ASPE
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

REPORT

Evaluation of the Impact of the No Surprises Act on Health Care Market Outcomes: Initial Post-Implementation Trends

Third Annual Report

The Third of Five Reports Required
by the Consolidated Appropriations Act, 2021

February 9, 2026

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation

Office of the Assistant Secretary for Planning and Evaluation

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Executive Summary

The No Surprises Act (NSA)[1] was signed into law by President Trump on December 27, 2020 to address certain kinds of "surprise" medical bills, especially in situations where patients do not have the ability to choose their provider or facility. These situations include circumstances where individuals with private health plans and coverage[2] are unknowingly or unavoidably treated by an out-of-network (OON) health care provider, emergency facility, or provider of air ambulance services.

Specifically, the NSA prohibits balance billing for: emergency items and services[3] furnished by OON providers or emergency facilities; non-emergency items and services furnished by OON providers with respect to a patient's visit to certain types of in-network health care facilities; and air ambulance services from OON air ambulance service providers.[4] In this report, these kinds of bills will be referred to as "surprise bills." Under the law, an OON provider[5] subject to the law's balance billing prohibitions generally may not charge patients with private health plans and coverage more than the patient's in-network cost-sharing requirement based on the recognized amount for non-air ambulance items and services, or the lesser of the qualifying payment amount (QPA) or billed charges for air ambulance services.[6]

Among other provisions, the law creates a process for resolving disputes over payment rates between providers and private health plans and issuers under certain circumstances and requires providers to provide "good faith estimates" (GFEs) of the expected costs of items and services to self-pay and uninsured patients before treatment in certain circumstances. The enactment of the NSA, as well as several previous state surprise billing laws, was motivated by consumer concerns about the adverse financial impacts of surprise bills.

Section 109 of the NSA requires the Secretary of Health and Human Services (HHS), in consultation with the Federal Trade Commission and Attorney General, to produce five annual reports to Congress on the

[1] The No Surprises Act was included as part of the Consolidated Appropriations Act, 2021 (P.L. 116-260, 134 Stat. 1182, Division BB, Title I).

[2] This report will use the term "private health plans and issuers" to refer to the payers regulated by the NSA which include non-federal governmental plans, and will use the term "private health plans and coverage" to refer to the products offered by plans and issuers. See Chapter 1 for additional detail on the private health plans and coverage regulated by the NSA.

[3] The NSA surprise billing provisions apply to both eligible items and services. At times in this report, we refer to items and services collectively as "services."

[4] Balance billing is when an OON provider bills for the difference between the provider's charge and the amount allowed by the health plan.

[5] In this report, "provider" refers to providers, facilities, and providers of air ambulance services that are subject to NSA requirements.

[6] The qualifying payment amount is generally the median contracted rate as of January 31, 2019, for the same or similar item or service in the same insurance market and provided by a provider in the same or similar specialty or facility of the same or similar facility type, in the geographic region in which the item or service is furnished, updated for inflation with the Consumer Price Index for Urban Consumers (CPI-U). The recognized amount (45 CFR 149.30) is the lesser of the amount billed by the provider or facility or the QPA if an applicable specified state law or All-Payer Model Agreement does not provide for a different OON rate. For air ambulance services provided by a nonparticipating provider, the cost-sharing requirement must be based on the lesser of the QPA or the billed amount.

impact of the NSA on patterns of vertical or horizontal integration, overall health care costs, and access to health care items and services. This is the third of those reports.[7]

The portions of the NSA which provide protections against surprise billing for patients with private health plans and coverage, requirements for GFEs for self-pay and uninsured patients, and mechanisms for resolving payment disputes took effect on January 1, 2022.[8] This third report extends trends in claims data (2012-2021) presented in the second report in this series into 2022, the first year after implementation of the NSA. Surprise bills are challenging to cleanly identify in claims data; therefore, we generally examine trends in all OON bills associated with emergency services provided at a health care facility (regardless of facility network status) or non-emergency items and services furnished with respect to a visit at an in-network health care facility[9], which we define as "potential surprise bills."

In 2022, the prevalence of OON bills, which is defined as the share of OON claims among all professional claims for each year from 2014 – 2022, declined 15 percent for emergency services and 11 percent for non-emergency services at in-network facilities relative to 2021. Compared to the baseline of 2019 (prior to both the COVID-19 pandemic and enactment of the NSA), there was a 24 percent and a 17 percent decline in the prevalence of OON bills for emergency services at any facility and non-emergency services at in-network facilities, respectively, in 2022. The report also includes an initial analysis of data on completed Federal Independent Dispute Resolution (IDR) disputes over payment rates between providers and private health plans and issuers. In 2023, providers won around 80% of Federal IDR determinations over disputed claims over OON emergency services and non-emergency services at in-network facilities and around 85% of IDR determinations over disputed claims of OON air ambulance services.

The financial protections under the NSA may have broader effects on health care markets, such as impacting payment rates and providers' network participation. This could influence negotiations between providers and private health plans and issuers as well as the incentives providers face to consolidate in order to maintain negotiation leverage with private health plans and issuers. This report includes an analysis of trends in consolidation in health care markets to investigate whether there is evidence of these sorts of changes.

[7] The first annual Report to Congress was posted in June 2023 (https://aspe.hhs.gov/reports/no-surprises-act-report-one) and the second annal report in November 2024 (https://aspe.hhs.gov/reports/no-surprises-act-report-two).
[8] Although the law's provisions took effect on January 1, 2022, the implementation of the payment dispute resolution process required additional time for launch. This process, referred to as the Federal independent dispute resolution (IDR) process, was launched on April 15, 2022. Certain IDR functions were suspended between August 3, 2023 and October 6, 2023.
[9] In the data, OON professional claims were considered to be "with respect to a visit at an in-network health care facility" when they were OON professional claims for services furnished within the same service dates of an in-network facility claim. However, under the NSA, OON professional claims do not have to be within the same service dates in order to be considered "with respect to a visit" to an in-network facility.

Chapter 1. Introduction and Overview

The NSA was signed into law by President Trump in 2020 and includes multiple provisions that increase the price transparency of health care in the United States. The first and current Trump Administrations have established health care price transparency as a priority, with broad transparency initiatives such as those laid out in Executive Order 13877 "Improving Price and Quality Transparency in American Healthcare to Put Patients First" signed on June 24, 2019, and Executive Order 14221 "Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information" signed on February 25, 2025.

The NSA was enacted in part to protect participants, beneficiaries, and enrollees in private health plans and coverage from surprise bills, which consumers may experience as instances of particularly opaque health care pricing; and to provide a method to resolve OON payment amount disputes between private health plans and issuers and providers in instances where the NSA applies. The NSA also furthers price transparency by requiring providers to furnish GFEs of the expected costs of items and services to self-pay and uninsured patients upon scheduling or request; if the billed charges are more than $400 higher than the GFE, the patient may dispute the charge through a specific patient-provider dispute resolution process. The NSA's provisions providing protections against surprise billing for patients with private health plans and coverage, requirements for GFEs for self-pay and uninsured patients, and mechanisms for resolving payment disputes took effect on January 1, 2022.[10]

These NSA requirements (other than those that protect self-pay and uninsured patients) apply to items and services provided to most individuals enrolled in private health plans and coverage, including:

- Employment-based group health plans, including both self-insured and fully insured plans sponsored by private employers, unions, or state and local government employers
- Individual or group health insurance coverage on or outside the Federal or State-based Exchanges
- Federal Employee Health Benefits (FEHB) plans
- Certain church plans within Internal Revenue Service jurisdiction
- Student health insurance coverage

In this report, surprise billing refers to certain situations where an individual, in addition to being charged OON cost-sharing by their plan or coverage, receives an OON bill from a provider for the difference between what the provider charges for an item or service and what the individual's private health plan or issuer will pay.[11] Surprise bills from OON providers are often for emergency or ancillary items and services when patients do not have a choice of provider. Typical examples include emergency care, anesthesia services, and diagnostic testing. These situations may occur at both OON emergency facilities (for emergency services) and at in-network facilities where a treating physician or other

[10] Although the law's provisions took effect on January 1, 2022, the implementation of the payment dispute resolution process between providers and private health plans and coverage required additional time for launch. This process, referred to as the Federal independent dispute resolution (IDR) process, was launched on April 15, 2022. Certain IDR functions were suspended various times in 2023 due to court decisions. Details about the suspensions are available: https://www.cms.gov/nosurprises/notices

[11] The term surprise bill as used in this report does not include unexpected medical bills as a result of an individual having not met their deductible, in instances where the NSA does not apply.

provider is OON (for emergency and non-emergency services). Prior to the NSA, patients frequently received OON items and services which may have resulted in a surprise bill. For large employer health plans, 18 percent of emergency department (ED) visits and 16 percent of in-network inpatient stays had at least one OON charge in 2017 (Pollitz et al., 2020). Other studies have found that 22 percent of ED visits at in-network facilities included care by OON physicians from 2014 to 2015 (Cooper and Scott Morton, 2016), and 20 percent of inpatient admissions from the ED, 14 percent of outpatient visits to the ED, and 9 percent of elective inpatient admissions involved an OON provider in 2014 (Garmon and Chartock, 2017). Surprise bills were often much higher than patients had anticipated before receiving those health care items and services. Patients may have had no way of knowing that these providers were not in their health plan's or issuer's network and might receive bills from these providers for items or services that exceed their in-network cost-sharing amount. The NSA, as well as several previously enacted state surprise billing laws, was designed to address these kinds of surprise bills (ASPE, 2021).

The NSA requires private health plans and issuers to cover certain OON bills with patient cost-sharing requirements not greater than the requirements that would apply if the provider were in-network. In the absence of a specified state law or an All-Payer Model Agreement that would determine the OON rate payable to the provider, private health plans and issuers and providers that are unable to agree on the OON rate payable to the provider after a 30-day open negotiation period may enter the Federal IDR process to arbitrate the OON rate. More details on the NSA's surprise billing provisions are included in the first annual report[12] as well as at https://www.cms.gov/nosurprises.

There are challenges in estimating the impacts of the NSA, particularly the NSA effects referenced in Section 109 of the NSA for this series of reports: impacts on vertical or horizontal integration, overall health care costs, and access to health care items and services. The surprise billing provisions took effect on January 1, 2022. However, the full impact may take time to emerge, because both providers and private health plans and issuers may have an evolving response to the provisions of the NSA and because it takes time for sufficient and complete data to accrue post-implementation of the NSA surprise billing provisions. Further, surprise bills are likely to be a relatively small proportion of total health care claims for items and services, limiting the potential for observable market-wide impact. Existing data suggest surprise bills, and therefore the law's impact, may be concentrated in a few services, such as emergency and air ambulance services. For example, the most common medical procedure codes among disputes with payment determinations in the Federal IDR system between July 1, 2023 – December 31, 2023 were ED services (59 percent) and radiology (14 percent) (The Departments of Treasury, Labor, and Health and Human Services, 2024). Therefore, these services may see significant impacts, while the majority of items and services in the health care sector may be less directly impacted by the law. Finally, the trends in the impacts that are the subject of these reports are influenced by many factors over time, including but not limited to demographic changes, technology changes that affect health care delivery, economic conditions, the COVID-19 pandemic, and health care policies that alter financial incentives. Distinguishing NSA impacts from these other influences is methodologically challenging.

[12] Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Evaluation of the Impact of the No Surprises Act on Health Care Market Outcomes: Baseline Trends and Framework for Analysis – First Annual Report. July 2023. https://aspe.hhs.gov/reports/no-surprises-act-report-one

Another challenge is changes in how the NSA is implemented. Various parties have brought lawsuits that challenged aspects of how the NSA has been implemented. Several court cases have led the Departments of the Treasury, Labor, and Health and Human Services (collectively referred to as the Departments) to pause Federal IDR processing and issue rules and guidance updating Federal IDR processes. These changes to NSA implementation could have impacts on the outcomes of the program, making it difficult to conduct a robust evaluation of the NSA.

In Chapter 2, this report describes recent trends in OON and surprise billing. Chapter 3 presents an analysis of public data on Federal IDR disputes. Chapter 4 presents recent trends in health care market consolidation. Finally, in Chapter 5, the report concludes with a description of the analyses that we aim to include in future reports and discusses related interested party discussions with private health plans and issuers and providers on how the NSA has impacted their contract negotiations.

Chapter 2. Descriptive Analysis of Trends in OON Billing

This chapter presents descriptive analyses of trends in OON billing prior to and following the implementation of the NSA (2014 to 2021 and 2022, respectively). The analysis identifies the ways in which the NSA may be changing the following key outcomes for emergency services and non-emergency services at in-network facilities: prevalence of OON bills, average total payments for OON bills, and average out-of-pocket payments for OON bills. The chapter includes information on the prevalence of OON bills for air ambulance services; however, due to the small sample, air ambulance OON total and out-of-pocket payments are not included in the findings.

All analyses use Health Care Cost Institute (HCCI) data. The sample consists of individuals under the age of 65 with employer-sponsored insurance (also referred to as commercial insurance) who received emergency services, non-emergency services at in-network facilities, and air ambulance services.[13,14] This dataset represents about a third of enrollees with commercial insurance across the United States. The prevalence of OON emergency services is defined based on Current Procedural Terminology (CPT) codes and place of service codes. When comparing average payment rates of in-network and OON [] emergency services at any facility and non-emergency services at in-network facilities, the analyses of payment rates for emergency services is limited to professional claims with emergency evaluation and management (E&M) services CPT codes.

The report uses 2019 as a benchmark year to assess the many factors that influence the changes in outcomes identified in this chapter, particularly the COVID-19 pandemic.[15] Therefore, for many of the estimates, this chapter describes (1) overall trends over time (2014 to 2022); (2) average annual changes from year to year, with a specific focus on whether the magnitude of change is greater from 2021 to 2022 compared to prior years, and (3) changes from 2019, prior to the beginning of the COVID-19 pandemic, to 2022, one year after the implementation of the NSA. Although the estimates presented in this Report are descriptive and include only one full year of data after NSA surprise billing provisions went into effect, they nonetheless allow for an identification of early changes in outcomes that may be affected by the NSA surprise billing provisions.

Key findings from analyses of the HCCI data include the following:

- From 2014 to 2022, the number of patients who received OON bills declined significantly for both emergency services and non-emergency services at in-network facilities.
- The prevalence of OON bills in 2022 was lower for services that were covered under the NSA surprise billing provisions than in prior years.
    - Between 2021 and 2022, one year after the NSA went into effect, the prevalence of OON bills declined 15 percent for emergency services and 11 percent for non-emergency services at in-network facilities.

[13] Due to the low prevalence of air ambulance services, total and out-of-pocket payments are not presented for air ambulance services.
[14] HCCI data includes enrollment and claims information for over 55 million commercially insured individuals per year, including from large national insurers that participate in HCCI across the entire sample period.
[15] The COVID-19 pandemic resulted in disruptions to health care in 2020, including triggering a dramatic reduction in health care utilization that did not return to previous levels for several years.

    - Compared to 2019, prior to the COVID-19 pandemic, there were 24 percent and 17 percent declines in OON bills for emergency services at any facility and non-emergency services at in-network facilities, respectively, in 2022.
- For all services covered under the NSA, average total payments and average out-of-pocket payments for OON bills declined over time.
- The average annual decline for OON total payments was greatest in 2022 compared to 2021 for both emergency services and non-emergency services at in-network facilities (28 percent and 21 percent, respectively). Declines in OON total payments are also observed in 2022 compared to 2019, one year prior to the COVID-19 pandemic, for both emergency services and non-emergency services covered by the NSA (38 percent and 35 percent, respectively).
- The average annual decline for OON out-of-pocket payments between 2014 and 2022 was greatest in 2022 compared to 2021 for both emergency services and non-emergency services at in-network facilities (29 and 28 percent, respectively). Compared to 2019, the average out-of-pocket payments for OON bills declined 54 percent for emergency services and 32 percent for non-emergency services at in-network facilities.
- The observed declines in OON bills for total average payments and average out-of-pocket payments for services covered under the NSA may have been influenced by the COVID-19 pandemic; however, the larger per-year decline in these outcomes between 2021 and 2022 suggests possible impacts from the NSA. Analyses with additional years of data and statistical methods that account for confounding factors will be necessary to identify the extent to which identified effects can be causally attributed to the NSA.

Prevalence of OON Bills Among Patients and Overall Claims

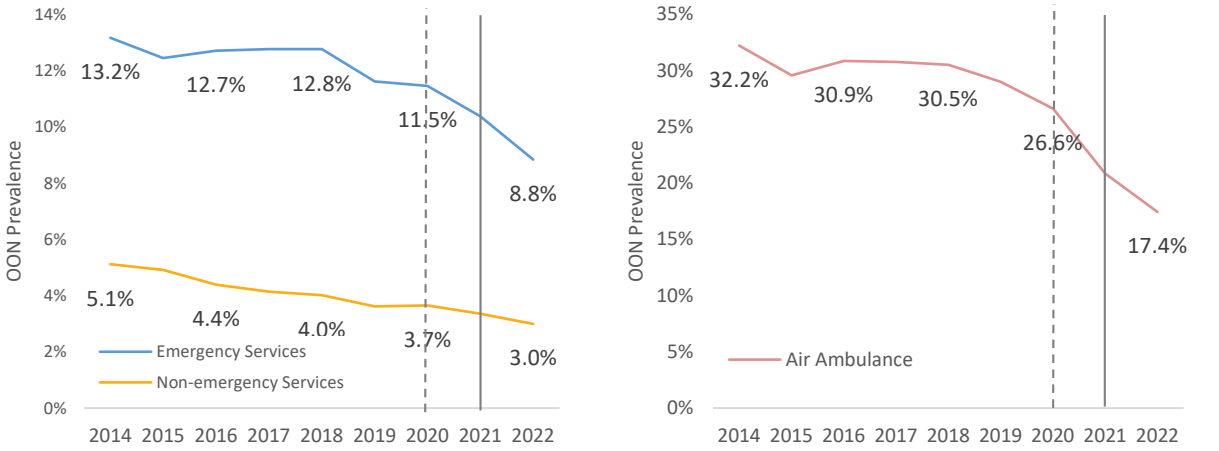
In 2014, about 1 million patients received an OON bill for emergency services, which represents about 17 percent of patients who received emergency services in the HCCI dataset.[16] This estimate declined to about 500,000 in 2022, representing about 11 percent of patients receiving emergency services in the HCCI dataset. During the same period, the share of patients who received an OON bill for non-emergency services at in-network facilities declined from about 8 percent (about 1 million patients) in 2014 to about 6 percent (about 600,000 patients) in 2022.[17]

Figure 2-1 presents the prevalence of OON bills as the share of OON claims among all professional claims for each year from 2014 – 2022, by type of service. Although there are declines in the prevalence of OON bills pre-NSA (from 2014 to 2021), the average annual percentage change is greater after the NSA's enactment at the end of 2020. From 2021 to 2022, there was a 15 percent decline in the prevalence of OON bills for emergency services, an 11 percent decline for non-emergency services at in-network facilities, and about a 16 percent decline for air ambulance services. The COVID-19 pandemic may have affected these estimates, so it is necessary to compare the prevalence of OON bills after implementation of the NSA in 2022 with the prevalence prior to the pandemic. Results show that compared to 2019, OON prevalence in 2022 was 24 percent, 17 percent, and 40 percent lower for emergency services, non-emergency services at in-network facilities, and air ambulance services, respectively.

[16] The denominator is the total number of patients in the HCCI dataset who received emergency services.
[17] The denominator is the total number of patients in the HCCI dataset who received non-emergency services at in-network facilities.

It is possible that some of the earlier declines in the prevalence of OON bills, which generally began in 2017, may have been driven by states enacting various balance billing laws.[18] Between 2020 and 2021, the observed declines in the prevalence of OON bills may have been driven partly in anticipation of the NSA surprise billing provisions going into effect in 2022, among other factors.

Figure 2-1 – Prevalence of OON Bills by Type of Service, 2014–2022



Source: Analysis of Health Care Cost Institute 2.0 data.
Notes: The dashed vertical line indicates the last year before the passage of the NSA (in December 2020), and the solid vertical line indicates the last year before the implementation of the NSA, which began in January 2022.
OON = Out-of-Network

As noted above, a number of states had surprise billing protections prior to the implementation of the NSA; however, most self-insured plans (that is, employer-sponsored plans for which the employer generally carries the plan's claims risk) were not subject to these state policies.[19] Therefore, examining the prevalence of OON bills separately by type of health plan provides insights into the potential impacts of the NSA, which requires all plans – including self-insured plans – to follow the surprise billing provisions. Preliminary analyses not featured in this Report suggest that self-insured plans had a lower prevalence of OON bills in both 2021 and 2022,[20] but the rate of decline in OON bills was greater for self-insured plans than fully insured plans (that is, employer-sponsored plans for which an issuer of coverage carries the plan's claims risk) for emergency services and non-emergency services at in-

[18] Some states had different approaches to address surprise or balance billing: California, Connecticut, Florida, Illinois, Maryland, and New York had comprehensive surprise or balance billing protections as of 2017; Colorado, Delaware, Indiana, Iowa, Massachusetts, Mississippi, New Hampshire, New Jersey, New Mexico, North Carolina, Pennsylvania, Rhode Island, Texas, Vermont, and West Virginia had limited protections as of 2017; Georgia, Maine, Michigan, Ohio, Oregon, Virginia, Washington, Arizona, Minnesota, Nebraska, and Nevada enacted some protections between 2017 and 2021. All other states had no protections for surprise or balance bills.
[19] These state laws apply only to health plans and issuers regulated by state agencies and do not apply to most self-insured employer-sponsored plans that are regulated under the federal Employee Retirement Income Security Act (ERISA). The NSA defers to state balance billing laws when the state law provides at least the same level of consumer protection as the NSA.
[20] Self-insured plans generally have larger networks than fully insured plans (Graves, et al., 2020), which may explain our finding of fully insured plans having a higher prevalence of OON bills.

network facilities from 2021 to 2022. This suggests that the NSA surprise billing provisions had the greatest impact on plans that were not subject to state surprise billing laws.

Additional preliminary analyses suggest that health care providers in the highest quintile of prevalence of OON claims historically (from 2014 to 2019) are driving the reductions in OON prevalence.[21] In addition, there are no differences in OON prevalence rates by patient characteristics, specifically by region, age, sex, insurance type, and geographic area (rural or urban) in the share of patients having any OON bills. All patient groups experienced a decline in OON bills over time, with the largest decline occurring between 2021 and 2022 compared to previous years.

Average Total Per-Claim Payments for OON Services Regulated by the NSA

The average total payments per OON claim ("per-claim OON payment")[22] for emergency services and non-emergency services received at in-network facilities, inflation-adjusted to 2019 dollars, were generally steady or rising from 2014 to 2017, after which they began to decrease (see Table 2-1). As expected, the OON payments were higher than in-network payments for both emergency and non-emergency services, on average, until 2022, at which point OON payments for non-emergency services fell below in-network payments.

Moreover, as expected, the average payments for services covered by the NSA decreased at a faster rate after enactment (12/27/2020) and then again after implementation (1/1/2022) of the NSA surprise billing provisions. Between 2021, one year before the NSA went into effect, and 2022, there was a steep decline in average total per-claim OON payments at in-network facilities for both emergency E&M services and non-emergency services (28 percent and 21 percent decline, respectively). These declines occurred amid a general rise in prices for medical care and hospital and related services from 2021 to 2022.[23] Compared to 2019, just prior to the COVID-19 pandemic, there was a 38 percent decline in OON total average payment per claim for emergency E&M services and a 35 percent decline for non-emergency services at in-network facilities. This steeper decline for OON payments means that the gap between OON payments and in-network payments narrowed over time.

[21] All National Provider Identifiers (NPIs) that billed over 500 claims between 2014 and 2019 were grouped into quintiles based on their average OON prevalence between 2014 and 2019 for emergency services at any facility and non-emergency services at in-network facility, with quintile 1 having the lowest OON prevalence and quintile 5 the highest.

[22] Total payments include the sum of payments for each claim (i.e., plan and patient cost-sharing).

[23] Prices for medical care and hospital and related services increased from December 2021 to December 2022 (4 percent and 4.6 percent, respectively). For more information, please see here: Consumer Price Index: 2022 in review : The Economics Daily: U.S. Bureau of Labor Statistics

Table 2-1 – Inflation-Adjusted Average Per-Claim Total Payments by Service, 2014 – 2022

	2014	2015	2016	2017	2018	2019	2020	2021	2022
Emergency Services									
In-Network Payments	$236	$254	$266	$270	$276	$278	$282	$286	$256
OON Payments	$508	$531	$524	$545	$480	$450	$415	$386	$280
Annual % Change for OON Payments*		4.5%	-1.2%	4.0%	-12.0%	-6.3%	-7.6%	-7.0%	-27.5%
% Change OON (2019 – 2022)									-37.7%
Non-Emergency Services at In-Network Facilities									
In-Network Payments	$186	$191	$193	$193	$195	$196	$202	$200	$190
OON Payments	$276	$284	$297	$299	$280	$282	$259	$233	$184
Annual % Change for OON Payments*		2.9%	4.8%	0.4%	-6.2%	0.6%	-8.0%	-10.1%	-21.1%
% Change OON (2019 – 2022)									-34.7%

Notes: *Annual percent change is calculated using the previous year estimate as the base year. For example, the annual percent change for 2022 for OON emergency services is calculated based on the 2021 OON estimate for emergency services with the following formula = ($280 - $386)/$386) and then multiplied by 100. Payments are inflation adjusted to 2019 dollars using the annual average CPI-U.
OON = Out-of-Network

Table 2-2 and Figure 2-2 show the average per-claim total payments for in-network and OON services, separately for self-insured and fully insured health plans. The decline in average OON total claims payments over time is particularly dramatic for self-insured plans, where average total per-claim payments fell from about $559 per claim in 2014 to about $292 per claim in 2022. The largest annual decline for emergency E&M services and non-emergency services received at in-network facilities was in 2022 compared to 2021 for both self-insured plans (31 percent and 25 percent, respectively) and fully insured plans (16 percent and 11 percent, respectively). In-network per-claim payments also decreased, though more modestly from 2021 to 2022, for both self-insured and fully-insured in-network claims (13 and 6 percent, respectively).

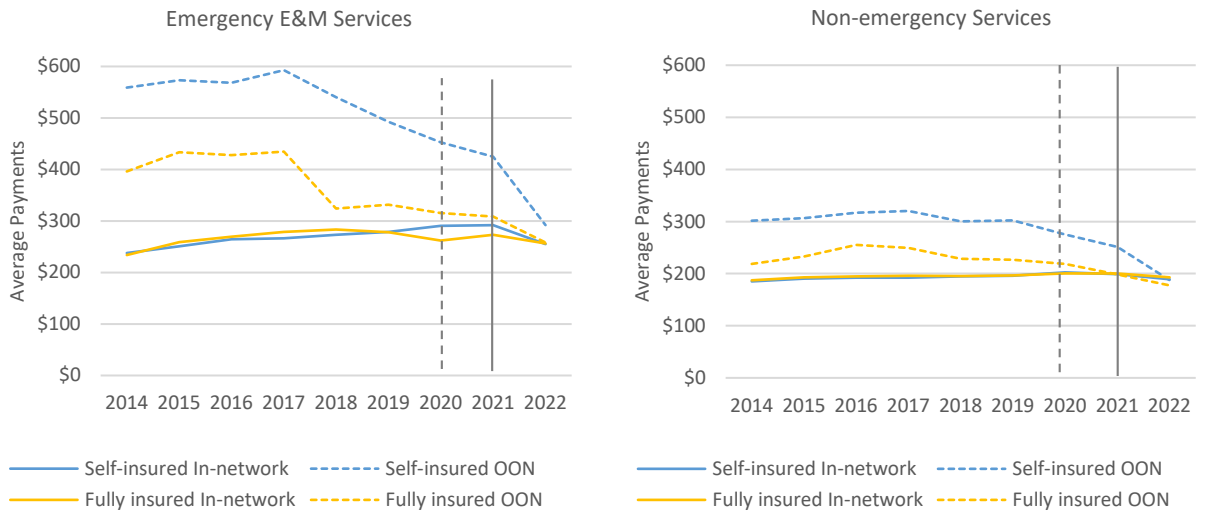
The declines in reimbursement during this period may have been influenced by a number of factors, including the COVID-19 pandemic. However, between 2019, just before the COVID-19 pandemic began, and 2022, one year after the implementation of the NSA, there were also significant declines in the average total per-claim payment for both self-insured and fully insured plans. Among self-insured plans, average total per-claim payments declined by 41 percent for emergency E&M services and 38 percent for non-emergency services at in-network facilities between 2019 and 2022. The trends were similar among fully insured plans, though the magnitude of difference was smaller, with average total payments declining about 22 percent for both emergency E&M services and non-emergency services from 2019 to 2022.

Table 2-2 – Inflation-Adjusted Average Per-Claim Total Payments for In-network and OON Services, by Plan Type, 2014 – 2022

	2014	2015	2016	2017	2018	2019	2020	2021	2022
Self-insured Plans									
Emergency E&M Services									
In-Network Total Payments	$238	$251	$264	$266	$273	$279	$291	$292	$255
OON Total Payments	$559	$573	$568	$593	$540	$493	$452	$425	$292
Annual % Change for OON Payments*		2.6%	-0.9%	4.3%	-8.9%	-8.8%	-8.1%	-6.1%	-31.3%
% Change OON (2019 – 2022)									-40.7%
Non-Emergency Services at In-Network facilities									
In-Network Total Payments	$185	$191	$192	$192	$195	$196	$202	$199	$189
OON Total Payments	$302	$306	$317	$320	$300	$302	$275	$251	$188
Annual % Change for OON Payments*		1.5%	3.5%	1.0%	-6.2%	0.6%	-9.0%	-8.7%	-25.3%
% Change OON (2019 – 2022)									-37.9%
Fully Insured Plans									
Emergency E&M Services									
In-Network Total Payments	$234	$259	$270	$279	$283	$278	$262	$273	$256
OON Total Payments	$396	$433	$428	$435	$324	$332	$316	$308	$258
Annual % Change for OON Payments		9.4%	-1.3%	1.6%	-25.4%	2.3%	-4.8%	-2.3%	-16.3%
% Change OON (2019 – 2022)									-22.2%
Non-Emergency Services at In-Network Facilities									
In-Network Total Payments	$187	$193	$195	$196	$195	$197	$200	$200	$193
OON Total Payments	$219	$233	$255	$249	$228	$227	$219	$198	$177
Annual % Change for OON Payments		6.3%	9.7%	-2.3%	-8.4%	-0.8%	-3.5%	-9.3%	-10.6%
% Change OON (2019 – 2022)									-21.7%

Source: Analysis of Health Care Cost Institute 2.0 data.
Notes: *Annual percent change is calculated using the previous year estimate as the base year with following formula = (y2-y1)/y1 and then multiplied by 100. Payments are inflation adjusted to 2019 dollars using the annual average CPI-U.
E&M = Evaluation and Management
OON = Out-of-Network

Figure 2-2 – Inflation-Adjusted Average Per-Claim Total Payments for In-Network and OON Services, by Plan Type, 2014 – 2022



Source: Analysis of Health Care Cost Institute 2.0 data.
Notes: The dashed vertical line indicates the last year before the passage of the NSA (in December 2020), and the solid vertical line indicates the last year before the implementation of the NSA (started in January 2022). Payments are inflation adjusted to 2019 dollars using the annual average CPI-U.
E&M = Evaluation and Management
OON = Out-of-Network

Average Out-Of-Pocket Payments for OON Services Regulated by the NSA

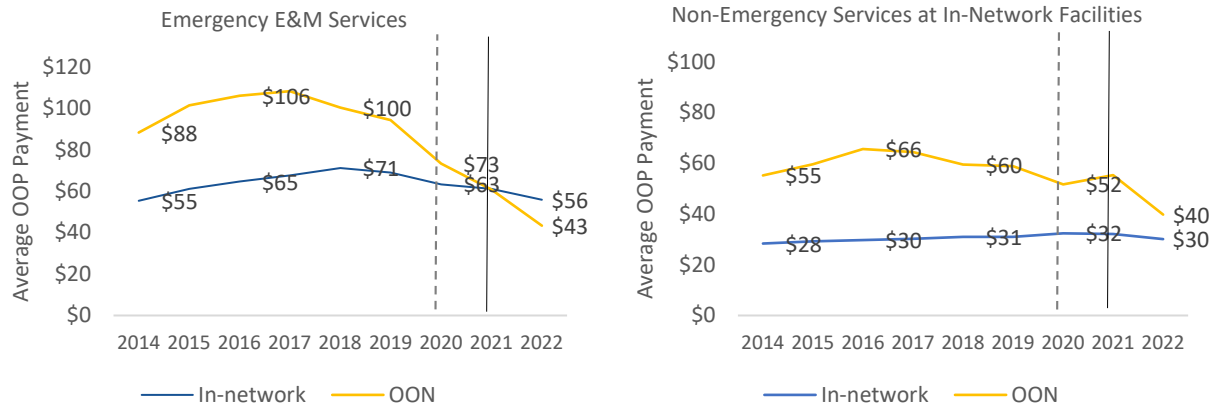
Similar to OON total per-claim payments, average out-of-pocket payments for OON bills subject to the NSA surprise billing provisions (emergency E&M services and non-emergency services at in-network facilities) were increasing from 2014 to about 2017, after which they began declining. The magnitude of the decline was greatest between 2021 and 2022 for both emergency services and non-emergency services at in-network facilities (about 29 percent and 28 percent respectively). Compared to 2019, there was a decline of 54 percent in average out-of-pocket payments for OON emergency E&M services and 32 percent in average out-of-pocket payments for OON non-emergency services at in-network facilities.

Table 2-3 – Inflation-Adjusted Average Out-Of-Pocket Payments for OON Bills, by Type of Service, 2014 – 2022

	2014	2015	2016	2017	2018	2019	2020	2021	2022
Emergency Services									
In-Network OOP Payments	$55	$61	$65	$68	$71	$69	$63	$61	$56
OON OOP Payments	$88	$101	$106	$108	$100	$94	$73	$61	$43
Annual % Change for OON OOP Payments*	-	14.7%	4.6%	2.1%	-7.3%	-6.0%	-22.3%	-17.0%	-28.7%
% Change OON (2019 – 2022)									-54.0%
Non-Emergency Services at In-Network Facilities									
In-Network OOP Payments	$28	$29	$30	$30	$31	$31	$32	$32	$30
OON OOP Payments	$55	$60	$66	$64	$60	$59	$52	$55	$40
Annual % Change for OON OOP Payments*		7.8%	10.1%	-1.9%	-7.6%	-1.0%	-12.2%	7.1%	-28.1%
% Change OON (2019 – 2022)									-32.4%

Source: Analysis of Health Care Cost Institute 2.0 data.
Notes: *Annual percent change is calculated using the previous year estimate as the base year. For example, the annual percent change for 2022 for OON emergency services is calculated based on the 2021 OON estimate for emergency services with the following formula = ($43-$61)/$61) and then multiplied by 100. Payments are inflation adjusted to 2019 dollars using the annual average CPI-U.
OON = Out-of-Network
OOP = Out-of-Pocket

Figure 2-3 – Inflation-Adjusted Average Out-Of-Pocket Payments for Emergency and Non-Emergency Services, 2014 – 2022



Source: Analysis of Health Care Cost Institute 2.0 data.
Notes: The dashed vertical line indicates the last year before the passage of the NSA (in December 2020), and the solid vertical line indicates the last year before the implementation of the NSA (started in January 2022). Payments are inflation adjusted to 2019 dollars using the annual average CPI-U.
E&M = Evaluation and Management
OON = Out-of-Network
OOP = Out-of-Pocket

As expected, self-insured plans had greater declines in average per-claim out-of-pocket payments for all services subject to the NSA compared to fully insured plans (Table 2-4 and Figure 2-4). As with total payments, OON average out-of-pocket payments for self-insured plans generally increased in early years of our study and began to decline in later years, going from about $109 average out-of-pocket payment in 2014 to about $45 in 2022 for emergency E&M services and $57 to $40 for non-emergency services at in-network facilities. The magnitude of the decline was greatest between 2021 and 2022 for emergency services and non-emergency services covered by the NSA (34 percent and 32 percent respectively). Compared to 2019, a year before the beginning of the COVID-19 pandemic, out-of-pocket payments per claim declined by 57 percent for emergency E&M services and 34 percent for non-emergency services at in-network facilities in 2022.

Among fully insured plans, the greatest average annual decline was in 2022, with average out-of-pocket payments for OON bills falling about 11 percent for emergency services and 21 percent for non-emergency services at in-network facilities. Compared to 2019, prior to the COVID-19 pandemic, the decline in 2022 was 37 percent and 29 percent for emergency services and non-emergency services, respectively.

Table 2-4 – Inflation-Adjusted Average Out-of-Pocket Payments for In-network and OON Services, by Plan Type, 2014 - 2022

	2014	2015	2016	2017	2018	2019	2020	2021	2022
Self-insured Plans									
Emergency E&M Services									
In-Network Total Payments	$52	$55	$59	$61	$65	$64	$62	$59	$51
OON Total Payments	$109	$122	$123	$122	$114	$105	$83	$68	$45
Annual % Change for OON Payments*		12.0%	1.0%	-0.5%	-7.1%	-7.3%	-21.5%	-17.4%	-34.4%
% Change OON (2019 – 2022)									-57.4%
Non-Emergency Services at In-Network Facilities									
In-Network Total Payments	$26	$27	$28	$28	$29	$30	$31	$30	$28
OON Total Payments	$57	$61	$67	$65	$60	$60	$53	$58	$40
Annual % Change for OON Payments*		6.1%	9.8%	-1.8%	-7.7%	-0.4%	-11.9%	10.2%	-31.6%
% Change OON (2019 – 2022)									-33.5%
Fully Insured Plans									
Emergency E&M Services									
In-Network Total Payments	$63	$73	$76	$81	$86	$81	$65	$66	$65
OON Total Payments	$44	$56	$70	$77	$67	$65	$48	$46	$41
Annual % Change for OON Payments*		25.7%	25.2%	9.8%	-13.0%	-3.4%	-25.2%	-5.2%	-11.0%
% Change OON (2019 – 2022)									-36.8%
Non-Emergency Services at In-Network Facilities									
In-Network Total Payments	$33	$33	$34	$35	$36	$34	$36	$36	$34
OON Total Payments	$51	$58	$64	$62	$58	$56	$49	$50	$40
Annual % Change for OON Payments*		12.1%	11.1%	-2.3%	-7.6%	-3.0%	-12.9%	2.3%	-20.5%
% Change OON (2019 – 2022)									-29.2%

Source: Analysis of Health Care Cost Institute 2.0 data.

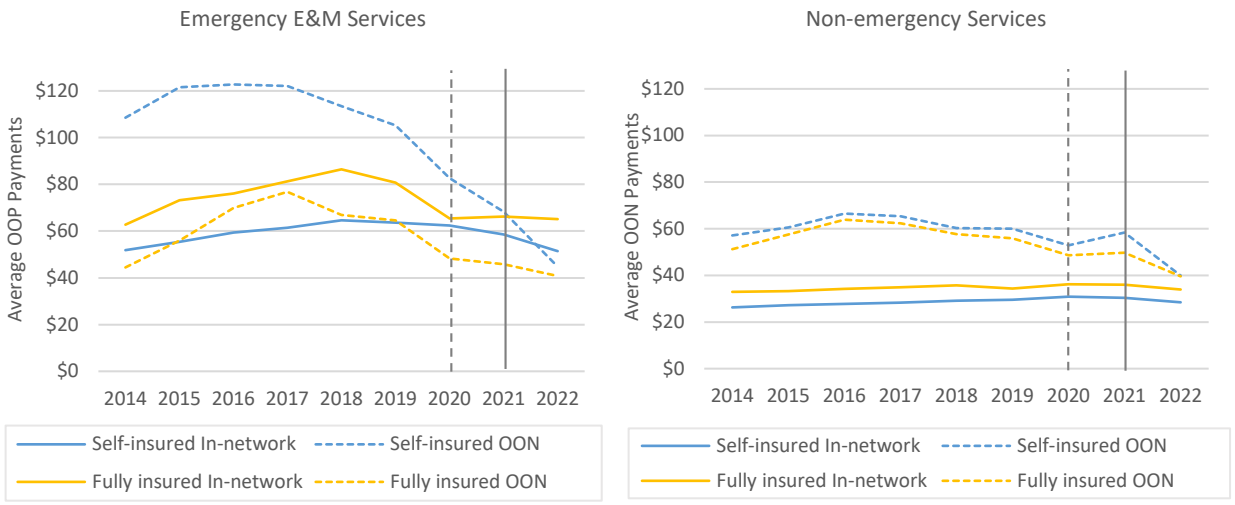
Notes: *Annual percent change is calculated using the previous year estimate as the base year. For example, the annual percent change for 2022 for OON emergency services is calculated based on the 2021 OON estimate for emergency services with the following formula = (y2 – y1)/y1. Payments are inflation adjusted to 2019 dollars using the annual average CPI-U.

E&M = Evaluation and Management

OON = Out-of-Network

OOP = Out-of-Pocket

Figure 2-4 – Inflation-Adjusted Average Per-Claim OOP Payments for In-Network and OON Services, by Funding Type



Source: Analysis of Health Care Cost Institute 2.0 data
Notes: The dashed vertical line indicates the last year before the passage of the NSA (in December 2020), and the solid vertical line indicates the last year before the implementation of the NSA (started in January 2022). Payments are inflation adjusted to 2019 dollars using the annual average CPI-U.
E&M = Evaluation and Management
OON = Out-of-Network
OOP = Out-of-Pocket

Chapter 3. Qualitative and Quantitative Findings on the Federal IDR Process

The NSA established the Federal independent dispute resolution (IDR) process as an arbitration process to settle disputes over OON payments between private health plans and issuers and providers absent an applicable specified state law or All-Payer Model Agreement.[24] This chapter discusses the Federal IDR process, briefly describes perspectives of interested parties (that is, provider groups, insurance firms, and administrative partners often hired by these two parties) on the Federal IDR process, and presents the results of analysis of the IDR Public Use Files (PUFs) conducted by RAND on behalf of ASPE.

Key Findings

Key findings in this chapter include:

- Surveys of health insurance issuers estimate that the vast majority of NSA-eligible claims were not submitted to the Federal IDR process in the first three quarters of 2023.[25]
- Both providers and private health plans and issuers interviewed by RAND reported that going through the Federal IDR process was costly and time-consuming. Providers also reported that independent providers and smaller provider groups had difficulty using the Federal IDR process.
- In 2023, four large provider firms affiliated with private equity firms were responsible for over two-thirds of the IDR disputes over OON claims closed in 2023.
- Providers expressed concern about the lack of transparency surrounding the calculations of QPAs and reported they were sometimes given QPAs lower than Medicare rates, which made them skeptical that QPAs were being calculated correctly.
- Providers and private health plans and issuers interviewed by RAND expressed differing views on the ramifications of the IDR process for contract negotiations between providers and private health plans and issuers.
- In 2023, providers won around 80 percent of IDR disputes over OON claims for emergency services, and for OON non-emergency services at in-network facilities and around 85 percent of IDR disputes over OON air ambulance services.
- The number of IDR disputes has been substantially higher than originally predicted. In 2022, the Departments estimated that 17,000 IDR disputes were expected to be submitted annually.[26] The IDR PUFs for 2023, however, contain 209,286 unique disputes, or approximately 12 times as many as expected.

[24] The Departments first issued an interim final rule for the IDR process in October 2021 and issued a final rule in August 2022. For further details, please see: https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets.

[25] AHIP (2022). No Surprises Act Prevents More than 9 Million Surprise Bills Since January 2022. https://www.ahip.org/resources/no-surprises-act-prevents-more-than-9-million-surprise-bills-since-january-2022; AHIP (2024). No Surprises Act Continues to Prevent More than 1 Million Surprise Bills Per Month, While Provider Networks Grow. https://www.ahip.org/resources/no-surprises-act-continues-to-prevent-more-than-1-million-surprise-bills-per-month-while-provider-networks-grow.

[26] See 86 FR 55980 (Oct. 7, 2021)

- IDR disputes closed in 2023 generally took longer to adjudicate than the timeline laid out in the NSA statute and regulations.[27] The statute and regulations allow for up to 39 business days between IDR initiation and the final payment determination by the certified IDR entity (IDRE) and allow for timeline modifications at the discretion of the Departments under certain circumstances.[28] On September 7, 2022, the Departments announced that they were utilizing this timeline modification authority to allow IDREs additional time to collect information and evaluate the eligibility of disputes. In 2023, the mean length of time for determination for IDR disputes involving OON emergency services and non-emergency services at in-network facilities was 91 days and the median was 73 days. Air ambulance IDR disputes had similar lengths of time for determination: a mean of 86 days and a median of 66 days.
- Median QPAs were mostly above Medicare rates but, for some procedure codes, over a third were below local Medicare rates.
- Median payment determinations were markedly higher than median OON payment rates in the HCCI commercial claims database.

Overall, the evidence here suggests that in 2023, the Federal IDR process was being used by some large, well-resourced provider firms who have been successful in receiving higher payment rates for their OON services than the initial payments offered by private health plans or issuers. Smaller provider groups, however, reported that they were not using the Federal IDR process due to the costs of participation, the length of time it takes to reach a determination, and delays in receiving payment for their services.

The IDR Process Under the NSA

When a patient incurs an OON bill subject to the NSA, the provider may submit a claim to the patient's private health plan or issuer. The private health plan or issuer must make an initial payment or issue a notice of denial of payment to the provider within 30 calendar days of receipt of necessary claim information.[29] If the provider disagrees with the rate offered by the private health plan or issuer, they have 30 business days to initiate an open negotiation period also lasting 30 business days, during which the provider and private health plan or issuer must engage in good faith negotiations and attempt to settle the payment dispute. Figure 3-1 provides a visual representation of the IDR timeline.

[27] Certain IDR functions were suspended various times in 2023 due to court decisions. Details about the suspensions are available: https://www.cms.gov/nosurprises/notices.
[28] See 42 U.S. Code § 300gg–111(c)(9)
[29] For air ambulance services, this 30-day calendar period begins on the date that the provider submits a claim (*Texas Medical Association, et al. v. United States Department of Health and Human Services et a*l., Case No. 6:22-cv450-JDK). For non-air-ambulance items and services, this 30-calendar-day period begins on the date that the plan or issuer receives the information necessary to decide a claim for payment for the services (45 CFR 149.110(b)(3)(iv)(A)).

Figure 3-1 – Visual Representation of the IDR Timeline

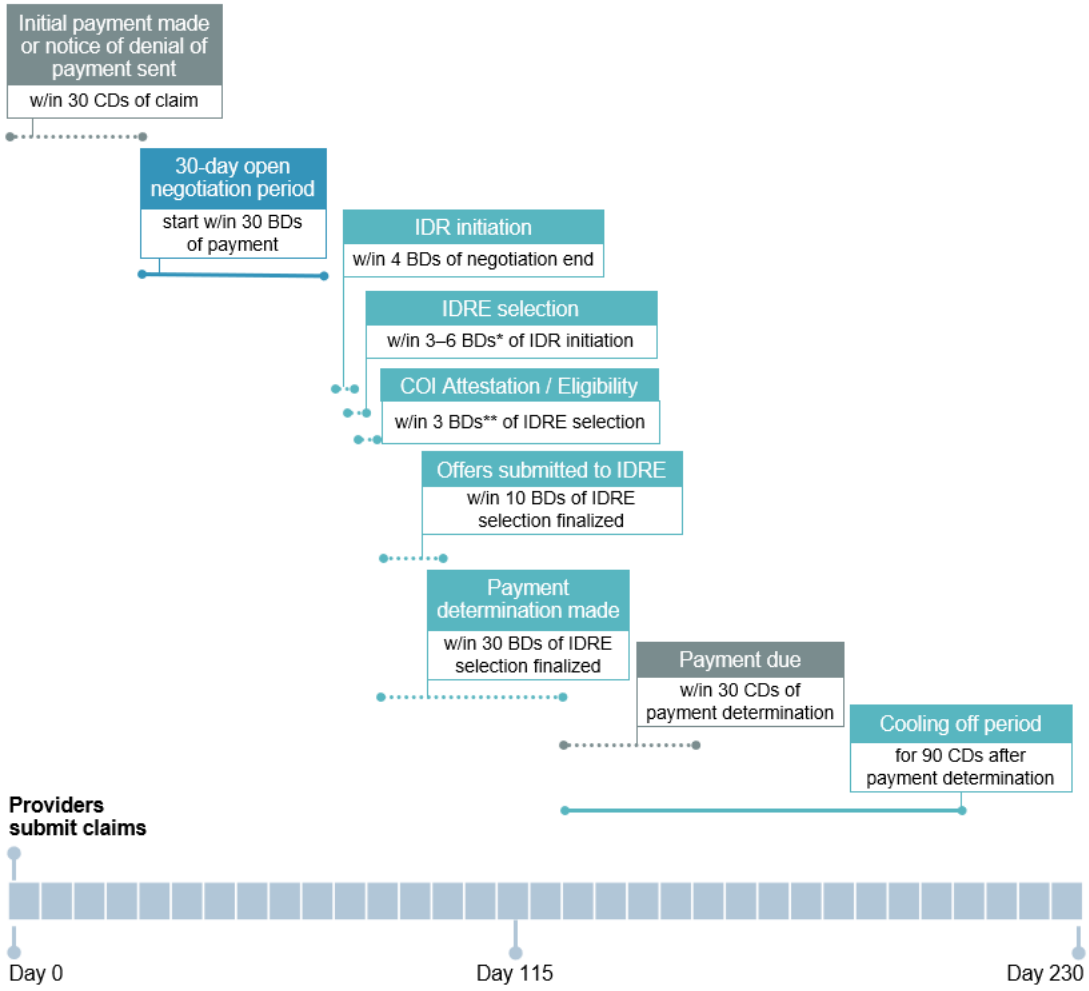


Figure by RAND. Source: https://www.cms.gov/files/document/federal-independent-dispute-resolution-guidance-disputing-parties.pdf and https://www.cms.gov/files/document/independent-dispute-resolution-idr-timeline-claims.pdf.
Notes: *If parties do not agree on an IDRE within 3 business days, the Departments select an IDRE within 6 business days of IDR initiation. **A selected IDRE has 3 business days to respond to their selection and complete a conflict of interest statement. Once the IDRE has attested that they have no conflicts, the IDRE selection is finalized. 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 gray block in the scale at bottom represents 7 calendar days.
BD = Business Day
CD = Calendar Day
IDR = Independent Dispute Resolution
IDRE = IDR Entity
w/in = within

If the two parties do not resolve the dispute during this open negotiation period, either the provider or private health plans and issuers can initiate the Federal IDR process by submitting the claim to the

Federal IDR portal and selecting an IDRE to independently arbitrate and resolve the payment dispute.[30] Both disputing parties then pay a non-refundable administrative fee[31] and a certified IDRE fee[32], [33] and submit an offer that represents what the party believes to be the appropriate OON rate for the dispute to the IDRE alongside any additional information about the claim and dispute that they would like to provide. If one party fails to submit an offer or pay their fees, a default decision is made in favor of the party that successfully submitted their offer and paid their fees, and the IDRE issues a final decision ("payment determination"). For disputes where both parties submit offers and fees, the IDRE then reviews the offers and information provided by the parties and issues a payment determination.

The IDRE must consider several factors, if submitted, when making their decision, including the QPA for the disputed service. The QPA is calculated by the private health plan or issuer and is the median contracted rate of the item or service provided in the same or similar specialty or facility of the same or similar facility type for a defined geographic area and insurer market as of 2019 and updated by economy-wide inflation.[34] Additional factors that the IDRE must consider if submitted include the provider's level of training, experience, and quality; provider market share; patient acuity; and demonstration of good faith efforts to enter into network agreements. IDREs also must consider any additional information submitted by a party that is relevant to the party's offer, so long as that information does not contain prohibited factors (such as usual and customary charges, billed charges, or rates paid by a public payor).

The IDRE must select one of the two submitted offers.[35] The non-prevailing party is responsible for paying the certified IDRE fee while the prevailing party is refunded their certified IDRE fee. Both parties must pay the administrative fee. If the offer selected by the IDRE is higher than the initial payment made by the private health plan or issuer and any cost-sharing paid by the patient, the private health plan or issuer must pay the provider the difference between the initial payment and cost-sharing amounts and the IDRE's payment determination. Or, if the offer selected by the IDRE is lower than the initial payment made by the private health plan or issuer and any cost-sharing paid by the patient, the provider must

[30] The Federal IDR process does not apply in cases in which a specified state law or All-Payer Model Agreement applies. In some states, there is a bifurcated system where some disputes go through the state process and some go through the federal IDR process. For more information, please see: https://www.cms.gov/files/document/caa-federal-idr-applicability-chart.pdf.

[31] For much of 2023, the IDR administrative fee was set at $350. Following a court decision vacating this fee, the fee was lowered to $50 for disputes initiated between August 3, 2023, and the end of 2023. Please see: https://www.cms.gov/files/document/idr-admin-fees-faqs-081123-508.pdf-0. In December 2023, the administrative fee was raised to $115 for disputes initiated in 2024 (https://www.cms.gov/newsroom/fact-sheets/federal-independent-dispute-resolution-idr-process-administrative-fee-and-certified-idr-entity-fee).

[32] The median IDRE fee in the IDR PUFs analyzed by RAND was $395 and the maximum IDRE fee was $1,340.

[33] In 2024, IDRE fees ranged from $200 to $840 for single determinations and $268 to $1,173 for batched determinations. For batched determinations with more than 25 line items, IDREs can set a fixed fee ranging from $75 to $250 for each increment of 25 dispute line items, beginning with the 26th line item. Please see: https://www.cms.gov/newsroom/fact-sheets/federal-independent-dispute-resolution-idr-process-administrative-fee-and-certified-idr-entity-fee.

[34] CMS, Qualifying Payment Amount Calculation Methodology, December 2021. https://www.cms.gov/files/document/caaqualifying-payment-amount-calculation-methodology.pdf. The *TMA III* order vacated certain provisions of the regulation establishing the methodology for calculating the QPA: https://www.cms.gov/nosurprises/notices (September 21, 2023).

[35] This is often referred to as "baseball style" or "final offer" arbitration.

pay back the private health plan or issuer the difference between the initial payment and cost-sharing amounts and the IDRE's payment determination.

After a payment determination is rendered, the two parties enter into a 90-calendar day cooling off period, during which the initiating party for the prior IDR dispute cannot submit a subsequent Federal IDR dispute with the same opposing party to the Federal 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 Federal IDR process within 30 business days following the end of the 90-day cooling off period.

Surveys of health insurance organizations (in their roles as issuers and/or third-party administrators [TPAs]) conducted jointly by AHIP and the Blue Cross Blue Shield Association estimate that the vast majority (between 93 and 97 percent) of eligible claims (approximately 0.7% of private insurance claims processed by surveyed insurance organizations) were not submitted to the Federal IDR process in the first three quarters of 2023.[36] However, the availability of the Federal IDR process may have implications for negotiations over contracted payment rates between providers and private health plans and issuers and the decision by each whether to enter into a network agreement.

Perspectives on the Federal IDR Process from Interested Parties

RAND conducted discussions on ASPE's behalf with a number of key interested parties likely to be affected by the NSA.[37] These parties included provider groups, provider partners (such as revenue management firms), benefits consultants, insurance firms (both in their capacity of insurers of fully funded plans and as TPAs of self-funded plans), and insurer partners who participate in claims processing, cost-management, and negotiations.

Both providers and private health plans and issuers reported that the Federal IDR process had effects on their operations through several channels. Providers reported that participating in the Federal IDR process added administrative complexity for them. Providers also reported inequities in access to the Federal IDR process based on provider size and capacity. A small provider group reported being unable to submit to the Federal IDR portal all the claims they wanted to challenge because of resource constraints. Some provider groups developed infrastructure and hired staff to manage IDR submissions, while others outsourced management of the Federal IDR process to third parties such as revenue cycle management firms and law firms.

Private health plans and issuers reported a similar added administrative burden from the Federal IDR process and similar strategies for addressing it. Some insurance firms have built internal capacity for calculating QPAs (both for the Federal IDR process and determining cost-sharing for claims subject to the NSA) and handling IDR cases, while others outsource that work to third parties such as cost

[36] AHIP (2022). No Surprises Act Prevents More than 9 Million Surprise Bills Since January 2022. https://www.ahip.org/resources/no-surprises-act-prevents-more-than-9-million-surprise-bills-since-january-2022; AHIP (2024). No Surprises Act Continues to Prevent More than 1 Million Surprise Bills Per Month, While Provider Networks Grow. https://www.ahip.org/resources/no-surprises-act-continues-to-prevent-more-than-1-million-surprise-bills-per-month-while-provider-networks-grow.

[37] For a detailed description of these discussions, please see the accompanying report by RAND: "The Implications of the No Surprises Act on Contract Dynamics, Negotiations, and Finances: Perspectives from Key Stakeholders." https://aspe.hhs.gov/reports/perspectives-key-stakeholders

management firms. Before the NSA was enacted, many of these firms already outsourced their OON billing to third parties. Private health plans and issuers reported that the Federal IDR process represents a new source of revenue for those third parties. Private health plans and issuers also mentioned the impact of the NSA on shared savings arrangements between employers and TPAs. Under these arrangements, TPAs or cost management firms pay OON providers at a discount from their billed charges with patients being held harmless. The TPA or cost management firm and the employer share in the savings from the discount. A benefits consultant told RAND that some large insurance carriers make significant revenue from these arrangements (for all OON claims, not only those subject to the NSA). The NSA provides a way for these carriers to increase revenue since, under the NSA, OON reimbursement is lower (as shown in Chapter 2) and these discounts off the charges are larger, resulting in higher shared savings.

Discussants expressed dissatisfaction with multiple parts of the Federal IDR process. First, provider groups across specialties expressed concerns about the lack of transparency surrounding the calculations of QPAs by private health plans and issuers and noted that sometimes QPAs were lower than Medicare rates, which struck them as implausible.[38] Providers also noted that the QPA formula does not acknowledge quality differences among providers, though IDREs may take this into account when deciding on an appropriate OON rate.[39] Both providers and private health plans and issuers acknowledged long delays in IDR processing timelines, a finding corroborated by analysis of the IDR Public Use Files (PUFs) data by RAND, discussed below. Providers also added that when an IDR payment determination that favored them was made, private health plans and issuers did not always pay them in a timely fashion. Private health plans and issuers stated that IDREs sometimes made determinations on claims that were not regulated by the NSA and as a result not eligible for the Federal IDR process.

The availability of the Federal IDR process and how it is managed has ramifications for negotiations between providers and private health plans and issuers over network participation and in-network rates. The QPA and IDR win rates were both seen by discussants as contracting tools. One emergency medicine group representative said that their possession of infrastructure for handling the Federal IDR process improved their position in negotiations over network participation. On the other hand, some providers expressed concern that private health plans and issuers' outsourcing of IDR work might reduce private health plans and issuers' willingness to enter into network agreements, because the plans' and issuers' distance from IDR operations diminishes opportunities for provider-insurer relationship building that could lead to network agreements.

Similar concerns were strongly expressed by providers about the presence of shared savings agreements which, as discussed above, are revenue producers for TPAs (through flat or percentage-based fees) who also build provider networks on behalf of employers and therefore may receive more shared savings revenue under network exclusions. Multiple discussants, including benefit consultants and providers, noted the conflict of interest inherent in this arrangement – since under these arrangements, firms tasked with building robust provider networks are financially rewarded for out-of-network services –

[38] Under the regulations, providers may request certain information from payers on QPA calculations. See 45 CFR 149.140(d)(2), https://www.ecfr.gov/current/title-45/part-149/section-149.140#p-149.140(d)(2).
[39] *See* 45 CFR 149.510(c)(4)(iii)(B)(*1*).

and urged employers to be more aware of these agreements and their ramifications. Some private health plans and issuers reported they moved away from these agreements after the NSA was enacted.

Analysis of the 2023 Federal IDR PUFs

In February 2024, the Departments released PUFs for IDR disputes closed in the first two calendar quarters of 2023, and in June 2024, the Departments subsequently released PUFs for IDR disputes closed in the third and fourth calendar quarters of 2023.[40] These files included IDR disputes over items and services that took place both in 2022 and 2023. ASPE commissioned RAND to conduct an analysis of these PUFs to answer questions such as:

- Who were involved in the IDR disputes? Which side tended to win disputes?
- How long did the Federal IDR process generally take to reach a payment determination?
- How much variation is there in QPAs and how do they compare to other payment rates, such as Medicare?
- How much variation is there in payment determinations and how do they compare to other payment rates, such as Medicare?

In general, analysis of the PUFs supported the qualitative responses described above with regard to such issues as delays in the IDR timeline, what kind of providers submit disputes to the Federal IDR process, the win rate for providers versus private health plans and issuers, and the relationship between QPAs and Medicare rates.

As noted above, the vast majority of NSA-eligible OON claims are not submitted to the Federal IDR process, but the number of IDR disputes has been substantially higher than originally predicted. In 2022, the Departments estimated that 17,000 IDR disputes were expected to be submitted annually.[41] The IDR PUFs for 2023, however, contain 209,286 unique disputes, or approximately 12 times as many as expected.

Participants in IDR Disputes and Outcomes of Disputes

Table 3-1 shows basic characteristics of IDR disputes over OON emergency services and non-emergency services that were closed in 2023. Practices and facilities of all sizes filed IDR disputes, although the majority were filed by organizations with at least 50 employees. 60 percent of IDR disputes were filed by emergency medicine providers and roughly 15 percent were filed by radiology providers, with the remaining quarter spread across other specialties. For comparison, emergency medicine and radiology providers represented approximately 11 percent and 8 percent of OON professional claims, respectively, in 2016 (Kennedy et al., 2019). Providers won around 80 percent of IDR disputes and private health

[40] As of summer 2025, the Departments have released PUFs for IDR disputes closed in the four calendar quarters of 2024, but they are not a part of the analyses for this Report.

[41] Centers for Medicare & Medicaid Services (2022). Frequently Asked Questions Regarding the Federal Independent Dispute Resolution Process. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-FAQs-Federal-Independent-Dispute-Reolution-Process.pdf.

plans and issuers won around 20 percent, with a very small number having a split decision[42] or the outcome was not recorded in the data.

A notable feature of IDR disputes over emergency services and non-emergency services at in-network facilities was their concentration in four large firms affiliated with private equity funds: TeamHealth, SCP Health, Envision, and Radiology Partners.[43] These four firms filed over two-thirds of the IDR disputes in Table 3-1. The first three are large emergency medicine providers and Radiology Partners is a large provider of radiology services. The disproportionate share of IDR dispute initiations by these large providers in the IDR PUFs.

Table 3-1 – Characteristics of IDR Disputes over OON Emergency Services and Non-Emergency Services at In-Network Facilities (2023)

	OON Emergency Services and Non-Emergency Services at In-Network Facilities	
	n	*%*
Total unique payment determinations	197,744	100.0%
Practice or facility size		
Fewer than 20 employees	23,275	11.8%
20–50 employees	41,029	20.7%
51–100 employees	27,408	13.9%
101–500 employees	57,632	29.1%
Over 500 employees	41,433	21.0%
Not reported	6,967	3.5%
Specialty or facility type		
Emergency Medicine	118,733	60.0%
Radiology	30,190	15.3%
Surgery	16,006	8.1%
Neurology	10,334	5.2%
Anesthesiology	7,451	3.8%
Critical Care	5,667	2.9%
Other	9,321	4.7%
Prevailing party		
Decisions in favor of provider	158,072	79.9%
Decisions in favor of private health plan or issuer	39,566	20.0%

[42] Disputes may involve multiple line items (these are referred to "batched" disputes). These disputes can end with split decisions, which occur when the two parties prevail in an equal number of line items. When a split decision occurs, each party pays half of the certified IDR entity fee.

[43] TeamHealth, Envision, and SCP Health were respectively the first, second, and fourth largest emergency medicine employers by emergency departments staffed in 2023 (https://emworkforce.substack.com/p/state-of-the-us-emergency-medicine).

Split/not reported	106	0.0%

Source: Analysis of 2023 IDR PUF data.
IDR = Independent Dispute Resolution
OON = Out-of-Network

IDR disputes over OON air ambulance services have somewhat similar characteristics (not shown). Air ambulance providers won approximately 85 percent of IDR disputes and private health plans and issuers won approximately 15 percent. Similar to OON items and services, a large share (87.7 percent) of IDR disputes were initiated by a small number (five) of large provider groups.

Table 3-2 shows the characteristics of private health plans and issuers involved in IDR disputes. Nearly two-thirds of disputes over OON emergency services or non-emergency services at in-network facilities were with either partially or fully self-insured employment-based group health plans. Around 19 percent were with fully insured group health plans. A small number of IDR disputes were with other types of plans. For IDR disputes involving air ambulance providers, slightly less than half involved partially or fully self-insured group health plans and roughly a quarter involved fully insured group health plans with the remainder spread across other types of health plans.

Table 3-2 – Characteristics of Private Health Plans and Issuers Involved in IDR Disputes (2023)

	OON Emergency Services and Non-Emergency Services at In-Network Facilities		OON Air Ambulance Services	
	n	*%*	*n*	*%*
Total unique payment determinations	197,742	100.0%	11,542	100.0%
Health plan type				
Either partially or fully self-insured private group health plan (employment-based)	131,191	66.3%	5,585	48.4%
Fully insured private group health plan (employment-based)	36,910	18.7%	2,833	24.5%
Individual health insurance issuer	3,004	1.5%	666	5.8%
Federal Employees Health Benefits carrier	1,783	0.9%	299	2.6%
Non-federal government plan (or state or local government plan)	2,273	1.1%	156	1.4%
Church plan	0	0.0%	4	0.0%
No plan/issuer response	22,581	11.4%	1,999	17.3%

Source: Analysis of 2023 IDR PUF data.
IDR = Independent Dispute Resolution
OON = Out-of-Network

Length of Time for Payment Determinations in IDR Disputes

As shown above in Figure 3-1, based on the timeframes prescribed in the NSA regulations, a final payment determination in an IDR dispute should be made no more than 39 business days after the dispute initiation (up to 9 business days to select an IDRE and up to 30 business days for the IDRE to make a determination). However, the Departments have exercised their statutory waiver authority with

respect to the timeline to make payment determinations due to the unexpectedly high volume of disputes.[44] During 2023 the IDR process was paused multiple times as a result of court decisions.[45]

RAND found from their analysis of the PUFs that, in practice, it generally took much longer than 39 business days to resolve IDR disputes. As shown in Table 3-3, across all of 2023, the mean length of time for determination for closed IDR disputes involving OON emergency and non-emergency items and services was 91 business days and the median length was 73 business days. For air ambulance IDR disputes closed in 2023, the mean length of time for determination was 86 business days and the median was 66 business days. Furthermore, the average lengths of time it took to resolve IDR disputes rose throughout 2023; IDR disputes over OON items and services that closed in the fourth quarter of 2023 took a mean time of 102 business days and a median time of 83 business days and IDR disputes over OON air ambulance items and services took a mean of 139 business days and a median time of 125 business days to close.[46] Finally, Table 3-3 only shows statistics for IDR disputes that actually closed in 2023; IDR disputes that were opened in 2023 and then continued into 2024 are not shown.

[44] Centers for Medicare and Medicaid Services, Untitled Notice, September 7, 2022. Available at https://www.cms.gov/nosurprises/notices.

[45] For a more detailed timeline of the court decisions and their impacts, see "Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities. December 2023 Update to March 2023 Guidance." Available at https://www.cms.gov/files/document/federal-idr-guidance-idr-entities-march-2023.pdf

[46] Pauses to IDR submission as a result of court decisions likely contributed to longer lengths of time to close a dispute in 2023 Q3 and Q4.

Table 3-3 – Descriptive Statistics of Closed IDR Disputes (2023)

OON Emergency Services and Non-Emergency Services at In-Network Facilities	*All*	*Q1*	*Q2*	*Q3*	*Q4*
Number of IDR payment determinations	197,744	24,273	53,781	46,594	73,096
Length of time until determination (business days)					
Median	73	52	71	86	83
Mean	91	62	84	99	102
Max	399	210	282	330	399
IDRE compensation (dollars)					
Median	$395	$365	$395	$395	$397
Mean	$445	$391	$429	$443	$477
Max	$1,340	$1,340	$1,219	$1,126	$938
OON Air Ambulance Services	*All*	*Q1*	*Q2*	*Q3*	*Q4*
Number of IDR payment determinations	11,542	2,434	3,320	3,326	2,462
Length of time until determination (business days)					
Median	66	47	41	76	125
Mean	86	55	64	92	139
Max	383	209	254	295	383
IDRE compensation (dollars)					
Median	$395	$365	$395	$395	$397
Mean	$385	$365	$375	$370	$440
Max	$1,340	$1,340	$938	$938	$700

Source: Analysis of 2023 IDR PUF data.
Notes: IDRE compensation varies depending on the number of items or services under dispute, with separate fees for single disputes and batched disputes (which contain multiple line items representing multiple items and services). Batched dispute fees increase by a set amount (the 'tiered fee') for every 25 additional line items under dispute.
IDR = Independent Dispute Resolution
IDRE = IDR Entity
OON = Out-of-Network

Variations in QPAs and in Payment Determinations in the IDR PUFs

Table 3-4 shows descriptive statistics of QPAs for the most commonly disputed CPT codes in a selection of specialties in the IDR PUFs. There is wide variation in QPAs within each code, with maximum QPAs for a code being from eight times to hundreds of times as much as the median QPA for that code. Variation in QPAs is unsurprising given the formula for the QPA described above; even for the same code, there can be differences in QPAs across geographic areas and insurance markets.

We note certain limitations of analyzing the QPAs in the IDR PUFs. First, these QPAs are not representative of all QPAs calculated by private health plans and issuers but just of those that wind up in an IDR dispute. It is very likely therefore that they are lower on average than the broader set of all QPAs. Second, the QPAs in the IDR PUFs are submitted by the initiator of the dispute, usually the provider, and there is no indication that they have been reviewed for accuracy by the plan or issuer. Certified IDR entities can edit the QPA through the Federal IDR portal if they receive a corrected QPA from the plan or issuer, but it is not always clear whether they have done so.

Table 3-4 – Descriptive Statistics of QPAs for Most Commonly Disputed CPT Codes in Each Specialty (2023)

	Number of line items	Minimum	Median	Mean	Maximum
Emergency medicine					
99284: Emergency department visit for problem of high severity	41,415	$25	$229	$304	$21,505
Anesthesiology					
00812: Anesthesia for exam of colon using an endoscope	685	$41	$276	$300	$2,450
Radiology					
71045: X-ray of chest, 1 view	9,748	$1	$9	$9	$320
Pathology					
88305: Pathology examination of tissue using a microscope, intermediate complexity	240	$20	$21	$51	$468
Air ambulance					
A0431: Rotary wing air transport (one way)	1,856	$1	$13,684	$15,880	$122,236

Source: Analysis of 2023 IDR PUF data.
CPT = Current Procedural Terminology
OON = Out-of-Network
QPA = Qualifying Payment Amount

Table 3-5 shows descriptive statistics of final payment determinations for the same set of CPT codes as in Table 3-4. In general, average payment determinations (both median and mean) are notably higher than average QPAs, especially for the air ambulance code. This finding is unsurprising given the high provider win rate of roughly 80 percent reported above; IDR disputes where providers win will likely have higher payment determinations than QPAs.

Table 3-5 – Descriptive Statistics of Payment Determinations for Most Commonly Disputed CPT Codes in Each Specialty (2023)

	Number of line items	*Minimum*	*Median*	*Mean*	*Maximum*
Emergency medicine					
99284: Emergency department visit for problem of high severity	41,415	$0	$529	$587	$19,731
Anesthesiology					
00812: Anesthesia for exam of colon using an endoscope	685	$0	$790	$1,252	$9,950
Radiology					
71045: X-ray of chest, 1 view	9,748	$0	$36	$51	$800
Pathology					
88305: Pathology examination of tissue using a microscope, intermediate complexity	240	$20	$146	$161	$1,744
Air ambulance					
A0431: Rotary wing air transport (one way)	1,856	$250	$32,041	$32,517	$57,799

Source: Analysis of 2023 IDR PUF data.
CPT = Current Procedural Terminology

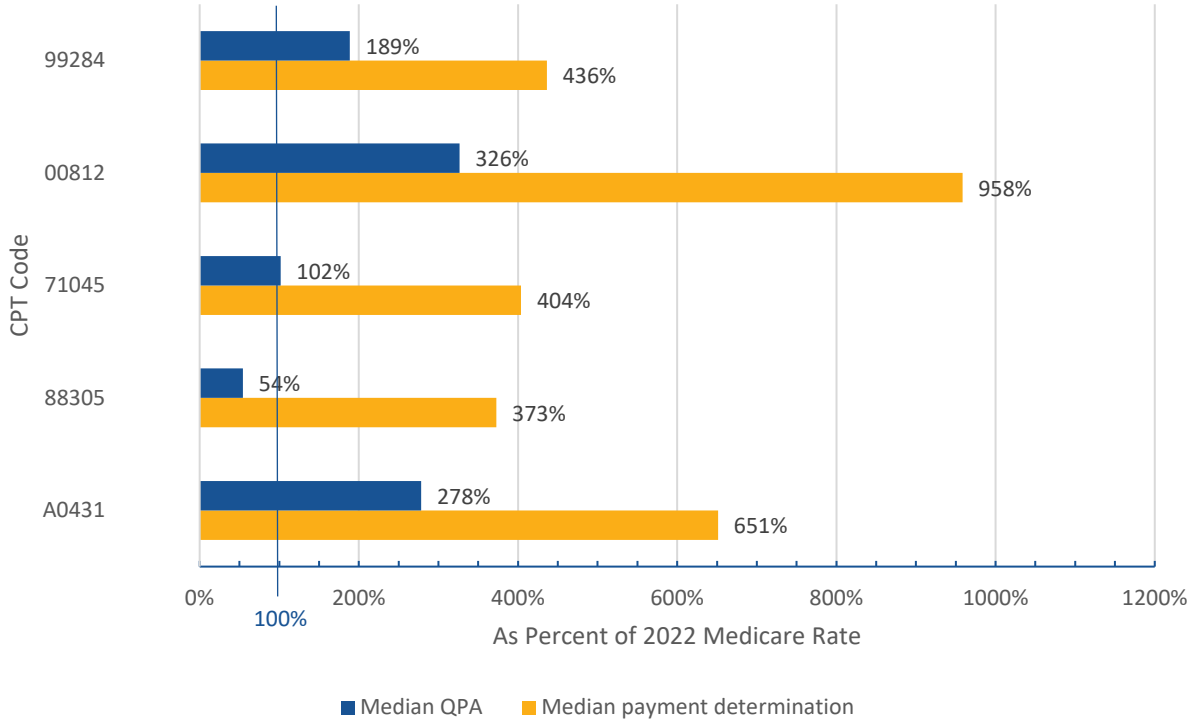
Comparison of QPAs and Payment Determinations with Medicare and Commercial Rates in the IDR PUFs

Figures 3-2 and 3-3 show comparisons of median QPAs and median payment determinations with Medicare payment rates in 2022. In discussions with RAND, some providers expressed skepticism that the QPA was being calculated correctly because at times it was below Medicare payment rates when commercial rates are generally higher than those of Medicare.[47] For most codes shown below in Figure 3-2, median QPAs were above Medicare payment rates; the only exception is a pathology code where the median QPA was 54 percent of the Medicare payment rates for the same code.

Median payment determinations were very high in comparison to QPAs and Medicare payment rates, corroborating the data described above. They were all at least twice the corresponding median QPA and multiple times the corresponding Medicare payment rate; the ratios of payment determinations to Medicare rates ranged from 373 percent to 958 percent.

[47] A recent Congressional Budget Office (CBO) report found that the average commercial prices for hospital services were 240 percent of Medicare FFS's prices for outpatient services and 182 percent of Medicare FFS's prices for inpatient services. For physician services the report found that commercial insurers' prices were 117 percent of Medicare FFS's prices for primary care services or office visits, on average and 144 percent of Medicare FFS's prices for specialty services (CBO 2022).

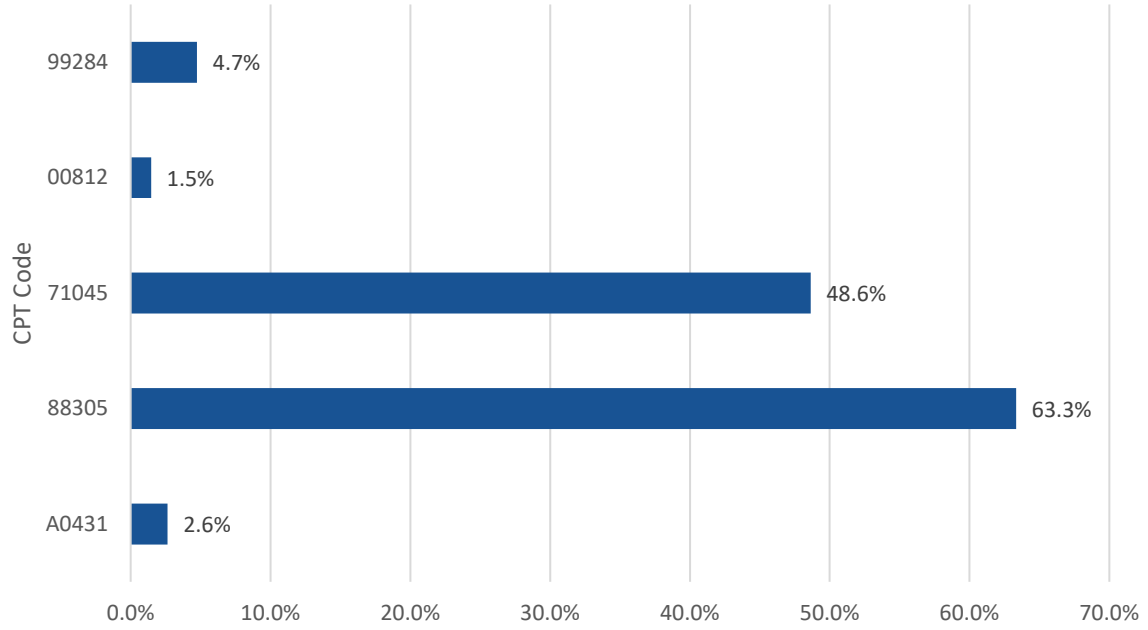
Figure 3-2 – Median QPAs and Payment Determinations in IDR PUFs as Percents of 2022 Medicare Local Payment Rates for Selected CPT Codes (2023)



Source: Analysis of 2023 IDR PUF data. Comparison is with the locality-specific Medicare rate for that CPT code.
Notes: See Tables 3-4 and 3-5 for explanations of CPT codes.
CPT = Current Procedural Terminology
IDR = Independent Dispute Resolution
PUF = Public Use File
QPA = Qualifying Payment Amount

Figure 3-3 shows the share of QPAs below the corresponding Medicare payment rate for selected CPT codes and corroborates reports from providers that QPAs are sometimes below the Medicare rate. The percent of QPAs below 2022 local Medicare payment rates varies across codes and is over 30 percent for the most common radiology (71045) and pathology (88305) codes submitted to the Federal IDR Portal. This may reflect selection into IDR by providers, who may be more likely to contest services for which they are reimbursed below the Medicare rate.

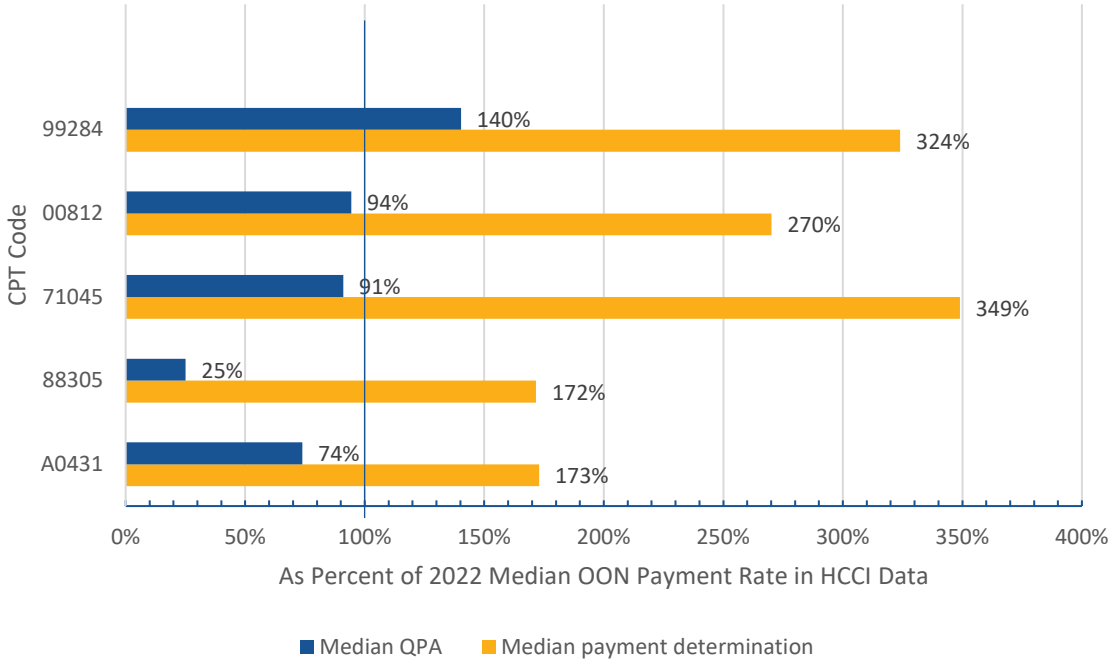
Figure 3-3 – Percent of QPAs Below 2022 Local Medicare Payment Rates for Selected CPT Codes (2023)



Source: Analysis of 2023 IDR PUF data.
Note: See Tables 3-4 and 3-5 for explanations of CPT codes.
CPT = Current Procedural Terminology
QPA = Qualifying Payment Amount

Figure 3-4 compares the median QPAs and median payment determinations of selected CPT codes with the corresponding national median OON payment rates in the 2022 HCCI commercial claims data. Median QPAs were generally similar to the median OON payment rate, with the exception of the pathology code (88305), where the median QPA was only one quarter of the median OON payment rate. Median payment determinations were markedly higher than the median OON payment rate, with the ratios ranging from 172 percent to 349 percent.

Figure 3-4 – Median QPAs and Payment Determinations as Percents of National Median OON Payment Rates in HCCI Data for Selected CPT Codes (2023)



Source: Analysis of 2023 IDR PUF data and 2022 HCCI commercial claims data.
Notes: See Tables 3-4 and 3-5 for explanations of CPT codes.
CPT = Current Procedural Terminology
OON = Out-of-Network
QPA = Qualifying Payment Amount

Chapter 4. Recent Trends in Health Care Consolidation

As discussed in the prior annual reports, the financial protections afforded to patients under the NSA for certain OON items and services may have broader effects in health care markets.

Prior to the NSA, potential OON payment rates may have influenced negotiations between providers and private health plans or issuers, impacting both in-network payment rates and providers' network participation. These dynamics may have been impacted by the implementation of the NSA. It is too early to tell the magnitude and direction of that impact, however, since the initial results from the Federal IDR process show that it creates a mix of benefits and burdens for private health plans and issuers and providers.

For example, in some areas, providers may see OON billing opportunities as an attractive alternative to joining a private health plan or issuer's network. By modifying expectations about OON payments, the NSA may change the bargaining dynamic between private health plans and issuers and providers with several possible outcomes that may vary by geography, market characteristics, and other factors. One possibility is that the NSA puts more pressure on providers to join plan and issuer networks to avoid potentially protracted and expensive disputes over OON payment rates in the Federal IDR process. The resulting changes to network structures could further reduce the incidence of OON billing. Private health plans and issuers may also find the ability to send providers an initial payment subject to a potential IDR dispute an outcome preferable to their currently negotiated in-network rates, even accounting for Federal IDR process costs. In this scenario, private health plans and issuers might lower or not raise payment rates, drop providers from their networks, or refrain from adding new providers. However, given the high win rates and payment amounts providers are experiencing through the Federal IDR process, it may instead be that providers find the Federal IDR process provides them with higher reimbursement than they would be able to negotiate on their own, even accounting for Federal IDR process costs, which may make providers more willing to go OON to get higher rates. Ultimately, given the lack of direct evidence, it is still too early to tell what impact the NSA will have on negotiations between private health plans and issuers and providers.

If it ends up being the case that these changes reduce the costs and negative consequences of leaving providers out of network, private health plans and issuers may have more leverage to negotiate lower in-network prices. Lower in-network prices would reduce spending for self-insured employers and could also reduce growth in premiums, though the evidence on whether such savings would meaningfully reduce premiums is mixed (Ritz, 2024). Providers with reduced revenue could also limit supply and reduce investments in quality improvement over the long term. Further, given the challenges that smaller providers face with respect to the NSA, providers may attempt to strengthen their bargaining position through consolidation. Greater market consolidation often leads to higher consumer prices and may also adversely affect quality of care (Liu et al., 2022). Private health plans and issuers, for their part, may view accelerating consolidation by providers as motivation for their own consolidation to maintain their negotiating leverage. Given the uncertainty surrounding all these issues, it will be important to conduct further studies as more evidence becomes available.

This section simply presents recent data on consolidation measures in both provider and insurance markets. This section does not attempt to estimate any specific effects of the NSA on these measures of

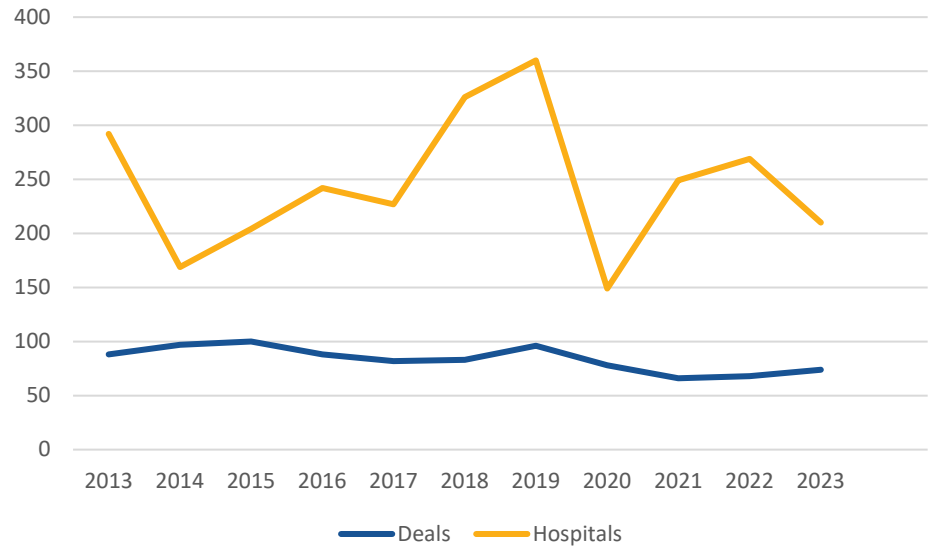
market consolidation. Rather, it provides recent data on trends in health care market consolidation to track alongside the implementation of the NSA.

Hospital Markets

For years, hospital markets have become more concentrated as a result of hospital consolidations. Between 2010 and 2022 there were more than 1,000 announced hospital mergers and acquisitions (Liu et al., 2022).

Data collected by Irving Levin Associates show that the annual number of hospital merger and acquisition deals in the U.S. averaged 83 between 2013 and 2023. However, the number of hospitals in merger and acquisition deals has been volatile in recent years, increasing in both 2021 and 2022 after a steep decline in 2020 before declining again in 2023 (Figure 4-1).

Figure 4-1 - Summary in U.S. Hospital Acquisitions, 2013-2023



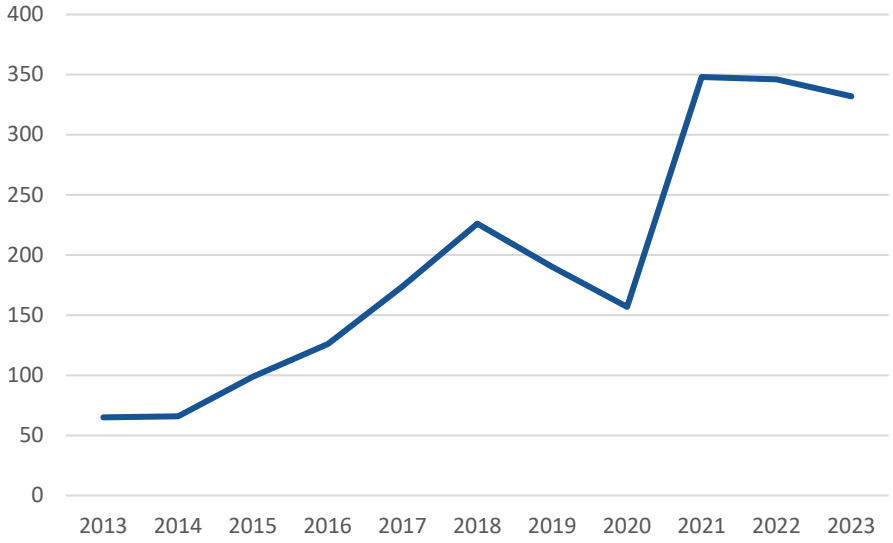
Source: Irving Levin Associates. Health Care Services Acquisition Report. 2018-2024.

Physician Markets

Physician provider markets have also grown more concentrated in the past decade, with more physicians belonging to larger practices and fewer physicians in single or small practices (Capps, Dranove, and Ody, 2017; Muhlestein and Smith, 2016; Kane, 2021). Additionally, vertical integration[48] between hospital or health systems and physicians is increasing (Furukawa et al., 2020). Data from Irving Levin Associates (Figure 4-2) show that the number of physician medical group mergers and acquisitions increased over the past decade, though the number of mergers and acquisitions has been relatively stable in 2021-2023.

[48] The term "vertical integration" refers to mergers and acquisitions of non-competing entities where one entity's product or service is a complement or necessary component of the others.

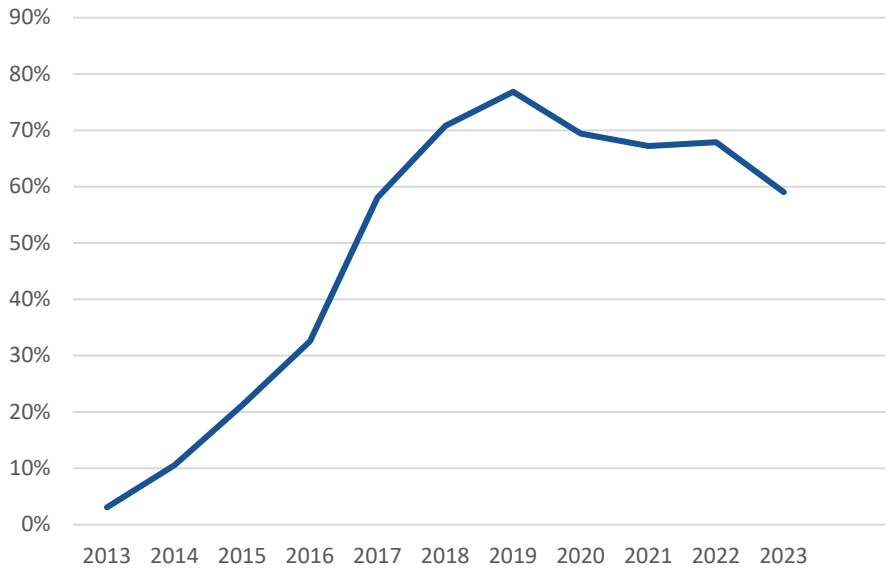
Figure 4-2 - Physician Medical Group Mergers and Acquisitions, 2013-2023



Source: LevinPro HC, Irving Levin Associates, November 2024 levinassociates.com
Notes: Physician medical group mergers and acquisitions exclude transactions where the target sector is dental, dental services, eye care, management, and podiatry.

During this period the rate of these deals where the acquirer is a private equity firm increased rapidly, peaking in 2019 and decreasing since then (Figure 4-3).

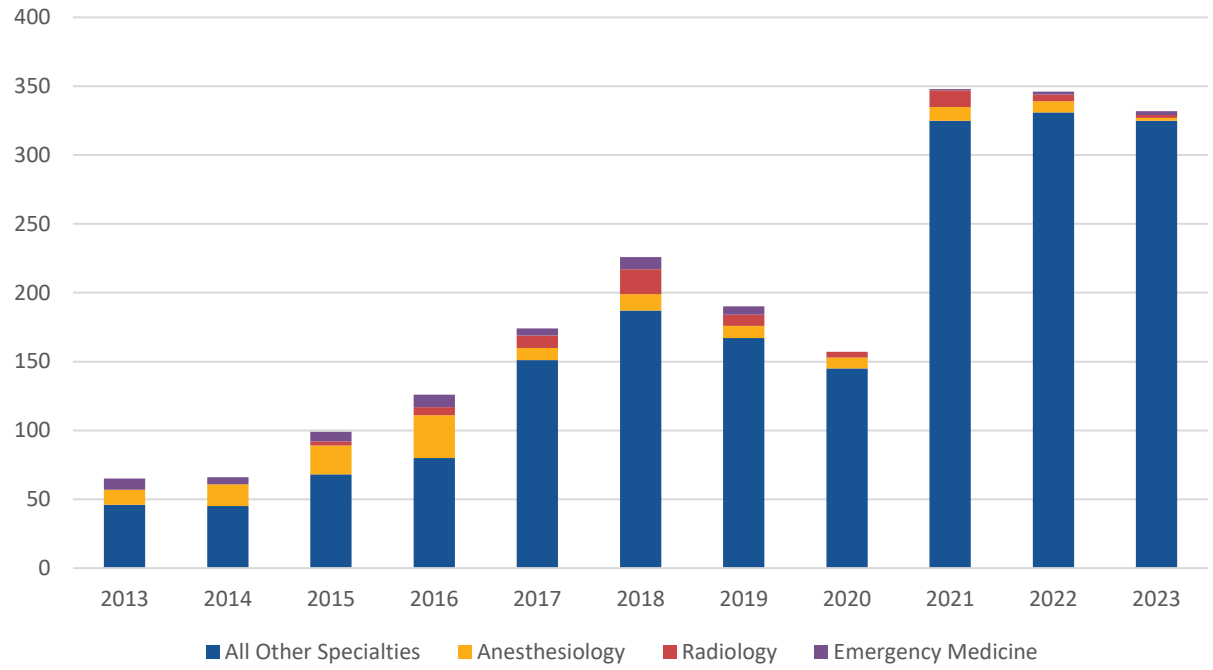
Figure 4-3 – Percent of Physician Medical Group Mergers and Acquisitions with Private Equity Identified as the Acquirer, 2013-2023



Source: LevinPro HC, Irving Levin Associates, November 2024 levinassociates.com
Notes: Physician medical group mergers and acquisitions exclude transactions where the target sector is dental, dental services, eye care, management, and podiatry.

The proportion of mergers and acquisitions since 2020 where the target was a physician specialty commonly associated with surprise bills – anesthesiology, emergency medicine, or radiology – (Figure 4-4) has decreased as a share of physician merger and acquisition deals to just 2 percent in 2023. By comparison, between 2013 and 2016 those specialties represented roughly 35 percent of acquisitions.

Figure 4-4 - Physician Specialties by Merger and Acquisition Deal Volume, 2015-2023



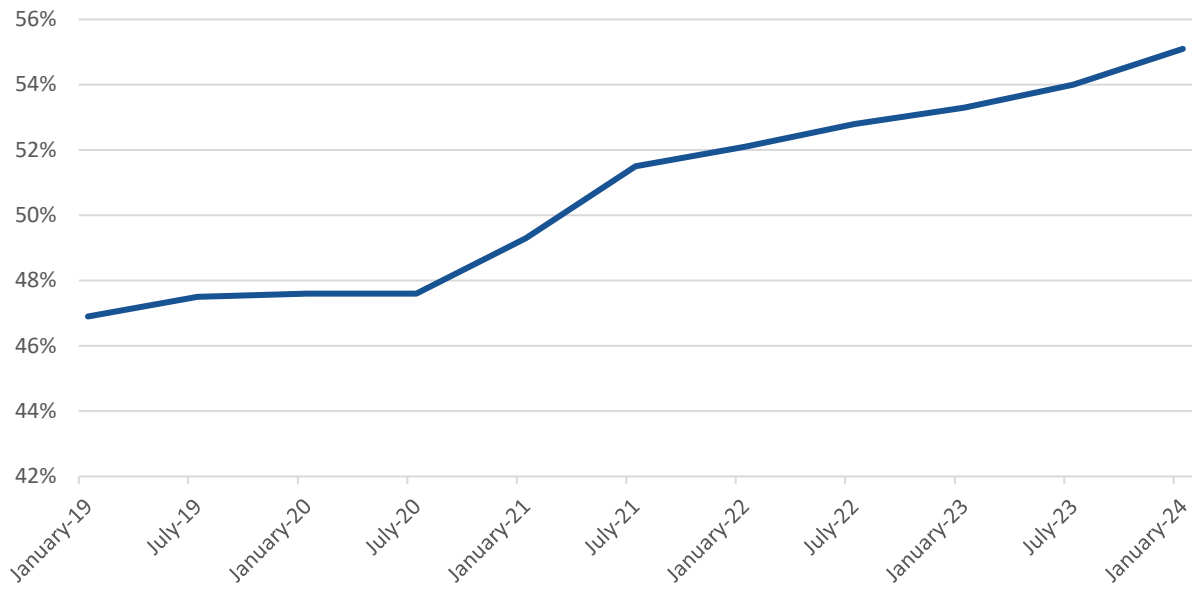
Source: LevinPro HC, Irving Levin Associates, November 2024 levinassociates.com
Notes: Physician medical group mergers and acquisitions exclude transactions where the target sector is dental, dental services, eye care, management, and podiatry.

Consolidation and Vertical Integration

In recent years, there has been an acceleration of vertical integration combining traditionally independent elements of the health care supply chain. One prominent example of these consolidations is hospitals purchasing or contracting with physicians' practices. A recent report estimated that in January 2024, 55 percent of physicians were employed by hospitals.[49] While the number of physicians employed by hospitals has been rising over time, there is speculation that the uncertain revenue impacts of the COVID–19 pandemic during 2020 accelerated this trend (Blumenthal and Gustafsson, 2021; Kaufman Hall, 2023). The figure below (4-5) shows that the percent of U.S physicians employed by hospitals grew most rapidly during the period July 2020 through July 2021. The trend continues to increase after July 2021, but at a somewhat reduced pace.

[49] For Avalere's analysis cited below, "hospital-employed" physicians are physicians in the IQVIA OneKey database indicated as employed by an integrated delivery network-owned practice, meaning a practice where the parent organization includes at least one acute care hospital and at least one non-acute entity. Other corporate entities are parent organizations not classified as IDNs. The remainder, independent practices, are those without an external parent corporate organization listed as an owner.

Figure 4-5 - Percent of U.S. Physicians Employed by Hospitals/Health Systems, 2019-2024



Source: Avalere analysis of IQVIA OneKey database that contains physician and practice location information on hospital/health system ownership (slide 14: https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI-Avalere%20Physician%20Employment%20Trends%20Study%202019-2023%20Final.pdf)

Geographic Trends in Health Care Market Concentration

Health insurance, hospital, and physician organization markets have been characterized as highly concentrated for years (Fulton, 2017). This section presents maps of a commonly used measure of market concentration, the Herfindahl-Hirschman Index (HHI), for several potential health care product markets at several levels of geography.[50] HHI is calculated as the sum of the squared market shares of firms in a given market; it therefore measures the relative sizes of firms in a market defined by a specific geographic area and by a specific set of products or services. The measure approaches zero when a market has a large number of firms of equal size ("perfect competition") and reaches its maximum of 10,000 when the market is a monopoly. The U.S. Department of Justice and Federal Trade Commission's 2023 Merger Guidelines describe markets with an HHI of greater than 1,800 as highly concentrated.

[50] Throughout this document, market definitions are not necessarily antitrust geographic, product, or geographic service markets, nor was a full analysis conducted in accordance with the U.S. Department of Justice (DOJ) and Federal Trade Commission Merger Guidelines § 2.1 that would establish any of these as an antitrust product or geographic market. There are multiple potential markets for health insurance and health care products and services. For example, in the context of commercial health insurance, the DOJ has defined markets for individual, small group, large group, and national accounts. With respect to national accounts (often with 3,000+ and several employment locations), it is not necessarily clear that concentration in a single geography is informative of overall competition for a given national account.

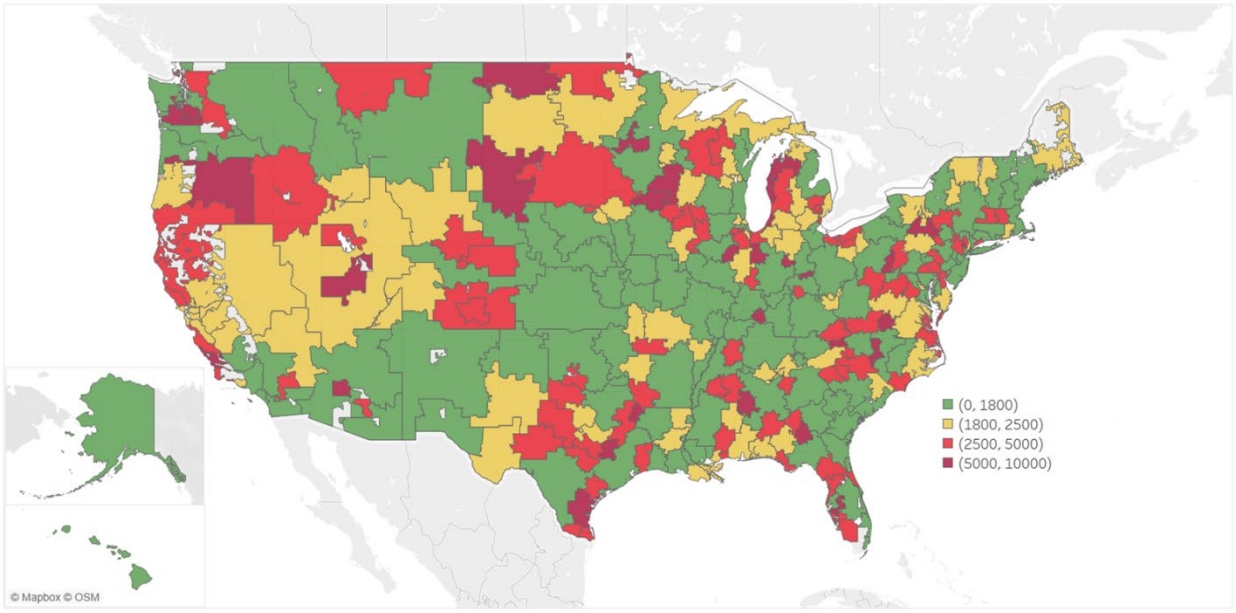
HHI scores for hospital markets are calculated based on data from the American Hospital Association Annual Survey. Adjusted hospital admissions[51] were used to measure the market share of each hospital or hospital system. For these analyses, hospital markets are defined as the hospital referral region (HRR).[52] HRRs are regional health care markets designated by the Dartmouth Atlas Project (Wennberg and Cooper, 1999). HRRs reflect patterns in inpatient tertiary care referrals while core-based statistical areas (CBSAs)[53] reflect urban commuting patterns.[54] Federal antitrust agencies conduct relevant market analyses on a case-by-case basis, meaning the relevant markets in antitrust enforcement actions may differ from the methodology described here.

For at least the past three decades, hospital markets have become increasingly concentrated (Gaynor, 2020). The percentage of HRRs with an HHI below 1,800 – meaning not highly concentrated – decreased from 33 percent (101 of 306) in 2008 to 17 percent (53 of 306) in 2022 (Figure 4-6).

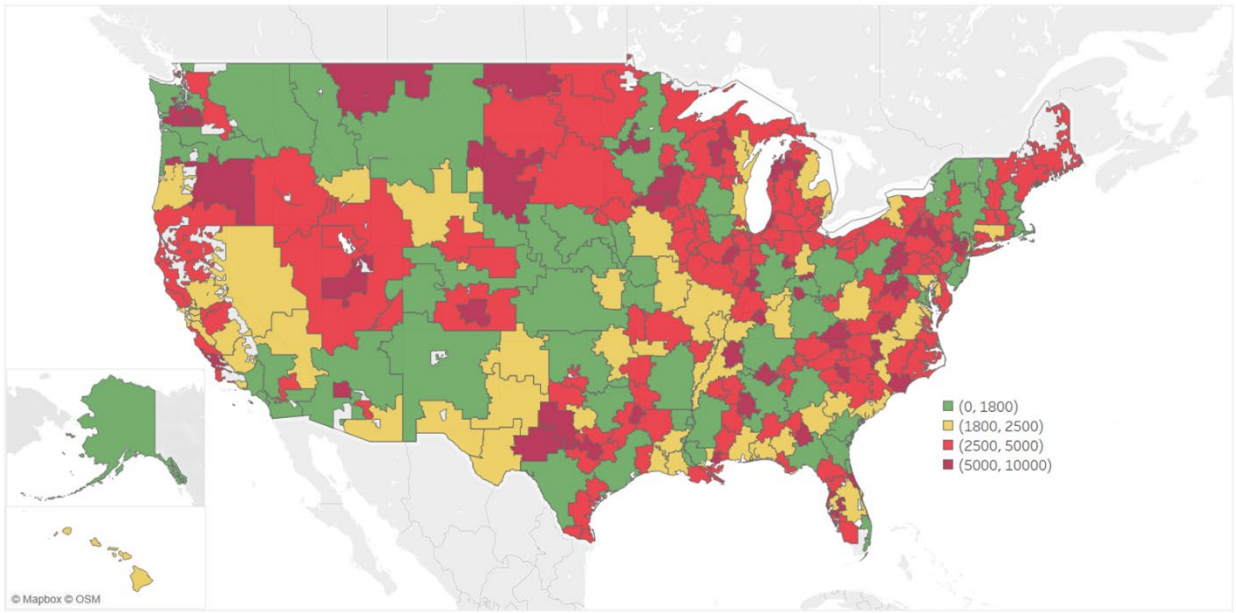
[51] AHA's adjusted admissions measure attempts to capture both inpatient admissions and outpatient volume by scaling based on relative revenue. Adjusted Admissions = Admissions + (Admissions * (Outpatient Revenue/Inpatient Revenue)).
[52] Because HRRs generally are too large to be considered markets, unless the market consists of specialized services, these numbers and figures used here are intended to be broadly illustrative rather than precise.
[53] A core based statistical area (CBSA) is that of an area containing a large population center, or urban area, and adjacent communities that have a high degree of integration with that population center.
[54] The increase in remote work and telehealth due to the COVID-19 pandemic may also influence the construction of relevant markets.

Figure 4-6 - Hospital Referral Region (HRR)-Level Herfindahl-Hirschman Index (HHI) Scores For Adjusted Admissions, 2008 and 2022

2008



2022



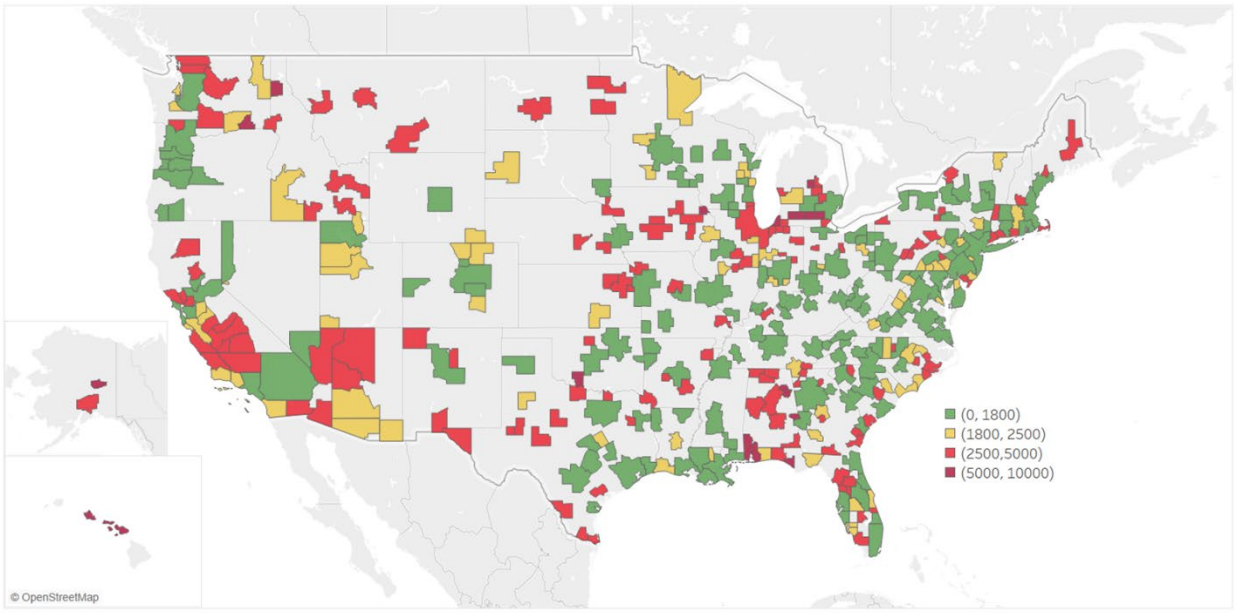
In Figure 4-7, health insurance HHI scores are calculated using Clarivate Managed Market Surveyor[55] data and are presented at the CBSA level. Most markets for health insurance remain highly concentrated, but the percentage of CBSA's with commercial health insurance HHI scores below 1,800

[55] Clarivate Managed Market Surveyor captures enrollment of health lives and affiliations by payer and geography.

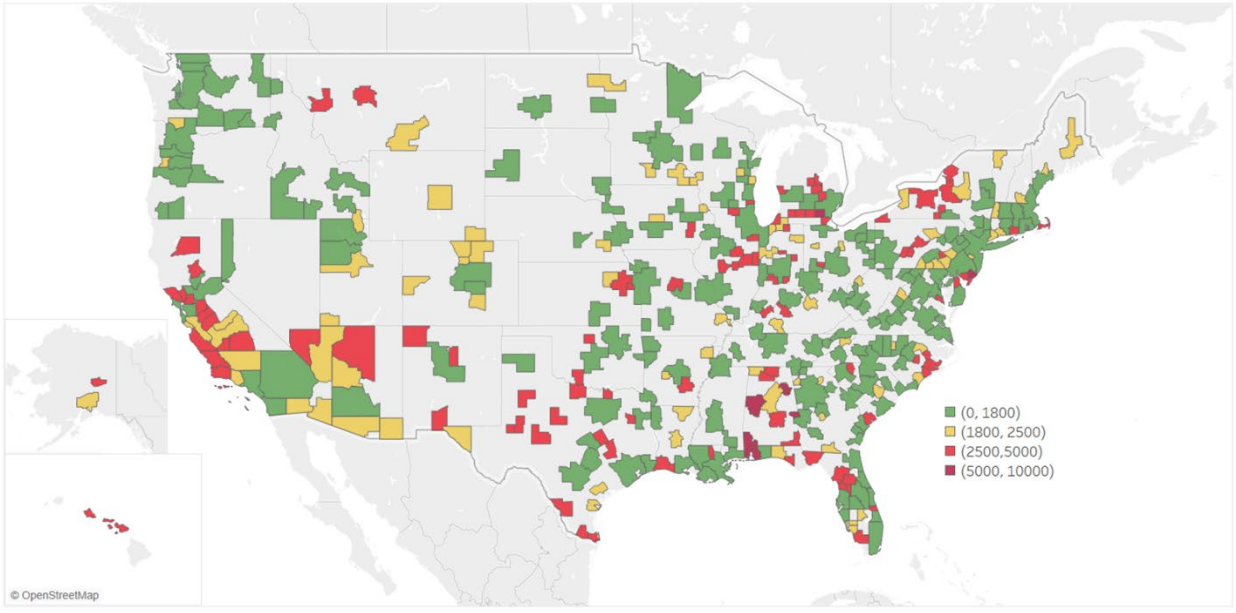
has increased in recent years. In 2008, 39 percent of CBSAs had commercial health insurance HHI scores below 1,800 (149 of 384). In 2023, 48 percent of CBSAs had commercial health insurance HHI scores below 1,800 (186 of 384).

Figure 4-7 - Core-based Statistical Area (CBSA)-Level Herfindahl-Hirschman Index (HHI) Scores for Commercial Health Insurance Membership, 2008 and 2023

2008



2023



Chapter 5. Conclusion and Discussion

A primary goal of the NSA is to provide protections for patients against the financial consequences of surprise medical bills. Surprise medical bills occur when individuals with a private health plan or coverage receive unexpected medical bills when they are unknowingly or unavoidably treated by an OON provider. For items and services furnished in certain situations, the law places requirements on both providers and private health plans and issuers to limit patients' exposure to surprise medical bills.

One concern is that in limiting patients' exposure to surprise bills, the NSA may have unintended consequences. On one hand, private health plans and issuers may see the patient financial protections as an opportunity to be more aggressive in contract negotiations with providers and seek to drive in-network rates lower than they might have in the absence of the NSA. On the other hand, some providers may seize upon the successes they are experiencing in the Federal IDR process to raise in-network rates higher. Further, providers, now restricted in their ability to balance bill in certain situations, may seek to make up lost revenue by merging with other providers to improve their bargaining position.

This series of reports will continue to investigate whether there is evidence of these sorts of consequences and impacts on consolidation, access, and health care costs. Balancing any tradeoffs between the intended patient protections of the NSA against its potential unintended consequences will be a task for policy makers going forward. Thus far, there is no evidence of major changes in consolidation trends since the implementation of NSA surprise billing protections, and it may take additional time for any potential effects on the marketwide prevalence of OON claims to become clear. Although this report suggests a decrease in the volume and cost of potential surprise bills since 2021, overall health care cost trends and health insurance premiums continue to increase post-NSA at similar rates to those seen pre-COVID-19 (Hartman et al., 2024; Claxton et al., 2024).

In these initial years of the implementation of the NSA, the impact on patient exposure to surprise bills appears to be in line with Congressional intent to remove patients from disputes between providers and health plans over payment amounts. In a series of discussions with both private health plans and issuers and providers, researchers at RAND found consistent support for the idea that patients are in a better place post-NSA (Rasmussen et al., 2024). 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."

A representative from one private health insurer said:

> "The most important thing about the No Surprises Act is the eradication of balance billing. […] It is a problem that we have been dealing with for so many years, and we didn't know how to address it."

There was also general acceptance that the prior status quo was not good, with a representative from one private health insurer saying:

> "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."

The above observations are broadly consistent with separate discussions summarized in the Year 2 report (ASPE, 2024). Despite broad agreement that the goals of the NSA were important and a sense that the central objective – limiting patient exposure to surprise bills – has been achieved, some interested parties noted challenges and growing pains (Rasmussen et al., 2024). For example, some providers and health plans found the Federal IDR process costly and time-consuming, and others noted that IDR disputes took longer to resolve than anticipated.

Continuing to track these outcomes will be important. Subsequent reports will employ a variety of methodological approaches to examine provider characteristics associated with IDR participation and outcomes, exploration of administrative costs associated with the NSA, and how the NSA has impacted arrangements between employers and insurers and third-party administrators (TPAs). Future reports will also examine impacts from anti-competitive consolidation of health care providers and of private health plans and issuers.

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Appendix A. Section 109 of the No Surprises Act

SEC. 109. REPORTS.

(a) REPORTS IN CONSULTATION WITH FTC AND AG.—Not later than January 1, 2023, and annually thereafter for each of the following 4 years, the Secretary of Health and Human Services, in consultation with the Federal Trade Commission and the Attorney General, shall—

(1) conduct a study on the effects of the provisions of, including amendments made by, this Act on—

(A) any patterns of vertical or horizontal integration of health care facilities, providers, group health plans, or health insurance issuers offering group or individual health insurance coverage;

(B) overall health care costs; and

(C) access to health care items and services, including specialty services, in rural areas and health professional shortage areas, as defined in section 332 of the Public Health Service Act (42 U.S.C. 254e);

(2) for purposes of the reports under paragraph (3), in consultation with the Secretary of Labor and the Secretary of the Treasury, make recommendations for the effective enforcement of subsections (a)(1)(C)(iv) and (b)(1)(C) of section 2799A–1 of the Public Health Service Act, subsections (a)(1)(C)(iv) and (b)(1)(C) of section 716 of the Employee Retirement Income Security Act of 1974, and subsections (a)(1)(C)(iv) and (b)(1)(C) of section 9816 of the Internal Revenue Code of 1986, including with respect to potential challenges to addressing anti-competitive consolidation of health care facilities, providers, group health plans, or health insurance issuers offering group or individual health insurance coverage; and

(3) submit a report on such study and including such recommendations to the Committees on Energy and Commerce; on Education and Labor; on Ways and Means; and on the Judiciary of the House of Representatives and the Committees on Health, Education, Labor, and Pensions; on Commerce, Science, and Transportation; on Finance; and on the Judiciary of the Senate.