financial arrangements that allowed the negotiations to take place.

This same anesthesiology group representative described a very different landscape post-NSA, saying that "the negotiation environment is no longer one that is a good-faith environment where there's a mutual benefit and desire to reach terms that are beneficial to the members and patients in our communities."

Another anesthesiology group representative's description was illustrative of the pre-NSA contract structure and tenor we heard from many providers:

> We typically would negotiate a multiyear agreement, typically had some escalator built in over that was tied to CPI [Consumer Price Index]. . . . It was, I would say, a reasonable negotiation. . . . We never really terminated to renegotiate. And quite frankly, the payers didn't either. So, it was definitely a partnership approach from both sides.

Post-NSA, a representative from this same anesthesiology group reported being "point blank told by some C-suite executives at these payers that there's a new dawn, a new day in negotiation because they don't have to pay anything but the median rate."

Looking in on the insurer-provider dynamic from the outside, one benefits consultant stated that negotiations have always been and remain confrontational under the NSA, saying, "I think that there's still the really contentious negotiations that go on with those that have historically tried to play the out-of-network game, and those, to some degree, are still not solved."

Stakeholders Noted a Shift in Leverage Toward the Insurers Under the NSA

Providers consistently stated that they felt disadvantaged by the NSA, across all specialty representatives with whom we spoke. In the words of one provider partner: "With NSA, it's very clear who's winning. The payers." As one radiology group representative stated, "It's certainly helped the insurance companies. I mean, it's given a power shift to them without a doubt." An anesthesiology group representative said that they used to have more leverage and now payers have more leverage: "The table has been completely turned." An emergency medicine group

representative stated, “Payers very quickly saw NSA as a mechanism for righting historical wrongs.” A provider coalition representative phrased this as “It’s a little bit lopsided, more towards the payers.”

An emergency medicine group representative added color to this sentiment, explaining the pressure points they feel:

> I think payers have felt like the NSA gave them leverage and power in the marketplace that in some instances they didn’t have before. And even among those that haven’t terminated contracts, their willingness to update the economics of in-network contracts short of terminating them has been moderated by the fact that they know in their back pocket they’ve got this NSA environment behind them that . . . is different than it was before the NSA and different in ways that favor the payers.

A benefits consultant also perceived a shift in leverage toward insurers:

> I think that it probably has tilted to the carrier having a little bit more power here. Because if you think about the intent, which is to not get a surprise bill, then the ER [emergency room] doc . . . has less negotiation power in the grand scheme of things than the carrier.

The leverage shift was also reported by an insurer coalition representative, who viewed the change as a restoration of market forces dictated by size and position in a market: “I think taking away that threat of balance billing has reverted to some more traditional market forces in play, where what leverage you have based on your market share and what competition you have is more at play rather than the threat to balance bill.”

Providers and Insurers Reported Experiencing or Initiating Contract Terminations Following the Implementation of the NSA, Including Take-It-or-Leave-It Offers from Insurers

Although there were some provider participants who did not experience any contract terminations or threats of termination, many providers across the specialties reported that insurers approached them with take-it-or-leave-it offers and threats of termination. In the words of one emergency medicine group representative: “We’ve generally seen a move toward either a strategy of what we’ve termed ‘terminate to negotiate’ or general contract terminations followed by reductions in reimbursement that we don’t consider to coincide with market rates.” This was also voiced by an anesthesiology group representative who said that they experienced insurers “putting physicians in either a significant rate decrease in order to stay in-network environment or an out-of-network environment.”

A provider coalition representative suggested that the providers with the highest rates were sometimes targeted for cancellation:

> After the No Surprises Act, it seems as though certain insurance companies . . . appeared to be cherry picking the practices. They were [canceling], I’ll say, the top 10 percent of whatever the unit rates were nationwide.

As one example of a take-it-or-leave-it offer, an emergency medicine group representative described how two insurers "had no interest in trying to have a productive discussion. . . . They said, '[We're] giving you notice; we're terminating your contract. You can stay in network if you'll take a 50 percent plus payment decrease. Otherwise, good luck.'"

A radiology group representative described their experience with having contracts canceled and looking toward lower in-network rates:

> We've had [more than 20] contracts canceled since the implementation of the NSA by payers. And we are actively trying to get back in the network at a fair rate with them. I find it extraordinarily unlikely that any of those individual negotiations will result in rates that are higher or equal to what they were previous to being canceled by them. . . . And right now, certainly while we're out of network, because the way the NSA was implemented, we're being paid significantly less. In some cases, less than half of what we were paid previously. And so dramatic decreases in revenue [are] a result of this.

Another radiology group had one large insurer terminate their contract when they would not agree to a rate decrease after the NSA was implemented: "They were quite explicit, saying, 'Well, guess what? You can't bill patients, there's no pressure there.' They thought that the ball was really in their court and they could do what they wanted to us."

This take-it-or-leave-it approach was also described when providers were looking to establish new contracts. One air ambulance organization representative described an experience in which "we have one large national insurer that we had one meeting with to go in network and they said, 'It's a take-it-or-leave-it rate.' And it was not a sustainable rate for us, and there wasn't any kind of good faith in negotiation."

Many providers also described that payers were less interested in contracting with them altogether in the lead-up to the NSA implementation. For example, in reflecting on changes in insurers' willingness to contract before NSA implementation, an air ambulance organization representative said:

> I think it's really important to understand that starting in 2021, payers actually began shutting down discussions on a network agreement. It was the exact opposite of what we really thought would happen. And the reason being is they were all waiting to see what was going to happen with the No Surprises Act.

Several provider groups across different specialties also reported having some contracts canceled in anticipation of the NSA and in the time between when the law was passed and it was implemented. One anesthesiology group representative said:

> Prior to the No Surprises Act, we had a termination or unilateral change to an agreement that was made with the knowledge of the No Surprises Act and the regulations that were coming forward. So, that was the termination that didn't necessarily happen after the legislation was enacted, but certainly happened because of the legislation.

A representative from one emergency medicine group reported receiving several terminations from insurers, and "some of those have been resolved where we were able to get back in network" while others remain out of network.

Insurers also reported deciding to terminate some contracts. One insurer described terminating a high-rate air ambulance contract under the NSA to try to improve their contracting position: "Once the No Surprises Act came in, [we] chose to term[inate] all of those [and] take our chance and try to improve our contract position." This insurer reported that the new terms were "an improvement in our contract."

Insurers also reported having some providers initiate contract terminations. One insurer provided an example of an emergency medicine group terminating their contract. Another reported network churn with "very few" leaving contracts and "an incremental, small to mid-size" number of providers coming in network.

Some Providers Have Moved In Network and Are Accepting Lower Negotiated Prices Than Before the NSA

Some providers and insurers did report seeing increases in network participation under the NSA. One insurer described that some providers are contracting with them because it is less profitable to be out of network post-NSA: "We've expanded because we've kept our doors open trying to contract with providers. They have recognized that staying out of network is not as lucrative." In this vein, an emergency medicine group representative reported: "We've been able to probably move in network 10 to 15 percent more than we were previously."

Several providers reported entering new contracts at lower payment rates than they previously would have had before the NSA. One radiology group experienced multiple terminations and has slowly come back into network with those insurers, but they reported seeing "decreases in the contracted rates." An emergency medicine group representative expressed concern about the uncertainty of the NSA in anticipation of its implementation and entered into lower contracts than they otherwise would have:

> We saw so much potential downside that we cut our losses, right? So we negotiated contracts that, pre-NSA, we probably would not have because there would have been a more reasonable expectation for a back and forth. And in this scenario, we basically said, "Look, if this all goes south and we get terminated by everybody, we're done, right?" You can't run the business if the insurers just unilaterally terminate every contract.

Multiple insurers also described more willingness to negotiate contracts and a move in network on the part of air ambulance providers. One insurer differentiated between air ambulance and the other provider types where interest in contracting had increased, although no new contracts were established yet: "For most specialty providers, no, still tough with leverage and high rates. For air ambulance, we've had some slight inroads to have discussions." Another

insurer representative said, "We did see that pickup in the air ambulance," and the average in-network negotiated payments declined by a few percentage points.

One air ambulance organization representative described going in network at a lower rate than they would have accepted in the past, driven by uncertainty:

> Yes, we were able to negotiate a number of contracts since [the implementation of the NSA]. Some of them, to be quite frank, were due to uncertainty in the market. And we did accept less reimbursement than historical[ly] and, quite frankly, less reimbursement than we're seeing going through the IDR process. And again, it was just out of uncertainty in the future and what we're seeing.

Another air ambulance organization representative described accepting much lower in-network rates than they would have prior to the NSA because they were facing cash flow delays and reductions in out-of-network reimbursement. The company went from having about one-quarter of services in network to now having more than three-quarters of services in network. However, these new in-network contracts are 40 percent lower than what they would have accepted in the past.

> We were around 27 percent in network. And that number has grown substantially to about 70 percent to 75 percent in network. I think for us, going into 2023 knowing how much cash challenges we've had, we took in-network rates where we took a 40 percent haircut on our reimbursement, because we didn't know if we could make our ends meet and make payroll at the end of the year. So, we were forced in many capacities to accept in-network rates because the payers had it over us.

This shift in air ambulance contracting, however, was not universal.

Stakeholders Say That Insurers and Providers Are Still Far Apart on Desired Price Points

An insurer shared that the gap between insurers' and providers' desired payment points is vast, particularly from larger emergency groups:

> I think even though we're seeing improved levels of participation . . . I think about the entities I'm dealing with and . . . particularly in that ER space it's not persuasive to them to agree to more reasonable rates. I think some of the smaller entities may be more reasonable, don't come out with that double-digit ask, and therefore it's easier for us to get a contract on at a more reasonable level.

A provider partner also described the situation, saying, "They're not offering anything that the providers even have to think twice about. It's an immediate no. Actually, it's almost 'How dare you?'"

One insurer described that they want to bring providers in network, but it was hard to come to an in-network price that made sense for them and their customers: "We still feel under pressure to try to bring these providers in network to the extent that we can. It's just the balancing act of at what price does it really make sense before we are essentially creating a worse experience than a better one for our customers."

The QPA and IDR Win Rates Are Seen as Leveraging Tools for Contract Negotiations

Several providers explained that their experience winning in IDR has been a factor in achieving contracts and that this is a tool for provider groups that are well positioned to use the IDR system. One emergency medicine group representative described their experience getting contracts:

> It's also worth noting that one of the reasons we've been able to be successful in getting some of those network arrangements back into place is because we have the infrastructure to use the IDR process. I think there is concern about a lack of that ability among smaller practices and that this could very well have the unintended consequence of further consolidation either vertically or horizontally.

Another provider explained that the IDR experience was a conversation starter, but contracts had not been entered into yet:

> Our experience is we're winning 85 or 90 percent of these adjudications at some point. . . . And I think as those wins have piled up, I think the health plans have realized "maybe if we had a more favorable, more reasonable in-network agreement, we could avoid all this." And we're starting to see some of that movement in recent months.

One emergency medicine group representative whose group had been paid on the low end of in-network market rates prior to the NSA and tried to use the NSA to increase their prices toward the market median shared that it did not work out very well for them:

> Right at the outset we thought that in markets where we were way under market, the equilibrium would have us regress up to the mean. In general, the dynamic has been downward pressure regardless of where you're starting. Largely because payers can do it, because the worst that a group like [ours] can do then is send claims to our arbitration.

Among insurers, the QPA was used as an unmovable benchmark for payment rates by some as part of their broader contract negotiation strategy, although this was not universal. Some insurers explicitly stated that they intentionally keep their QPA calculations and IDR proceedings completely separate from their contracting work. In the words of one such insurer:

> I would tell you one thing, from the very beginning we were very cautious about the concept of weaponizing the QPA. We knew that [weaponizing the QPA] was not going to be a great decision and it was going to get attention. And so we haven't been very aggressive down that path.

Another insurer also shared this approach:

> We don't give my team who are contracting with providers the QPA. So, their contracts and their negotiations are based on what we would pay in the marketplace. . . . We made that decision early on that we wouldn't utilize that.

Federal Court Rulings Have Reshaped NSA Rules in Ways That Boosted Leverage for Providers

The TMA litigation in federal court was raised by some providers and insurers as a minor factor that has shifted leverage in favor of providers, although it did not restore provider leverage to pre-NSA positions. The effect of the TMA lawsuits on negotiations largely comes from the way it has reduced the power of the QPA in the IDR process, turning it from the most important factor for IDREs to consider to just one of several factors that should all be weighed. Providers favor these changes, as expressed by this emergency medicine group representative:

> The other thing that we think moved the pendulum back somewhat were the four court cases that basically told the administration they were not correctly and validly implementing the law and the courts made them . . . change some of the rules.[12]

In contrast, insurers expressed disappointment about these litigation-driven changes in IDR rules:

> I think we were hoping it [the NSA] would incent providers to participate in network more, but with the way the TMA lawsuits have chipped away at QPA, the way arbitrators are not necessarily following the rules that were set out and how they should determine winners, there is no actual incentive for [providers to join networks]. . . . So, we've been a little disappointed at that. We didn't expect the process to be as favorable to providers as it seems to be, which is a little bit of, again, a disappointment. And I think the TMA lawsuits primarily are responsible for that. . . . When you devalue QPA and you allow providers to challenge the concept of QPA, then you've sort of taken out that level playing field.

Insurer Staffing, Operations, and Revenue Changes

Overview: To explore the impact of the NSA on insurer operations, we asked about administrative and procedural changes that insurers have made in response to the law. Insurers and their partners have made substantial administrative changes to accommodate the IDR process and to take on the work of computing QPAs. While some insurers handle IDR work themselves, others outsource it, which some providers characterized as a missed opportunity for provider-insurer relationship-building that could lead toward contracting discussions. Additionally, while some of the insurers' costs associated with the NSA are passed onto employers, there are mechanisms, such as shared savings arrangements and discounts, for insurers to benefit financially in their arrangements with employers by paying low amounts on out-of-network claims. These revenue mechanisms may be a disincentive for insurers to seek in-network contracts for services subject to the NSA.

[12] At the time of our discussions, the TMA III appeal ruling discussed in Chapter 1 of this report had not yet been issued.

Employers Rely on Insurers to Act as Their Third-Party Administrators for NSA Implementation, and Insurers Were Mixed in Handling IDR Work Internally Versus Outsourcing the Process to External Firms

Employers depend on their TPA to calculate QPAs and engage in the IDR process. As one participant described, "Employers aren't going to do that on their own." While the TPA processes IDR claims, multiple stakeholders explained that administrative fees for the IDR process are passed on to employers. One insurer said, "Those admin fees are being passed on to those customers. And so they're starting to feel the pinch of the NSA and cost."

Many large insurers built internal capacity to handle IDR processes for their TPA portfolio and fully insured business: "Yeah, we expanded, built an entire team around this. Even on our IDR team built a lot of stuff there in terms of proving and validation internally." A representative from one large national insurer reported hiring roughly 500 full-time staff to process IDR cases internally. A regional insurer described hiring more than 100 people with intentions of hiring dozens more soon.

Given the complexity of the NSA, some insurers are outsourcing QPA calculations and IDR work to specialized firms. In the words of one such insurer: "The process is so complicated that, as a company, you don't want to invest in figuring out how to do it and then learning how to do it and in staffing to do it, frankly." In some cases, insurers had already contracted with firms to process out-of-network claims prior to the NSA, so this was an expansion of an existing service contract. In other cases, new client relationships are forming to handle NSA-related procedures, including QPA calculations, negotiations of challenged out-of-network payments, and arbitration proceedings.

One insurer partner explained that while they had to make significant investments to be able to handle the new processes established by the NSA, the administrative complexity and turbulence in implementation enhanced their value proposition to clients who outsourced IDR work to them, adding efficiency to the process. However, some providers expressed concern that outsourcing IDR work was counterproductive to reaching new in-network agreements between insurers and providers:

> Payers are not even engaging in negotiations themselves. They've outsourced it. . . . There's no real authority, and it's not working toward an agreement, it's pushing a piece of paper. So, in my opinion, they shouldn't be allowed to outsource it to a third party, because that means they're not attempting to get to a network agreement. It's just a business expense to them.

The NSA Has Expanded the Potential for Increasing Revenue for TPAs and Supplementary Cost-Management Firms Under Shared Savings Arrangements

In the contract arrangements between TPAs and employers, an out-of-network "discount" is the difference between billed charges and the amount paid on the out-of-network claims. Out-of-network shared savings arrangements are contract structures in which the TPA retains a portion

of the discount as compensation. Similar arrangements are also in place when a complementary cost-management firm secures a discount on an out-of-network claim for a self-insured employer or fully insured plan. This is a mechanism for payers to pay less on claims and a source of revenue for TPAs and cost-management firms.

Shared savings arrangements were common prior to the NSA and are still in place in some contracts for claims subject to the NSA. In the words of one benefits consultant: "You do have to recognize that the carriers make revenue when there's out-of-network claims. . . . There are some [very large insurers], for example, that make a significant amount of their income on this out-of-network savings that they get to retain." This revenue mechanism for out-of-network claims may decrease the incentive for insurers to have more in-network providers.

A benefits consultant provided an illustration of how the NSA has expanded the potential for revenue on these shared savings arrangements. With a lower out-of-network reimbursement, the discount on charges is larger than it would have been on a high out-of-network payment prior to the NSA:

> When they're serving as a TPA, even now that there's the No Surprises Act, they're making money off of "savings relative to billed charges." So if the billed charges are $1,000, it used to be that they could balance bill for $1,000, and there would be reasons to pay that whole amount if you were an employer. But now with the No Surprises Act, maybe they're only going to pay $200 on that $1,000. That $800, they get to count that as shared savings. So, in those shared savings examples, they get to count that as savings. That's how they're playing the game right now.

Some stakeholders said that they had observed higher charges in recent years, and this was also contributing to higher shared savings calculations in some instances. As billed charges go up and shared savings arrangements are based on a percentage of the difference between charges and out-of-network reimbursement, then shared savings fees increase: "Yeah, if they save, they're giving us the same cut of that. So we're getting paid more, but they're saving more. So they don't net worse off generally in that case."

Multiple discussants, including benefits consultants and providers, emphasized that there is a need for more awareness of shared savings arrangements among employers: "This is where I will say that consultants are continuing to try to educate, but employers are very unclear about what really gets counted in shared savings, and that is controlled by the carriers, and it is the black box that you have to just try to figure out."

Several participants expressed strong feelings about shared savings arrangements, including an anesthesiology provider representative who described the practice as "racketeering with an assist from the federal government." A radiology group representative also described shared saving arrangements in a negative light:

> It's something insurers don't want anybody to know [about]. . . . If you can . . . cut doctors out of network, now you're paying the NSA rate in the actual plans with employers. They're saying that they saved you all this money and they're

> taking another cut of that "shared savings." Because it's a little bit complex, it's very unrecognized, under-reported.

A representative from an anesthesiology group also raised shared savings and other fees as concerning for the overall impact of the NSA on health care spending:

> I don't see the No Surprises Act benefiting anybody but these publicly traded payers who, see, they're not passing the savings back to anybody, and that's disconcerting. And then at these smaller self-[insured] employer groups, they're really getting hit with the No Surprises Act. Right? Because now they're going to have to pay an admin fee. If the provider files an arbitration claim, they're going to get stuck with an admin fee. They're already paying shared savings fees out of network. They're paying some sort of admin fee to manage the claim through the process, and I am afraid that the cost of all of that they have to incur.

Another anesthesiology provider group representative also indicated that shared savings arrangements were an incentive to keep providers out of network:

> There's an incentive for the payer to keep us out of network because they are making more money. So they are saying that they're coming back, but they are making significantly more money by keeping us out of network because they're charging [shared savings fees]. . . back to the employer in that situation. So not only are they asking for unreasonable rates, they're financially gaining as a result of us being out of network based on how they've structured their contracts, and that's not spoken about nearly enough at all, really.

The shared savings model is not universally used. One insurer partner described their contracts as using a mix of payment arrangements for the services they provide, including flat rates and shared savings. A large insurer also reported that they very intentionally moved away from a shared savings model on claims subject to the NSA:

> Our shared savings program does not include the NSA providers. We separated that . . . for the No Surprises Act [for] those providers who are covered under that. . . . We had those discussions early on and decided that for the NSA side of the house, we would no longer have those programs in place.

As an alternative to shared savings, the same insurer applies a flat fee per claim subject to the NSA:

> The cost themselves that are charged by the IDR entities are getting passed through [to the employer]. . . . I think there's a per-NSA claim charge. . . . So it's basically like an administrative charge that's tacked onto each NSA claim.

Some Insurers Used the NSA to Raise Discounts Used to Market Plans to Employers

Out-of-network payments under the NSA can also influence TPA discounts in marketing to self-insured employers. An insurer's discount is calculated as the difference between billed charges and the actual payment made for a claim. Under the NSA, payments for out-of-network claims subject to the law are likely lower because many insurers are making initial payments

equal to the QPA as opposed to paying the full billed charges amount in order to avoid their member getting a surprise bill. This, in turn, increases the calculated discount.

> During a sales [pitch] when consultants are talking to groups and brokers, they'll go, "Well, [Health Plan A] has got a 2 percent advantage on [Health Plan B]. You should definitely go with them." I mean, it's a big deal for sales. . . . Where the NSA plays in is out-of-network providers. So, prior to the NSA, if you have an out-of-network provider we go ahead and send them that check for 100 percent of the schedule [because] the consultants all say that that provider is going to balance bill the member. And so your [discount] on those for that claim is zero; you get zero discount. And so the NSA came in and said, well, now, for those providers that would fall under [the NSA] . . . that discount could be significant because . . . if we win 50 percent of the time at our QPA, that's a huge difference versus billed charges.

Provider Staffing, Operations, and Revenue Changes

Overview: We also asked providers about their administrative and operational changes under the NSA to better understand how those pressures affect their financial position, which can play a role in contract negotiations. Providers have taken different tactics in engaging with the IDR process. Large provider groups have predominantly built the capacity to navigate the IDR process internally. Although some smaller provider groups have looked to partner with external firms, the expense and administrative burden of the IDR process is a barrier to participation for others. Several provider organizations described realized or anticipated changes in structure or ownership that were due at least in part, or possibly predominantly, to the NSA. When facing financial constraints, providers sought to cut administrative costs first before considering adjusting clinical staffing. Providers also expressed concern about the viability of small practices and described struggles to maintain access to care in rural and underserved communities. Some providers look to hospitals to help stabilize their financial position, both through direct subsidies and support in negotiations with insurers.

In Navigating the IDR Process, Some Providers Handle IDR Cases Themselves, While Others Outsource IDR Work

Navigating the IDR process is administratively complex for providers. Some provider groups, particularly larger organizations, have managed the IDR process by building up internal staffing and capabilities. Other provider groups have outsourced these processes to other firms, including revenue cycle management groups, third-party negotiators, law firms, and new boutique firms established to meet demand for IDR services. One radiology group representative explained this heterogeneity in how provider groups are approaching the IDR process:

> It's a big administrative hassle, introduces a lot of cost. We have a big revenue cycle team that's able to do this. I personally know groups that I have talked to, like, "How are you dealing with this?" You know, somebody with 20 physicians

> or something like that, they outsource their revenue cycle to somebody else. They have no people to do this.

Some small groups have not been able to surmount administrative hurdles. In the case of a small radiology group, they reported that they were unable to bring all of the claims that they wanted to challenge into the IDR process because the administrative burden was too much. They cautioned that one should not assume that a lack of cases was indicative of provider satisfaction with payment; rather, it is a possible sign of cost barriers to IDR use:

> Honestly, one of the claims made on the [insurer] side is, "Look, not that many things are being disputed. That means that the QPA thing works." No, I would dispute all of them if I could. All of them, every single one. We provide a fantastic service. A very high level of care, very acute care. . . . One shouldn't use the volume of disputes as an indication of the process working. It's actually a function [of the fact] that I just can't afford to continue to sit on the portal all day.

A provider partner shared knowledge of an acquaintance in the field who has worked at a large provider group on their IDR work and was now starting his own business: "He's starting a company to do nothing but help people negotiate the IDR process."

Several large provider groups reported handling IDR processes internally and building up infrastructure and staffing for this: "We have had to add extra infrastructure and costs as it relates to managing the arbitration process. . . . We've expanded from a cost standpoint, from a technology standpoint." Similarly, a representative from a large emergency medicine group explained that handling the IDR was a substantial workload for their organization that required a new team beyond their revenue cycle management team: "We've had to build a team. The team that I run right now would not exist if it were not for the arbitration workflow. It's simply too much work to add on to an existing RCM [revenue cycle management] staff."

Some provider groups have augmented the manual labor of IDR processes with custom automated systems. One emergency medicine group representative described this use of automation in their organization:

> This whole cottage industry of software companies and bots that deal with arbitration [has] now sprung up and made it possible to just funnel everything through there. . . . A third-party partner . . . created custom bots for [us]. . . . By the way, the payers, of course, do the same thing. There's this, like, dueling armies of bots.

An anesthesiology group representative indicated that they may look to move IDR-related labor outside the United States for cost reasons, given the scale of their practice: "At some point, we may offshore some of this as a way to reduce our cost. But again, these are the kinds of things that we're big enough that makes sense. I think if you're a private practice, it's a lot harder to do."

Along with the NSA, Providers Described the Compounding Effects of Labor Shortages and Rising Demands for Compensation

Many providers from anesthesiology, emergency medicine, and radiology groups described unprecedented labor shortages in their specialties. Although these shortages were not attributed to the NSA, they were described as an important part of the landscape in which the policy change is occurring. In the words of one radiologist: "It's nearly impossible for most radiology groups to hire. Any other radiologist you're talking about, just ask them how is the hiring landscape . . . we're finding it harder to recruit."

Participants explained that these labor shortages had inflated compensation as organizations compete for workers. As an example, one provider coalition representative described the magnitude of compensation increases for certified registered nurse anesthetists (CRNAs): "Staffing costs have been going up. CRNA costs have gone up like 20 percent, easy, in most markets over the past few years."

We heard from an emergency medicine group representative that they especially felt pressure to keep new hire offers high for recruiting:

> We've had some challenges with respect to compensation. We're trying hard. It's creating a challenge for recruiting more than anything else. People who have been in the company and are committed and are partners in the company, they'll row against the tide as hard as they have to. But when you have somebody coming in new, they're not interested in the fact that there's economic strain, and it requires some change in behavior or enhanced commitment or whatever the case may be. So, it's recreated some challenges in recruiting.

Several participants explained that when staffing shifts could not be filled by their existing staff, they had to recruit *locum tenens* providers (temporary clinicians) and pay them much more than a regular staff member would be paid. This is a costly way to meet staffing needs. An emergency group representative explained this cost: "When we are not staffed by full-time physicians or advanced practitioners, we've got to cover that care, which means we have to pay for *locum tenens* coverage which is two X [the cost]." An anesthesiology group representative also described needing to turn to that model in order to maintain adequate staffing:

> We're having to solicit and utilize *locum tenens* because we can't keep certain locations staffed, because maybe we're out of network and we're getting paid less and we can't keep who we have and paying them. So we wind up having to do locums.

While most providers described inflation in labor costs and higher salaries, there were a couple of outliers who were in such difficult financial positions that they were having to reduce compensation to clinicians. One emergency medicine organization representative said, "The compensation cuts occurred for administrative staff first. This year, for the first time, we had to cut compensation to our physicians."

Business and Financial Structures Have Shifted for Many Providers Under the NSA and Other Pressures

Some providers with investors, including those with private equity backing, had debt structures that were financed assuming a continuation of status quo revenue prior to the NSA's passage. The NSA was especially disruptive for those entities. One provider organization representative explained that they "were financed with a view towards the future that didn't anticipate the NSA." In some cases, businesses have had to financially restructure or otherwise reorganize themselves.

Some organizations also made preemptive changes to their structure, based on updated projections and uncertainties in the post-NSA landscape.

> It's not like we're in jeopardy of having to shut down tomorrow, but it's obviously enough of a concern that it's leading to the kinds of deliberations that we're talking about here, which go beyond just looking for cost efficiency or a better rate on fuel or something. It's more existential than that.

Multiple provider organization representatives described diversifying their services to insulate themselves from the changes and ongoing fluctuations in payments for services subject to the NSA. For one organization, this included expansions of telemedicine services "prompted by our need to diversify or to do something different." A provider partner described a client that was acquiring to diversify:

> [The organization is] in the process of working to acquire a large ground ambulance entity to supplement their air because they really need to shore up their, you know, the eggs that they can rely on.

Some providers communicated that their overall revenue had declined under the NSA. As an example, one emergency medicine group representative said that after contract terminations, "our commercial revenue is down, my guess, 10 to 15 percent. We've made some of that up with volume and just trying to be smarter about how we document and stuff. But definitely down."

Providers also reported having to close operations, lay off staff, and take out loans because of issues related to revenue drops and longer accounts-receivable timelines under the NSA. A representative from a large emergency medicine group described the effect of the NSA on their operations that led them to borrow money and lay off staff:

> Delays in professional reimbursement by sending out such a huge chunk of our emergency medicine to arbitration made us cash flow negative, which meant that we were supporting payroll with borrowed money, which is generally frowned upon in the business world. As a consequence of all those changes, we had to lay off a couple of hundred people, and for the first time we have been giving compensation cuts across the board, and we just have to make ends meet. I don't think anybody will cry any rivers for us, but we felt the effects.

Another provider group similarly had to borrow money and sell assets:

> We had to go back to all of our members and borrow money just to stay out of the line of credit this year. . . . Typically, our days in [accounts receivable]

> were 65 days, and now they're 280. . . . That cash flow just isn't there. So, we sold aircraft that we bought or committed to prior to NSA.

One provider partner described the experience of a client who went out of business at least partially because of the long timelines for payment under the NSA:

> This client went out of business. They're no longer functional because they weren't making enough money. . . . They're out of business now, and we're still getting awards on their cases. We have cases that we filed back in 2022. They're out of business, but we just got an award for them that we filed in 2022 for $76,000. If that $76,000 came a year ago, that could have gone a long way to keeping them open another month or another month after that. . . . The delays and all of that basically put this provider out of business because they couldn't last until the process got around to actually awarding them their money.

Contrasting the experience of providers under the NSA with what they saw before the law, a provider partner said, "I can tell you that at my prior company, we never had clients complain about significant loss in revenue, never. Whereas post-NSA, we always hear clients complain about a loss of revenue."

Providers Reported Responding to Financial Strain Caused by the NSA by Trying to Run a Leaner Business to Avoid Changes to Clinical Staffing

When asked about staffing changes under the NSA, many provider groups reported that they had made no changes to clinical staffing. Some provider groups emphasized that they do not look to clinical staffing changes as a first course of action. The priority for efficiency is in administrative staffing, processes, and nonclinical operating expenses. In the words of one emergency medicine group representative: "The people who are administrative, the management service, that's where we keep squeezing first." They explained that when looking to cut costs, they ask, "What can we do smarter in the business? How can we be more cost effective with coding and billing and med[ical] mal[practice insurance] and everything else before we get through those questions about do we change anything at the bedside?"

Another emergency medicine group representative explained that they were maintaining their clinic staffing model and lowering costs by cutting the hours of administrative staff:

> When we talk about cutting down some hours, it's been some of the admin guys actually coming in. But we try to keep our national standard of two patients per hour, and we've tried to maintain that no matter what. . . . We want to make sure that we are taking care of our community and our patients.

An anesthesiology group representative expressed this same sentiment, explaining that when funds are tighter, "then we have to look around and see, okay, what departments are mission critical, getting claims out the door and all of that. And then what are 'value add' things that no longer make financial sense to provide in this situation."

When facing financial constraints, some provider organizations adjusted their clinical staffing by supplementing physicians with less expensive nonphysician clinicians. Several

providers emphasized the importance of maintaining quality of care when adjusting staffing. In the words of one large emergency group representative: "So do we use nurse practitioners and physician assistants in the mix? Yes, but it is a mix that we think is still clinically appropriate." Another large emergency medicine group representative described increasing staffing of advanced practice providers (APPs) to enhance efficiency while maintaining quality of care and the effect those decisions can have on contracting decisions with facilities:

> We have supplemented physician staff with nonphysician staff. So APPs, mid-levels. That's not inherently a bad thing where there can be efficiency and slotting in the right level of provider in the right spot. That can also be a driver as to whether or not we determine a contract where the facility is viable. We won't compromise the level of care necessarily. So if the only way to make a contract work is to replace what we would consider to be an unacceptable level of physicians with mid-levels, then that contract isn't viable. So the short answer is yes, we've augmented clinical staff with mid-levels. But we won't do that to a level at which we would be concerned about ability to supervise those mid-levels or that would impact quality of care.

One emergency medicine group representative explained that they had reduced the number of physicians per shift due to financial constraints:

> We only have like a finite number of levers that we can pull when we're like cash flow negative. Certainly, one of those levers is physicians have to see more patients. This generally means that a shift in the emergency department has like three doctors instead of four. . . . There's no doubt that patient volume per hour has gone up as a consequence.

Anesthesia in operating rooms can gain efficiency through the scheduling and number of operating rooms being used at a given time. This is due to unique aspects of anesthesia practice and billing that enable a physician to supervise advanced practice nurses and administer care to multiple patients at a time. Multiple participants described responding to financial strain by seeking more efficient use of operating rooms by their health system partners:

> I have to be very mindful with how I staff our operating rooms and try to maximize efficiencies. So, basically, we've had some very difficult conversations with our surgery centers, and trying to make sure that we're running every single room that we open to the max. And so, for example, at one of our anchor sites, we had eight operating rooms that are available and usually open every single day. But we've cut that down to six.

> One of the challenges that anesthesia is facing now is the efficient use of operating rooms. An operating room is a set cost, right? And anesthesiologists, they would love to have the surgeon start at seven, work right through three or four or five, whatever, just using that operating room the entire day. That's not how it actually works. Some surgeons want to start later in the afternoon, and there's this inefficient use of the operating room. But you have the anesthesiologist who's there, who has to be there. So they're standing around basically in operating rooms not being used.

Some Providers Looked to Hospitals to Help Stabilize Their Financial Position, Both Through Support in Negotiations with Insurers and Through Direct Subsidies

During our conversations with stakeholders, hospital-based provider groups and air ambulance organizations described how their relationships with hospitals has also been affected by the financial pressures they ascribe to the NSA. Hospitals sometimes pay their partner provider groups a stipend (also referred to as a subsidy or panel fee) as a part of their contract to staff the hospital. The stipend payments are revenue to the professional group in addition to their fee-for-service billing to payers. In markets where hospitals are competing for staffing and fee-for-service reimbursement is inadequate to retain sufficient staffing level, subsidies may be necessary to fully staff some hospitals. Introducing a subsidy or increasing the magnitude of a subsidy was described as a response to lower professional reimbursement under the NSA. One emergency medicine group representative described that stipends are dependent on the specifics of each hospital context and have changed because of the NSA:

> We do pursue subsidies from facilities when that's necessary in order to make the payer mix and reimbursement work. That's like any negotiation, very dependent on the contract itself, volume, paramedics, yada yada. But absolutely, we have had to increase the rate at which we either negotiate for a subsidy or the amount of the subsidy post-NSA to make up that gap.

An anesthesiology group representative described turning to hospitals for subsidies after experiencing reduced reimbursements under the NSA, yet acknowledged that hospitals may not have those funds:

> We're left with hard choices, as many physician groups around the country are, and the choice is, we have to either take these decreases, which is not sustainable, [or] the alternative to that is we have to go to our hospital partners and ask to be trued up to those losses. Most of our hospital systems are going to say, "We don't have those dollars either."

A similar dynamic was described by a representative from an air ambulance organization that, until this year, had never received a subsidy from hospitals. With delayed and reduced cash flow under the NSA, each hospital partner was asked to provide a subsidy:

> [In the past,] all of our program operated on transport revenue. That's our only source of revenue, and it's our only source of income completely. Up until recently, we didn't have a philanthropy department or anything. But we had to go back to all of our members and borrow money just to stay out of the line of credit this year.

Some providers described trade-offs in the solicitation of stipends from hospitals. One large anesthesiology group explained that professional groups lose autonomy when they rely too heavily on hospital stipends rather than subsist solely on payments from insurers and patients. If stipends grow too large, there is a risk that the hospital will not be willing to pay the stipend and may change to an employment model in which it will not need to pay a stipend to an external staffing group. Professional groups lacking financial independence may also be at risk of

acquisition. A representative from this anesthesiology group cautioned against the loss of professional independence:

> If the specialty of anesthesia, out of necessity because of the actions of the payers through the No Surprises Act, has to lean more heavily into the hospitals, those dollars are still going to have to come from somewhere. And so at the end of the day, the right answer is to have autonomy to have our own agreements with these payers and good faith negotiations that don't put the hospitals in those kinds of positions and allows us to negotiate in good faith to maintain our own financial viability.

Another anesthesiologist described their independent practice's experience of seeking a stipend from the hospital where their group had a long-standing exclusive contract:

> We went to the hospital for help, like, "Not a problem. Let's sit down, let's figure this out. We want to keep you guys intact. People have to stop leaving." So we hired a consultant, and then we started working through what their needs were and what our needs were. . . . And we just wanted a revenue guarantee. Just said, "If you want us for this many rooms, just pay the difference, just pay the delta. . . . We just need to be able to keep our people here."

When this anesthesiology group and the hospital ultimately could not reach an agreement for a stipend, the hospital terminated the contract and transitioned to an employment model for anesthesia services. This challenge for small independent anesthesiology groups was also reported in a discussion with a large national anesthesiology organization, which described benefiting from growth in the market when small groups struggled:

> We can't get any more money from payers. . . . As a result, you're seeing a ton of churn in the industry because hospitals are saying, "I don't want to do this anymore." So they're taking it in house, and they're switching anesthesia companies. For us, it's been great from a growth perspective because a ton of small . . . independent groups just can't deal with it, because they don't have the ability to really go through the IDR process in a sophisticated way. They can't negotiate rates in the first place and they . . . may have always been out of network. They don't know how to explain the revenue with the hospitals, or they're just so hard [up] that they're saying, forget it. So what's happening is hospitals are forced to either give that business to a group like us or take it in house.

A representative from another large anesthesiology group reported being solicited by hospitals that were considering transitioning staffing. The group has been asked by hospitals whether they would be interested in staffing their hospital and whether they would be needing a stipend if they were to take the contract.

Several providers also said that hospitals were financially challenged in the current environment, partially because of the NSA, among other factors, so the ability to pay stipends could be constrained. One anesthesiology group representative described a conversation with a hospital system reflecting this dynamic:

> I think at the end of the day, there's hospitals that are already subsidizing many groups across the country, and they're struggling with the payers in their own right. We met with one of the major hospital systems in [the state]. When we sat down with them and talked with them, they were talking about how difficult this No Surprises Act has [been] and the impact it's had on them to have good faith negotiations. So I think that the hospitals are also struggling to adequately bring inflationary increases into their agreements to subsidize costs.

One anesthesiology group representative put the hospital's stipend position succinctly: "They're doing it, but they're not happy about it."

Providers Described Smaller Groups as At Risk of Closure and Consolidation and Expressed Concern About the Risk of Reduced Access to Care, Including in Underserved Communities

Challenges from coronavirus disease 2019 (COVID-19), inflation, and other factors combined with the NSA have contributed to a difficult environment for small practices that could jeopardize their future viability. In the words of one market observer:

> I have heard that some of the smaller groups are suffering the most, and some of them may end up going out of business because of the loss of revenue, particularly rural small groups. . . . The NSA is definitely a factor they consider. It's not the only factor.

Some more pointedly attributed small practices' challenges and consolidation to the NSA implementation and IDR operations, leading to a path of greater consolidation:

> If the IDR does not get fixed, we're going to have to merge; bigger is better. . . . There's no doubt that this is not survivable for smaller groups and we're seeing consolidation. This is just driving up consolidation even more.

One small independent physician group joined a network of independent physicians in their state after receiving low initial out-of-network payments and struggling to navigate the IDR system. They attributed their decision to join this network of independent physicians as a direct result of their experience in the first few months after NSA implementation, stating, "I was starting to see this was going to be really bad. And especially for us, because we just didn't have the bandwidth to deal with it."

Some discussants expressed concerns that the NSA may disincentivize adequate provision of emergency medical services because of reduced reimbursement to emergency medical providers. In the words of one provider partner:

> We're dramatically jeopardizing the quality of our emergency health care. If there's any arena where you want to incentivize the best to be treating people, it's the emergency medical [context]. The way this law is going, they're putting that at risk. So, this ship has to be straightened, because it's the emergency medical industry that's on the line.

Multiple large anesthesiology groups explained that they provide services in hospitals with wide-ranging economic conditions and variable financial performance, with the goal of net

profitability even when some sites are not individually profitable. Financial strain under the NSA raises questions about the financial viability of continuing to serve unprofitable sites. In the words of one representative:

> The hospitals don't have more money to subsidize these payer decreases. So now as a physician group, in order to maintain that autonomy and financial viability, you have to look and say, where can we cut costs? And if there's facilities and partnerships that we have out there that are loss leaders, certainly, you're going to look at that and say, can I sustain that? Can I continue to provide services and provide care in this difficult location to a difficult population? And unfortunately, a lot of times I think the answer is no, I can't.

Providers described that a high share of publicly insured patients relative to commercially insured patients results in less fee-for-service revenue, because reimbursement rates from Medicaid and Medicare are typically much lower than those from commercial insurers. One anesthesiology group representative described that they staff some urban underserved areas with a high public payer share, and this may not be financially viable if they receive less reimbursement from commercial payers to balance out their payer mix:

> We provide care in a lot of those places that have low commercial payer [mix]. And the Medicaid rates certainly aren't going to sustain us. It's historically the commercial rates that allow you to provide care at those places.

Several provider organization representatives were acutely concerned about rural areas. They explained that the NSA coincided with an overall contraction of services in rural areas, and the NSA may be contributing to that trend. They reported that rural hospitals face financial hardship, and many have closed or are at risk of closing. Even where hospitals are staying open, they may be closing some service lines:

> If they pay the hospital-based providers, then they may cut other services. . . . The top three: maternity, peds [pediatric] services, and, unfortunately, behavioral health. When you look at the service-line closures, those are the first three that seem to be going.

A representative from the same anesthesiology group portrayed their experience of having to leave facilities in rural or underserved areas:

> We have some geographic areas where . . . 98 percent of the [health insurance] exchange population qualifies for reduced cost-shar[ing subsidies]. . . . We, in some instances, are the last shot at keeping maternity services open in some of the more rural areas. . . .If we can't feel like we can provide quality care, and they don't want to pay for it, then we're forced to leave. And so we have seen service-line closures; we've departed certain facilities.

Similarly, a radiology provider described moving to a fully remote care model in rural facilities because of reduced reimbursement under the NSA:

> We've done several things particularly in rural facilities. And sometimes it's in combination . . . with asking the hospital for financial support. So, it might be [that] we will only serve this hospital remotely at this point because we can't get

> somebody to go to a rural facility. . . . They won't have an on-site physical radiologist there, or we'll limit interventional radiology services or pediatric radiology services, or something like that.

Loss of hospital-based services and strains on air ambulances compound in ways that could also exacerbate access to care challenges in rural areas. When hospitals or service lines close in rural areas, air ambulance transportation becomes the only means of access to care in time-sensitive situations, such as labor and delivery, when a hospital or service has closed. In the words of one air ambulance provider:

> It's not necessarily even the [hospital] closures, it's the loss of services in our area. It's these OB [obstetrics] deserts. So, young folks starting a family, they might be two hours from home to go give birth. We're that connection, that access point from rural health to tertiary care for something that typically we would be requested [only] when there's a complication. And now, it's kind of like the invitation is open for us to be more readily available. . . . But the more that this impacts us negatively on the financial front, it's hard to focus and look at ways to solve problems in rural communities when you're just trying to survive.

One provider described a specific case of a small air ambulance provider closing a regional service subsequent to the NSA implementation and reduced commercial reimbursement. Reduced services were not expected to be replaced by another organization, and this raised concerns about access to care: "But there's going to be patients that are going to wait probably twice as long to get a helicopter when they need it."

In addition, air ambulance organizations described seeing an increase in medical necessity denials from insurers under the NSA. Medical necessity denials occur when an insurer deems a service provided to not be medically necessary. An air ambulance organization expressed concern that an increase in medical necessity denials could leave patients on the hook for the cost of their transports:

> We get a lot of medical necessity denials. Payers do not use CMS's definition. [With] CMS, we get very, very few medical necessity denials. But payers will use a very strict scrutiny on what they believe is medically necessary for air ambulance. And so, those are carved out of the No Surprises Act. We have to appeal those. Patients are still going to be balance billed for those, which we hate. We lobbied very, very hard for those to be included in the No Surprises Act. Because, again, the patient didn't order that; a physician ordered that.

Multiple hospital-based provider groups indicated that network adequacy requirements could be enforced or expanded as a policy mechanism to incentivize insurers to contract with more hospital-based providers and ensure access to care. Prior to the NSA, some insurers entered such contracts to avoid their enrollees receiving balance bills, but the incentive to do so was removed by the NSA. These providers said that insurers now had few incentives to contract with providers subject to provisions of the NSA. Providers said they had lost negotiating leverage to reach favorable network contracts, and additional network adequacy requirements beyond what is

currently required could restore some of providers' leverage in negotiations. A radiology group representative explained this by saying:

> We would love to see network adequacy standards clear and enforced because that's a concern. Do they have a reasonable number of hospital-based specialists in their network? And from their [insurers'] perspective, if the patients are not going to get balance billed, they want to have the least number because you're not going to get a balance bill.

Representatives from two anesthesiology groups specifically identified rural areas as markets where network adequacy could shore up access to care by incentivizing contracting and putting upward pressure on in-network contracted rates.

> How do we think about network adequacy, because there's got to be some incentive or penalty for insurers to bring in provider groups at a fair market-based rate. And maybe it's rural communities, whatever it is, but there's got to be a way for hospitals not to have to take it on themselves or asking individual anesthesia providers to make less money in a less desirable community than if they were working in an urban environment.
>
> It's important for us to try to bring us back in network and make sure that access doesn't leave, because if there's no anesthesiologist, there's no C-sections. Right? You can't have a C-section without any anesthesiologist present. And if we're not there, then that emergent C-section may have to travel 30 to 60 minutes away, which is, in our thought process, unacceptable. So, we've done a lot of work with rural health care to try to convince the [state's Department of Insurance] to go after network adequacy.

Overall Thoughts on the NSA

Overview: Overall, stakeholders reported that the NSA has been largely successful at eliminating surprise billing for services subject to the law. Although stakeholders described a challenging implementation process that has put pressure on them financially, they generally continue to support the NSA. Importantly, we heard about instances of patients being erroneously balance billed because of challenges that providers and insurers faced getting billing and claims processing systems updated. There were concerns from insurers and providers about future negotiations. Both expressed a need for more predictability and stability under the law and concern that, in the absence of improvements, tensions could grow and further stress their negotiating relationships. In the face of uncertainty, few said that the effects of the NSA on a variety of outcomes of interest were knowable in the near term.

Stakeholders Agreed That the NSA Has Largely Eliminated Balance Billing by Out-of-Network Providers and Has Taken Patients Out of the Middle of Payment Negotiations, and They Continue to Express Support for the Law

A recurring theme discussed by parties across stakeholder groups was the success of the law in nearly eliminating balance billing in the circumstances covered by the law and removing

patients from payment negotiations and disputes between insurers and providers. One air ambulance operator captured this sentiment by stating:

> We certainly applaud the work to remove the patient from the middle of us. That was a core value of what this was intending to do, and it's really great to see that that's happened.

One insurer captured this sentiment by stating: "The most important thing about the No Surprises Act is the eradication of balance billing. I mean, that is just, it is a problem that we have been dealing with for so many years, and we didn't know how to address it." A representative from an insurance partner echoed this, saying, "I think the biggest takeaway is, it is working in the sense that members aren't being balance billed."

Even as they noted changes that needed to be made, stakeholders on both sides expressed a desire to see the law continue and be successful. In the words of one insurer representative: "Getting these expensive balance bills did not reflect well on anyone in the health care ecosystem. And so, I think we should all want to see it succeed."

Some Erroneous Surprise Bills Have Been Sent to Patients, and Both Providers and Insurers Are Working to Address This Issue

We heard from both providers and insurers about some of the challenges they faced implementing the NSA, including getting billing and claims processing systems updated. As one insurer described:

> These are legacy systems that have to adapt to a number of different processes and bringing in new sources of data. And yeah, occasionally we do find things that need to be corrected. And then as we do, we do that as quickly as possible and go back and reconcile everything to the best of our ability. If there's something that impacted the payment to the provider, we'll reopen an opportunity for negotiation and IDR and then adjust any claims and payments due to the member as well.

These challenges with updating systems have also trickled down to the patient. Despite the general sense that the NSA had stopped purposeful balance billing by the provider specialties covered by the law, stakeholders reported having issues with accidental balance billing. One emergency medicine group representative highlighted this issue during our discussions, saying:

> The latest thing that we've identified is at times when we are winning in arbitration, the plans are then sending a revised EOB increasing the patient's cost-sharing in direct violation of the law . . . and we are notifying DOL and CCIIO [the Center for Consumer Information and Insurance Oversight] that this is happening, and . . . the question that comes back is, "Well, what did you do?" And what we say, "Well, a revised bill went out because the whole system is automated."

Such revised bills are in violation of the law, even if automatically generated because of incorrect information sent by the insurer. In situations in which these revised bills have been

identified, the Departments have worked with providers to secure voluntary compliance and return overpayments to consumers.

Other providers also reported experiencing this, including another emergency medicine provider as well as radiology group representatives and provider partners:

> We have absolutely seen several cases in which, post-IDR, we receive an updated remit that tells us to bill the patient for the increased amount. We have followed up with payers on that. Some payers have actually been pretty quick once notified to correct it and have been willing to provide us with evidence that they submitted an updated EOB to the patient, yada yada. But we are pretty big and sophisticated. I promise there are providers who aren't catching it and patients getting bills that they shouldn't.

> The payers have sent conflicting EOBs. So, we had one instance where the patient got a completely different EOB than [we] got. So, our system read our EOB [and] we processed the balance bill based on our EOB. The patient called and was like, "No, no, no, that's not the EOB I got." And so, then we're like, "Well, can you provide your EOB?' And it's clearly, clearly a difference.

One insurer described substantial challenges navigating the NSA, including issuing erroneous EOBs and incorrectly directing payments to providers. In their words: "It's been a mess. It's been difficult. And so we have the system issue, but managing the NSA day to day has been just kind of bootstrapped." The providers and insurers with firsthand experience with erroneous balance billing were actively working to address these issues.

Both Providers and Insurers Expressed a Need for More Predictability and Stability Under the Law to Better Understand Its Effects on the Future of Negotiations and Other Outcomes

Despite the progress that the law has made in protecting patients, stakeholders said that they thought that two years into its implementation the law would have reached a more stable place. However, over the first years of NSA implementation, the IDR process has been paused, and rules about how IDREs consider criteria in their payment determinations and the way the QPA is calculated have changed because of litigation. Both insurers and providers pointed to the uncertainty within the IDR process as reasons for why the law has not yet reached an equilibrium, which, in turn, has created a vaguer, more challenging environment for contract negotiations. One air ambulance organization representative anticipated that within the first two years of implementation, "the parties would figure out what the new normal was and then would contract based on that new normal. And what we're finding, in general . . . that has not happened at all." One insurer described this, saying:

> We're still waiting for things to reach an equilibrium with IDR, and that will occur when we have answers as to what the likely outcomes of the IDR determinations will be and both sides have an understanding of what the value of these services is likely to be. That may spur some additional openness to contracting and a better understanding of where those contracted rates might

> settle out. But the litigation has certainly delayed that and, to some extent, introduced a lot of uncertainty as to where things will reach a new equilibrium.

Likewise, an emergency provider group representative reported:

> I think what aggravates the impact of the NSA is not only that reduced reimbursement, but just the lack of predictability of when you could ever recover that through the mechanisms that have been created. So all of those delays that we see in determinations and getting payments, that makes it extremely difficult. That portion of the impact, I would say, dwarfs even the unpredictability of COVID. This is just such a long time to not know what's going to happen with outstanding disputes.

In hearing from stakeholders about the effects of federal court rulings and subsequent changes to NSA regulations, it was clear that both providers and insurers were hoping for more predictability and stability in how the provisions of the law would be operationalized and would function. In the face of uncertainty, stakeholders expressed concern that the effects of the law on a wide range of outcomes are unknowable. As one insurer explained, "Until there's more predictability in the IDR process, I think we're still going to see this jockeying back and forth." A representative from a provider partner expressed a similar sentiment, saying:

> It's very hard to predict where this is going to go because you don't know where a jump is going to take you if you're not on the stable platform. And right now, we're not on a stable platform.

Similarly, we heard from an emergency medicine organization representative:

> We still see so much uncertainty that it's hard to know when [we] talk to insurer X, do we really think things are going to continue to get better. . . . That crystal ball is still pretty murky.

The uncertainty for the future also materialized as concerns about future negotiations between insurers and providers. Providers were particularly concerned that insurers will cancel contracts, even those that have not experienced a termination under the NSA. One representative from an anesthesiology group that had joined a partnership that manages networking on their behalf said:

> As we go forward, the threat is there at any point in time; even though we've joined [a networking partnership], the payers could just throw them out of network, just like they've done with our other larger groups in other states.

Similarly, a representative from an emergency medicine group with contracts that are coming up for renewal described their hesitancy with engaging in negotiations:

> One of the calculations that we have to make as a provider given this environment is that we have three- or four-year deals that are coming up for renewal this year. And we have to decide . . . do we even want to engage the payer because there's at least some risk that they could take a look at the contract and say, "You know what? Beyond not really wanting to negotiate, maybe it's time that we terminate this contract." They weren't aggressively doing that, but that might be a question that they would think about when we knock on their

> door over a renewal. So we might be a little bit more cautious about renewing the agreements that we have relative to where we would have been three or four years ago before the NSA, when that was a known and understood part of the relationship between us and payers.

More broadly, most providers who have contracts are focused on keeping them because of the perceived relative challenges in out-of-network payment under the NSA: "I would say that there's been less [providers] trying to go out of network because of this, because they recognize that it's going to be harder for them to get paid and they're going to have to fight more to get that payment if they're out of network than if they're in network."

For those that have had some contracts canceled, the concern continues. As one radiology practice representative described:

> We are scared to death that tomorrow I'm going to get a certified letter that says you're out. Once you're on war footing because someone's invaded you, you don't just go back to like a peacetime economy immediately. We have a little bit of PTSD [posttraumatic stress disorder]. This was very hard on our group.

Insurers, on the other hand, are concerned that providers will see the win rates from IDR disputes that favor providers and choose to leave their networks, initiate more payment disputes, or feel emboldened to ask for even higher in-network rates.

> The provider is going to have a huge power. They're going to win [IDR] 90 percent of the time. Even if I approach [a provider group] for a contract, they're going to want 100 percent of billed charges. They're going to want 500 or 600 percent [of Medicare rates] or whatever the heck they can get because they know. And so the big question, I think, for us is, if that win rate stays the same, do we contract with them or not?

Many insurers said that they felt that, if the IDR outcomes were not favoring the providers as much, more providers would be willing to negotiate and come in network. However, in the absence of this, they said that they believed that the incentive for providers was to stay out of network and go through the IDR process.

> I think if there were more equitable outcomes, if we were seeing more of a 50/50 result, I think we would be able to have a better negotiating conversation with some of these entities. Like it's literally a 50/50 shot if you decide to take this claim through this process. So, is it worth it? Especially with the costs associated with the arbitration being at stake. I think that that would be helpful, but because the outcome does not look like that, it does not really help or bode well for leverage. So, if I'm being cynical, I would say we'll see more of these providers exit networks and rely on the NSA to the extent that they can.

Despite all of these challenges, providers and insurers maintained that the law has the potential to work well and said that they looked forward to smoothing out implementation challenges. A representative from a provider partner praised the strengths of the written law and hoped that it would work well one day, saying:

> [The NSA as written is] a beautiful thing because you don't have the inefficiencies of appeals. You don't have the challenges of getting the health plan and all that stuff. You're protecting the patient, and you're having a third party make a determination as to reasonableness, and both parties' positions, arguably, could be viewed as reasonable. It's a beautiful thing. What's happened, though, is because of the constant ongoing delays, first caused by the gross underestimate of the number of arbitrations and then the stuff that the court threw out that CMS was doing . . . it has made the first two years an absolute mess. But if it ever was working the way it's supposed to and was conceived to work, it's a beautiful thing.

An insurer representative shared optimism about a more stable future:

> It's a wild ride . . . but CMS is going to get better at it. The reports are going to get better. The IDREs are going to get better. Plans will get better at responding. Providers will get better at responding. And hopefully it comes to contracting.

AEOBs

Overview: We also spoke with stakeholders about their experience preparing for the AEOB provision of the NSA. Under the AEOB provision of the NSA, insurers will use the information given to them by providers about the cost of care that their enrollees are planning to get to issue AEOBs in advance of patients receiving care. The AEOBs will include details on patients' expected cost-sharing requirements for a specified service or item. Although the final rules for this part of the law have not yet been released, stakeholders described how they were preparing for implementation and their expectations for how AEOBs could affect their operations, insurer-provider relationships, and patients.

Work Is Underway Among Insurers and Providers to Establish Processes for Producing AEOBs

Several insurers reported taking preemptive steps to prepare for the AEOB provisions, including partnering with providers to determine what technological and other administrative changes might be needed. One insurer highlighted this, saying:

> We also have been collaborating in a pilot with [a health care system] on trying to figure out really how the provider side of the equation will work and what their expectations are, what their capabilities are. And this is all facilitated through [an electronic medical record system]. We're participating in this pilot with a provider just to get their take on how the process should work so that we can better map out what we think we might have to do.

Another described a similar experience:

> We have a pilot running in [a region] right now to kind of do a version. We've been doing a version of AEOB to see how it works. And I think it's been successful. . . . We've tried to narrow it down to those less complex, more common services to reach a broader group.

For their part, some provider group representatives reported sharing their data with larger "health system[s] so they can include our estimate if the patient calls and says, 'What's a head CT [computed tomography scan] cost?', right? They can include what our rate is."

Overall, stakeholders reported being in a holding pattern with AEOBs until further guidance is issued by the federal government. One insurer said:

> We've done a bunch of work on the front end, and now that the agencies have pushed off the proposed rule, we've stopped all of our work on AEOBs. Because we got to a point where we just need more information before we can do any more work on it.

Another similarly described the current situation as "a balance between doing as much planning as we can but not getting ahead of technical requirements and things like that."

Stakeholders Saw Potential for AEOBs to Help Patients but Expressed Concerns over Multiple and Competing Estimates Across Tools and Requirements

Some insurers stated that AEOBs have the potential to help patients understand their out-of-pocket costs. However, they also wondered how the AEOBs would fit into the current environment with existing cost estimator tools. Insurers captured this in the following comments:

> We also have parts of the system that are currently fairly tangent to what the [A]EOB would look like that there could be some instances of duplication that wouldn't necessarily be needed, just given some of the other regulatory constructs and operations that we need to follow.

> A real interesting question is how do those tools differentiate from an advanced EOB? Yes, advanced EOB, it's kind of like more sophisticated, more data; [it's] run through an adjudication system.

Insurers also highlighted the importance of patient education and knowledge of AEOBs in order for them to be truly useful. One insurer said:

> Prior to all of the transparency and coverage part of the CAA, health plans already had in place their estimator tools, their cost tools, and they all work really well. . . . We've kept our current or previous tool running and added to it to be compliant to the mandate. . . . But [AEOB's success] depends on whether or not [patients] know it's available. And I think really there just needs to be a lot of member education, because there are different tools out there.

However, insurers also emphasized the importance of getting right when and for what services AEOBs are required. Without any limitations on when AEOBs would be required, insurers expressed concern that it would be an overwhelming administrative burden to process and send out AEOBs that could confuse patients. As two insurers described it:

> If it's something that's a member initiative, they say to their doctor, "I don't feel like I understand this. I want an AEOB for this to make sure I totally have an idea of what this is going to cost." But [if it's] just sort of mailing out millions and millions of papers, it's hard to find a really compelling argument for it.

> Every time a member schedules a service, that's a lot of information. Maybe [they should] have more of an opt-in [system] to not bombard [the patient] and make it streamlined and as least confusing as possible for members.

An insurer explained how the process of sending out AEOBs would be different and likely more difficult for them than their current schedule of releasing EOBs, with AEOBs having to be sent out faster than EOBs today, saying:

> The other interesting thing from a user experience is that today for the EOBs that actually have a dollar amount on them . . . we'll put five or ten [EOBs] or [EOBs from the] same period of time in the same envelope [and send it to patients]. . . . That doesn't work with advanced EOBs, so now you're going to kind of get onesie, twosies for each of those bundles.

Stakeholders Emphasized That Coordination Between Insurers and Providers Will Be Needed for AEOBs to Represent an Improvement over the Status Quo

Both providers and insurers are key players in the AEOB process, and stakeholders emphasized that the two groups will need to work well together to be able to provide consolidated AEOBs to patients on the timelines established in the law. An insurer explained this dynamic and highlighted the importance of the convening provider, which is the provider who is responsible for putting together the cost estimate that informs the AEOB:

> We really need that convening provider to gather all of the good faith estimates of what all the co-providers anticipate will be included in the episode of care or the service. And we really need that convening provider to send us one good faith estimate with all of the various sole providers' estimates within it. Otherwise, what would happen based on the timelines in the statute, we would have to spend that rolling AEOBs back to the member and they would be piecemeal, and they wouldn't make sense. And then the member could get confused, and then they would likely go back to the provider, and then the provider would be confused. So, if it's consolidated into one GFE that the payer receives, then the payer can then apply whatever they need to apply with the benefits and everything and give the member one advanced EOB. Otherwise, the member would have to be tying them together just because there's no time within the statute to wait on the co-providers to submit their own and then [have] the payer be the one that consolidates it.

Chapter 4. Conclusion

The goal of this study was to explore how, in the years since its enactment, the NSA has affected insurer-provider dynamics, negotiations, and payment rates. From our conversations, we heard from stakeholders about changes to negotiation processes and dynamics between insurers and providers under the law and how those changes have affected their finances. **Stakeholders described how out-of-network payments have changed under the new law, with many reporting decreases in payments.** This largely comes from decreases in the initial payments made to out-of-network providers, which, according to both providers and insurers, are often at or below the QPA. Because the vast majority of these payments are accepted by providers without further dispute, out-of-network payments should be lower under the NSA. This is particularly true for self-insured plans, where some employers and TPAs shifted their payment practices from often paying 100 percent of billed charges (to avoid a patient receiving a balance bill prior to the NSA) to using the QPA as a benchmark for payment. However, when providers did take out-of-network claims to the IDR process, they reported frequently winning, a fact corroborated by insurers and recent data releases from CMS (CMS, 2024a; Hoadley and Lucia, 2024).

Our discussions also highlighted how negotiation leverage and contracting conversations have shifted under the NSA**. Both providers and insurers reported experiencing or initiating contract terminations following the implementation of the law.** These terminations included "take-it-or-leave-it" offers from insurers who were looking to significantly reduce in-network payments for some providers. **Both providers and insurers reported lower out-of-network payments under the NSA. Providers said that the NSA has shifted leverage to the insurers** because they could use the QPA as well as the threat of the administrative burden and hassle of the IDR process in negotiations, and because providers can no longer use the threat of balance billing as leverage. In addition, while providers are winning the vast majority of IDR disputes, providers described how the IDR process timeline and implementation has favored insurers—particularly as delays in IDRE payment determinations have grown—because it allowed insurers to keep payments they would otherwise be making to providers for a longer period of time and potentially invest the money. Both providers and insurers reported, however, that some providers are coming in network, sometimes at lower negotiated prices than what they were receiving prior to the NSA. Despite this, both insurers and providers described the two groups as still far apart on desired price points for those providers that remain out of network.

The evolving environment of negotiations and payment disputes under the NSA has also led to changes in how both insurers and providers operate. All stakeholders mentioned ways in which the law has increased administrative burden. Many providers reported hiring staff to handle the IDR process or turning to outside firms for support. Insurers also reported having

an increase in administrative burden under the NSA, largely due to the IDR process. Several insurers mentioned taking on the IDR process themselves, while others have hired outside firms. The administrative burden partly involved QPA calculations, which some insurers likened to maintaining a whole new fee schedule. Insurers explained that much of the administrative costs of navigating the NSA for self-insured clients were passed on to employers through a range of fee structures, such as a straight pass-through of IDR fees and shared savings arrangements. Providers described how the NSA is putting more pressure on them to find additional revenue from other sources. Several providers described turning to hospitals for additional payments, asking for stipend or subsidy payments. Some providers also reported having to make changes to their clinical staffing, lay off staff, or reduce pay. Providers described smaller groups as being at risk of closing or consolidating.

Across our discussions with an array of discussants, **stakeholders reported that the NSA has been largely successful at eliminating surprise billing for services subject to the law. Despite a challenging implementation process that has put pressure on them financially, stakeholders continue to support the NSA** and offered suggestions for improvement, such as greater transparency and enforcement of the IDR process and QPAs. Importantly, we heard about instances of patients being erroneously balance billed because of challenges that providers and insurers have faced with getting billing and claims processing systems updated. Looking to the future, both insurers and providers described uncertainty about future negotiations and their dynamic with one another. Both expressed a need for more predictability and stability under the law and concern that, in the absence of improvements, tensions could grow and further stress their negotiating relationships. Both insurers and providers were also apprehensive about how this uncertainty could affect patient costs and access to care, particularly in rural and underserved communities.

Finally, insurers described the work that is underway to establish processes for providers and insurers to work together in the future to provide AEOBs to patients. While initial steps have been taken, all parties are waiting for the final regulations from the Departments before moving forward. Stakeholders saw the potential for AEOBs to be beneficial to patients but expressed concerns over how AEOBs would fit into the existing billing and claims processing environment, as well as the potential for multiple and competing estimates across tools and providers to ultimately be more confusing for patients than the status quo. In addition, insurers emphasized the need for the forthcoming rules to limit when and for what services AEOBs are required. Insurers were apprehensive that the administrative burden to process and send out AEOBs in the time frame specified would be overwhelming. For AEOBs to be successful, stakeholders emphasized that providers and insurers will have to work well together to produce the estimates in an efficient, timely manner and that the role of the convening provider to consolidate estimates from all providers will be critically important.

Areas for Additional Inquiry

The inaugural years of the NSA have been complicated by implementation challenges and changes brought on by a series of lawsuits in the federal courts. From the conversations we held with a wide range of stakeholders, several areas of inquiry emerged for policymakers and researchers to consider in the coming years.

First, as the federal government ramps up efforts to audit the QPA process and as rulemaking around the QPA calculation methodology stabilizes, it will be important to assess how stakeholders' perceptions of the QPA evolve. As the QPA continues to be audited by the Departments and if it becomes more widely accepted as valid by providers and IDREs, there is potential for insurers and providers to arrive at greater consensus around its utility in benchmarking payment rates for both in-network and out-of-network claims. Tracking how stakeholders perceive the QPA and whether and how this affects contract negotiations over time will be critical for understanding the broader market impact of the NSA.

Second, our discussions highlighted how the NSA might affect employers through increased administrative costs from their TPAs for managing the IDR process, use of shared savings arrangements, and changes to the discount measures used in plan marketing. Further investigation is needed to better understand the impacts of the NSA on employer-insurer/TPA relationships and the financial implications for employers as health care purchasers. This is also an integral part of understanding whether and how the NSA is affecting the overall costs of health care.

Third, we heard from providers about their reliance on hospital subsidies when payment rates are cut. The relationship between hospitals and hospital-based provider groups is an important area to watch moving forward. Notably, claims data do not capture the cost of hospital subsidies, so other sources of data are needed to fully understand cost of the NSA to the health care system. Additionally, how the relationship between hospitals and ancillary providers plays out in rural and underserved areas is of particular importance in terms of understanding how the NSA affects access to care.

Fourth, provider discussants also emphasized how the financial pressures of the NSA could lead to greater consolidation—a key area for policymakers and researchers to monitor. This could come in the form of more providers joining hospitals as employees rather than independent groups or as smaller provider groups being acquired by larger groups. The challenges that smaller groups face in navigating the IDR process and the downward pressure on both in-network and out-of-network payment rates may encourage more providers to consolidate. Similarly, future research should examine the extent to which private equity investment in the specialties providing services subject to the NSA grows or cools.

Finally, because of the evolving nature of the NSA implementation, it will be important to continue to hear from stakeholders about their experience with the IDR process, contract

negotiations, and managing changing payment rates. This can be achieved through future qualitative (e.g., discussions and focus groups) and quantitative (e.g., surveys) research.

Appendix. Discussion Topics

The discussions covered, but were not limited to, the following topics:

- Could you describe the typical structure of a contract and what your organization's contract negotiation process was like prior to the No Surprises Act?
- Has the experience of negotiation changed since the No Surprises Act was implemented? If so, how?
- Have you had network changes that have corresponded with the implementation of the No Surprises Act?
- Have there been changes in payment amounts for the services subject to provisions of the No Surprises Act? If so, to what extent are these changes driven by in-network versus out-of-network payments?
- Have you made changes to your organization's staffing in response to the No Surprises Act?
- How do you view the impact of the No Surprises Act within the broader market and health policy landscape?
- What do you foresee for insurer-provider dynamics going forward?
- If power dynamics have changed as a result of implementation of the No Surprises Act, is there anything the federal government could or should be doing to address the resulting shift in the balance of power?
- What work is underway or planned within your organization to prepare for implementation of the No Surprises Act provisions relating to advanced explanations of benefits?
    - Do you expect good faith estimates and advanced explanations of benefits to have an impact on patients? If so, what impact?

Under each of these topics, there were a series of questions and probes that were tailored as needed for each specific stakeholder group. For example, we asked providers about specialty-specific considerations (e.g., the Emergency Medical Treatment and Active Labor Act, the average cost of a claim, historical network participation rates) and about their interactions with insurers. We asked insurers about regional differences in their experiences with providers, how the NSA has affected their role as a TPA, and about their interactions with different provider groups whose services are subject to the NSA.

Abbreviations

ACA	Patient Protection and Affordable Care Act
AEOB	advanced explanation of benefits
APP	advanced practice provider
ASO	administrative services only
ASPE	Office of the Assistant Secretary for Planning and Evaluation
CAA	Consolidated Appropriations Act
CCIIO	Center for Consumer Information and Insurance Oversight
CMS	Centers for Medicare & Medicaid Services
COVID-19	coronavirus disease 2019
CRNA	certified registered nurse anesthetist
DOL	Department of Labor
EOB	explanation of benefits
ER	emergency room
GFE	good faith estimate
HHS	Department of Health and Human Services
IDR	independent dispute resolution
IDRE	independent dispute resolution entity
NSA	No Surprises Act
QPA	qualifying payment amount
TMA	Texas Medical Association
TPA	third-party administrator

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