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: Exploring Pre-Implementation Trends

Second Annual Report

The Second of Five Reports Required
by the Consolidated Appropriations Act, 2021
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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 enacted on December 27, 2020, to address certain kinds of unexpectedly high medical expenses, 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, as well as circumstances where uninsured or self-pay patients are seeking care.

Specifically, the NSA prohibits balance billing for: emergency items and services 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.[3] In this report, these kinds of bills will be referred to as "surprise bills." Under the law, an OON provider[4] subject to the law's balance billing requirements 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.[5, 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 costs of items and services to self-pay and uninsured patients before treatment. 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 impact of the NSA

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

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

[5] 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).

[6] The Recognized Amount 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.

on patterns of vertical or horizontal integration, overall health care costs, and access to health care items and services. This is the second of those reports.

This second report focuses largely on updating pre-NSA trends in claims data presented in the first report. Surprise bills are difficult to cleanly identify in claims data; therefore, we generally examine trends in all OON bills associated with emergency items and services (regardless of network status) or non-emergency items and services furnished with respect to a visit at an in-network health care facility[7], which we define as "potential surprise bills." This report updates trends in OON bills and potential surprise bills as well as trends in market consolidation and concentration. It also identifies factors associated with high health care costs for families. In general, in 2021, trends in potential surprise bills continued the decline seen since at least 2012.

This report also describes discussions conducted with interested parties such as health care providers, private health plans and issuers, and patients. Providers highlighted the cost burden of implementing the NSA. Patients, even those who had experienced surprise bills in the past, had limited awareness of the NSA and its consumer protections. Both providers and private health plans and issuers reported that one of the objectives of the law appears to have been achieved, noting that patients are no longer caught in the middle of payment disputes between OON providers and private health plans and issuers with respect to items and services to which the NSA applies. Some patients, however, reported continuing problems with unexpected medical bills, although it was unclear to what extent these bills were surprise bills prohibited by the NSA. Providers also noted unexpected costs of implementing the NSA and concerns about a lack of transparency around QPA calculations.

[7] 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.

Chapter 1. Introduction and Overview

The NSA was enacted in part to (a) protect participants, beneficiaries, and enrollees in private health plans and coverage from surprise bills; and (b) provide a method to resolve OON payment amount disputes between private health plans and issuers and providers in instances where the NSA applies. It also requires providers to furnish GFEs of the expected costs of items and services to self-pay and uninsured patients upon scheduling or request; if the final costs 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.[8]

These NSA requirements 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 Benefit (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.[9] Surprise bills from OON providers are often for emergency or ancillary 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 in-network facilities where a treating physician or other 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 health care items and services. Patients may have had no

[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] 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.

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 state law or 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 independent dispute resolution (IDR) process to arbitrate the OON rate. More details on the NSA's surprise billing provisions are included in the first annual report[10] as well as at https://www.cms.gov/nosurprises.

The most common medical procedure codes initially reported among disputes in the Federal IDR system submitted between April 15 to September 30, 2022 involving emergency or non-emergency items and services were ED services (66 percent), radiology (9 percent), and anesthesia (7 percent) (The Departments of Treasury, Labor, and Health and Human Services, 2022).[11]

There are challenges in estimating the impacts of the NSA, particularly the NSA effects required to be reported by 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 in the law went into effect on January 1, 2022. It may take time to see the full impact of the law on these outcomes, 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 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 measurable market-wide impact. Existing data suggest surprise bills, and therefore the law's impact, may be concentrated in a few services, such as EDs and air ambulance services. 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 the NSA 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.

Another challenge is that 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

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[10] 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

[11] A new set of IDR public use files covering the first and second quarters of 2023 was released on February 15, 2024, following the initial drafting of this report. Analysis of those files will be presented in the next report, to be released in early 2025.

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 carry out a robust evaluation of the NSA.

This report describes recent trends in health care market consolidation (Chapter 2) and OON and surprise billing (Chapter 3) to better understand the context of any NSA impacts on consolidation as well as the patient demographics and providers on whom the NSA might have the most impact. In Chapter 4, we present a summary of interested-party discussions with health care providers, private health plans and issuers, and patients. Finally, in Chapter 5, the report concludes with a description of the analyses that we aim to include in future reports.

Chapter 2. Recent Trends in Health Care Consolidation

As discussed in the first annual report, effects of the NSA may extend beyond the financial protections afforded to patients for certain OON items and services. Historically, 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. For example, in some areas, providers may see OON billing opportunities as an attractive alternative to joining a private health plan's 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 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 IDR process. The resulting changes to network structures could further reduce the incidence of OON billing. Alternatively, private health plans and issuers may 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. 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. Similarly, providers may believe that the IDR process provides them with higher reimbursement than they would be able to negotiate themselves, even accounting for IDR process costs, which may make providers more willing to go OON to get higher rates.

To the extent that these changes provide more market power for private health plans and issuers, they may be able to negotiate lower in-network prices. Lower in-network prices could reduce growth in premiums and overall health care spending, though the evidence is mixed that such savings would meaningfully reduce premiums (Ritz, 2024).

In addition, lower prices resulting from private health plan and issuer market power may affect other provider decisions. Providers with reduced revenue may limit supply and reduce investments in quality improvement over the long term. Changes in the supply and quality of providers could in turn have implications for access to health care. Alternatively, providers may attempt to strengthen their bargaining position through consolidation. Greater market consolidation can lead 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 market power.

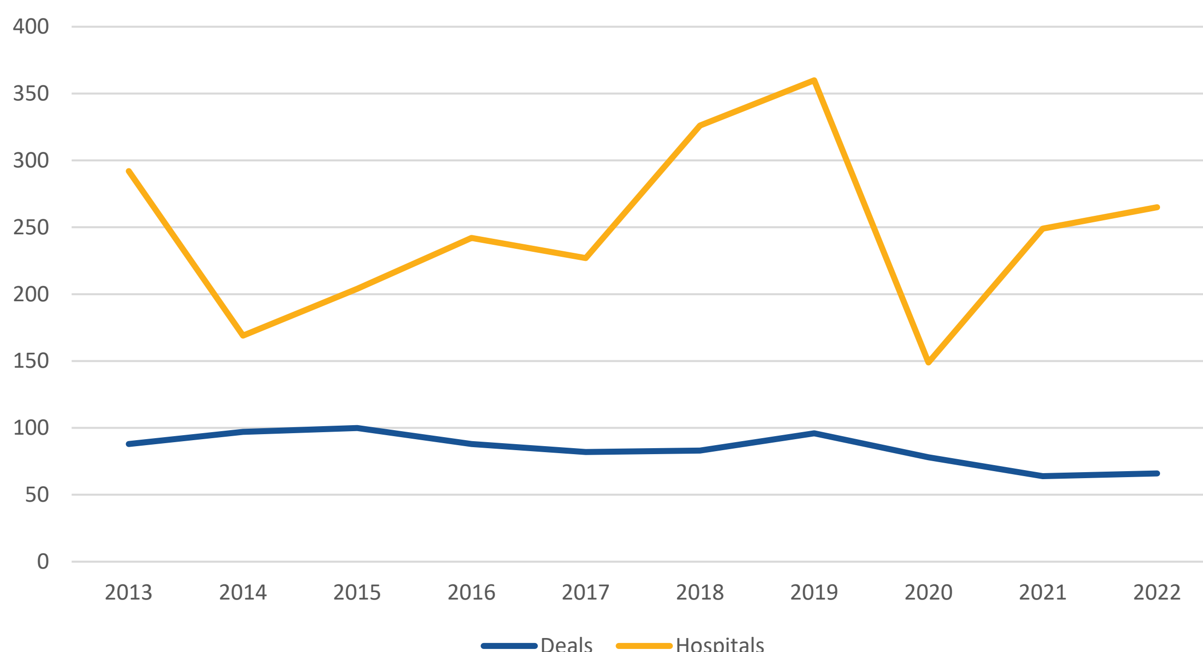
As a baseline for potential estimates of the NSA's impact, this section presents recent data on consolidation measures in both provider and insurance markets. This section does not attempt to estimate any specific effects of the NSA on these consolidation measures. For many years, hospital markets have become more concentrated as a result of a steady stream of hospital consolidations. Between 2010 and 2020, there were more than 1,000 announced hospital mergers and acquisitions (Liu et al., 2022). 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[12] between hospitals or health systems and physicians is increasing (Furukawa et al., 2020).

Hospital Markets

Data collected by Irving Levin Associates show that the annual number of hospital merger and acquisition deals in the U.S. averaged 84 between 2013 and 2022. However, the number of hospitals in merger and acquisition deals has been more volatile and increased in both 2021 and 2022, though 2022 was still below 2019 (Figure 2-1). Between 2013 and 2021, the total number of community hospitals declined from 5,359 to 5,157 (American Hospital Association, 2022) and the share of hospitals involved in mergers or acquisitions in each year varied from 2.8 percent to 7.0 percent.

Figure 2-1 - Summary in U.S. Hospital Acquisitions, 2013-2022



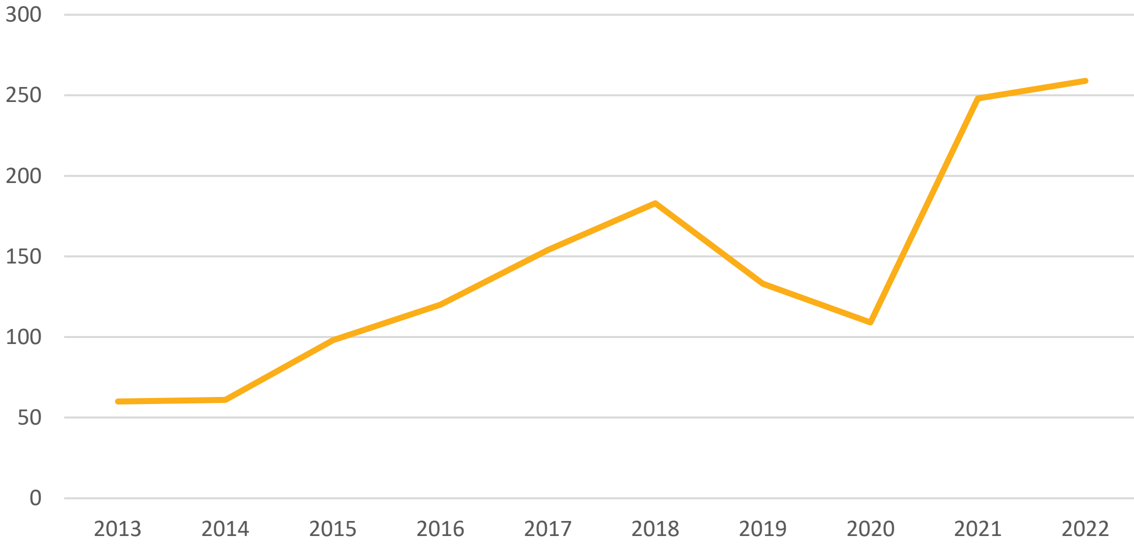
Source: Irving Levin Associates. Health Care Services Acquisition Report. 2018-2023.

Physician Markets

According to data from Irving Levin Associates, the number of physician group mergers and acquisitions increased steadily between 2014 and 2018 before falling slightly in 2019 and 2020 (Figure 2-2). The number of mergers and acquisitions then increased in 2021 and again in 2022. The 259 mergers and acquisitions completed in 2022 is the highest on record in Irving Levin Associates data going back to 2000.

[12] 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 other's.

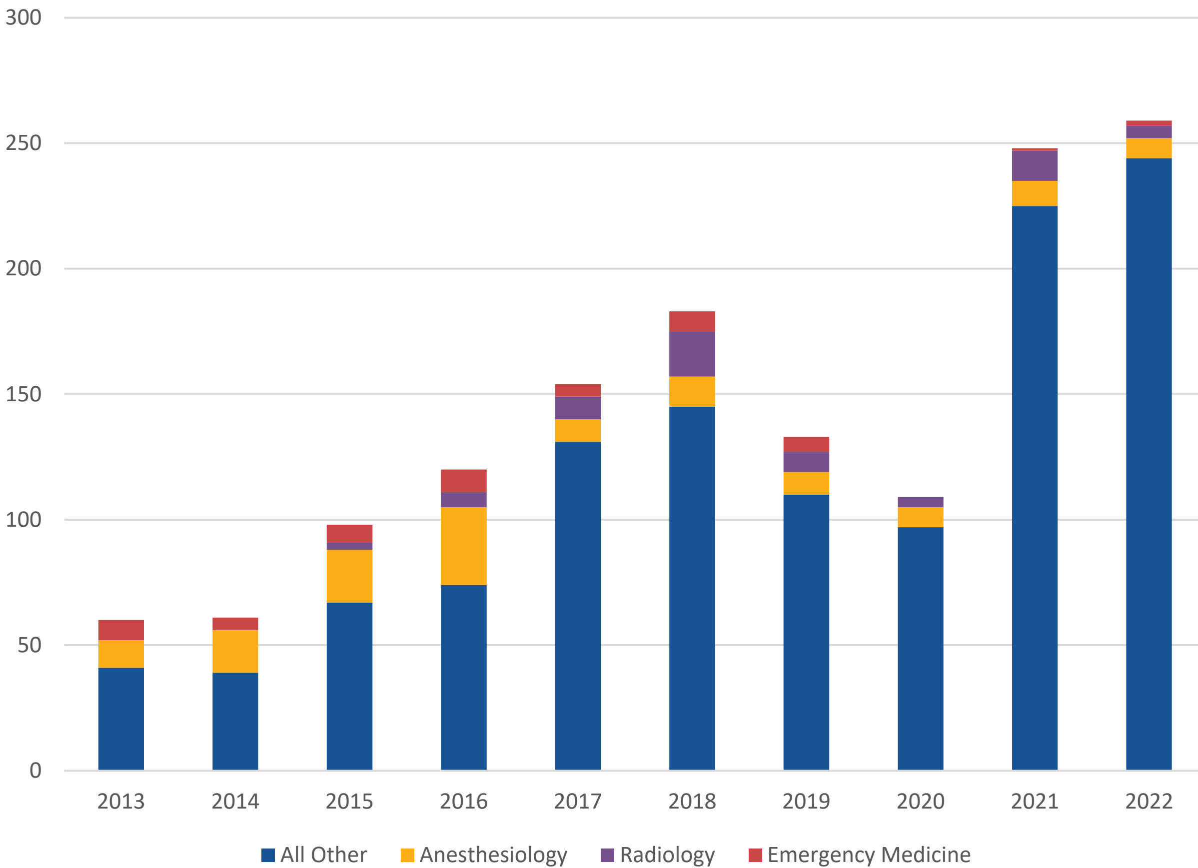
Figure 2-2 – Physician Medical Group Mergers and Acquisitions, 2013-2022



Source: LevinPro HC, Irving Levin Associates, December 2023 levinassociates.com
Note: 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 in 2021 and 2022 where the target was a physician specialty commonly associated with surprise bills – anesthesiology, emergency medicine, or radiology – was less than 10 percent (Figure 2-3). To put that value in perspective, between 2013 and 2016 those specialties represented roughly 35 percent of acquisitions.

Figure 2-3 - Physician Specialties by Merger and Acquisition Deal Volume, 2015-2022



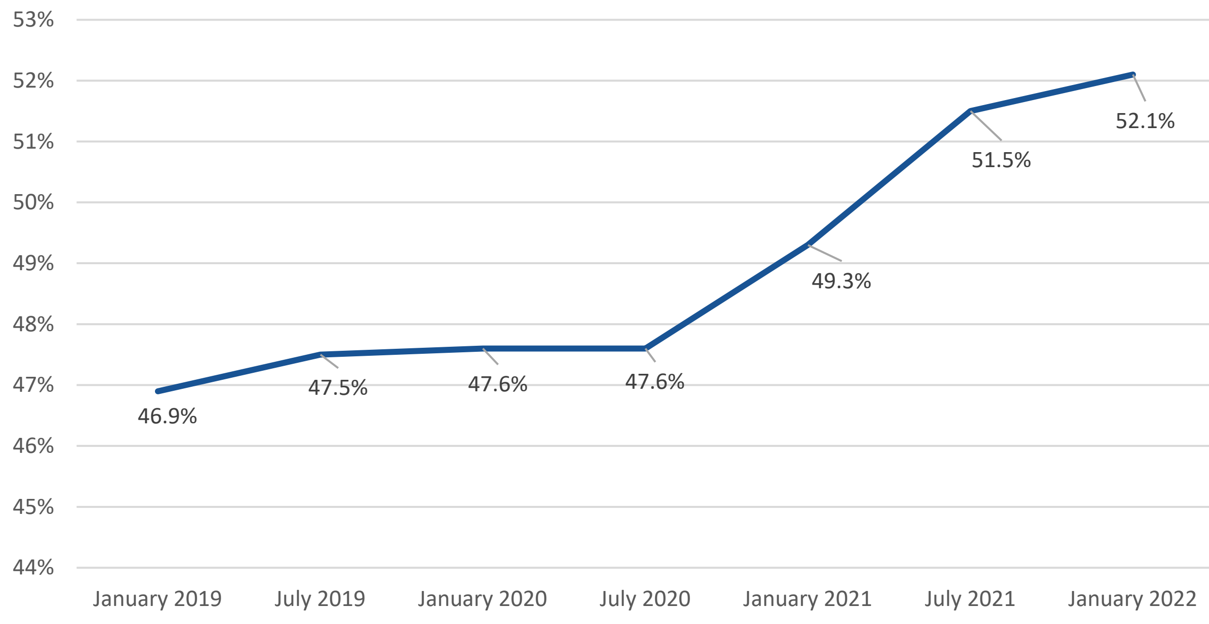
Source: LevinPro HC, Irving Levin Associates, December 2023 levinassociates.com
Note: Physician medical group mergers and acquisitions exclude transactions where the target sector is dental, dental services, eye care, management, and podiatry.

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. Most prominent among these consolidations has been hospitals purchasing or contracting with physicians' practices. A recent report estimated that in January 2022, over 50 percent of physicians were employed by hospitals (Figure 2-4).[13] While the number of practices 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).

[13] 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.

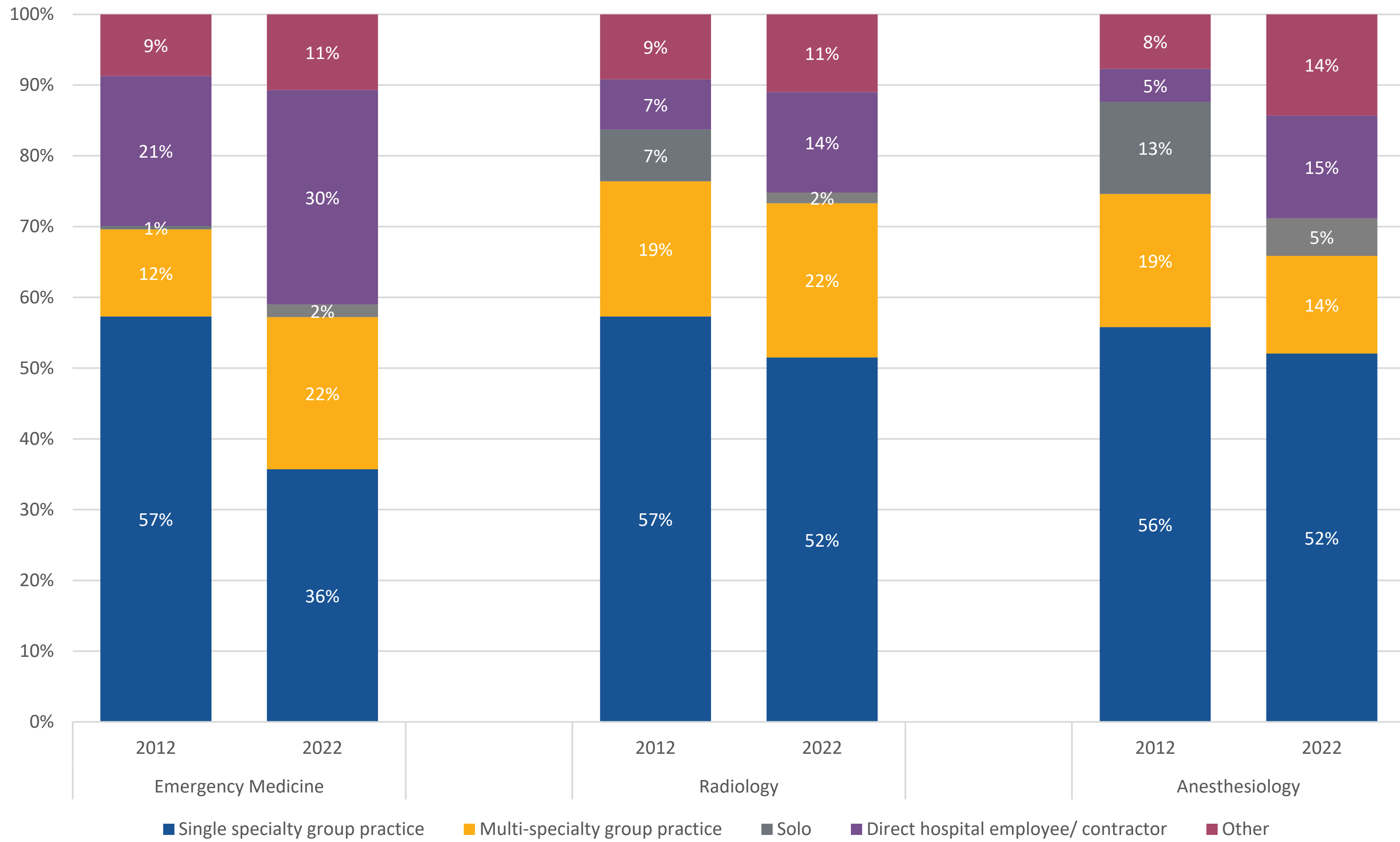
Figure 2-4 - Percent of U.S Physicians Employed by Hospitals/Health Systems, 2019-2021



Source: Avalere analysis of IQVIA OneKey database that contains physician and practice location information on hospital/health system ownership (slide 12 here: https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf?ver=ksWkgjKXB_yZfImFdXlvGg%3d%3d)

Hospital employment of physicians has grown in recent years. This growth has been particularly rapid for certain specialties. In the last ten years, the American Medical Association Physician Practice Benchmark Survey shows increasing numbers of physicians are either direct employees or contractors of hospitals. In the survey, only two specialties (pediatrics and psychiatry) saw little change in the percentage of physicians in a practice directly owned by or contracted with a hospital. The specialties with the largest percentage point increases of physicians in practices directly owned by or contracted with a hospital from 2012 to 2022 were anesthesiology (9.8 percentage point increase), emergency medicine (9.1 percentage point increase), and radiology (7.8 percentage point increase) (Figure 2-5).

There is also an increasing trend of insurers or private equity firms acquiring physician practices. In one recent study, the most common specialties among practices acquired by private equity are anesthesiologists at 33 percent of all physicians; emergency medicine specialists, 16 percent; family practitioners, 9 percent; and dermatologists, 6 percent (Zhu et al., 2020). Both emergency medicine and anesthesiology are specialties commonly associated with surprise billing. The interaction of private equity acquisitions and NSA impacts on further consolidation are unclear.



Source: American Medical Association Physician Practice Benchmark Survey 2012, 2022

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 health care product markets at several levels of geography.[14] 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.

HHI scores for hospital markets are calculated based on data from the American Hospital Association Annual Survey. Adjusted hospital admissions[15] 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).[16] 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)[17] reflect urban commuting patterns.[18] 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 2021 (Figure 2-6).

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[14] 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 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.

[15] 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)).

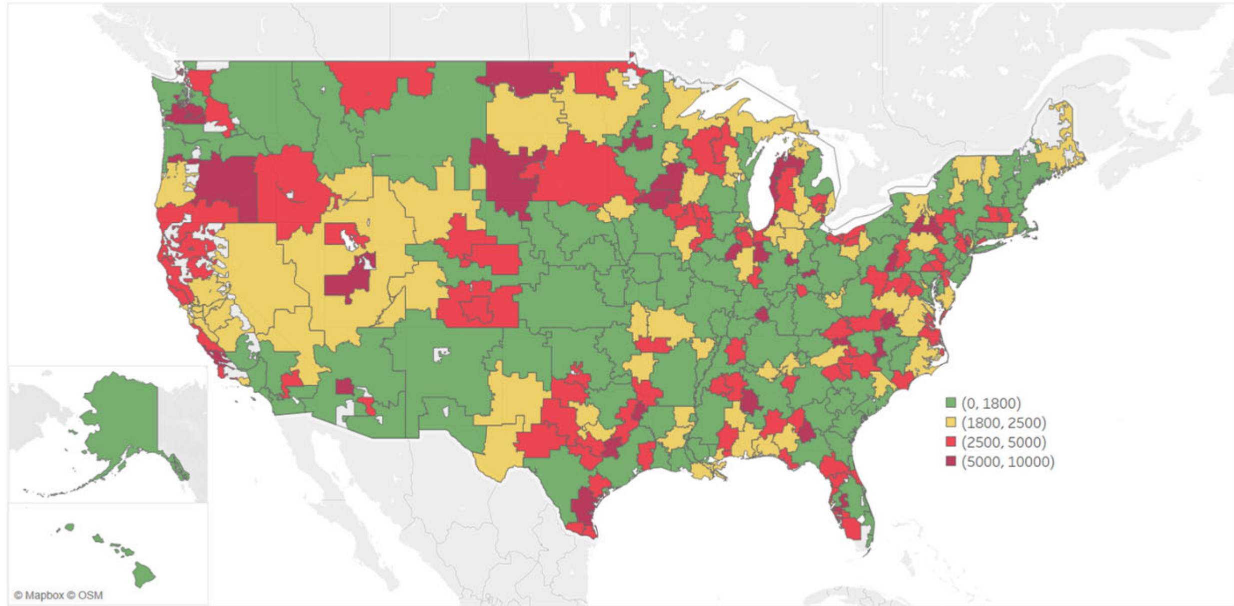
[16] Because HRRs generally are too large to be considered markets, unless the market consists of specialized services, these numbers and figures used here are intended to be broadly illustrative rather than precise.

[17] 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.

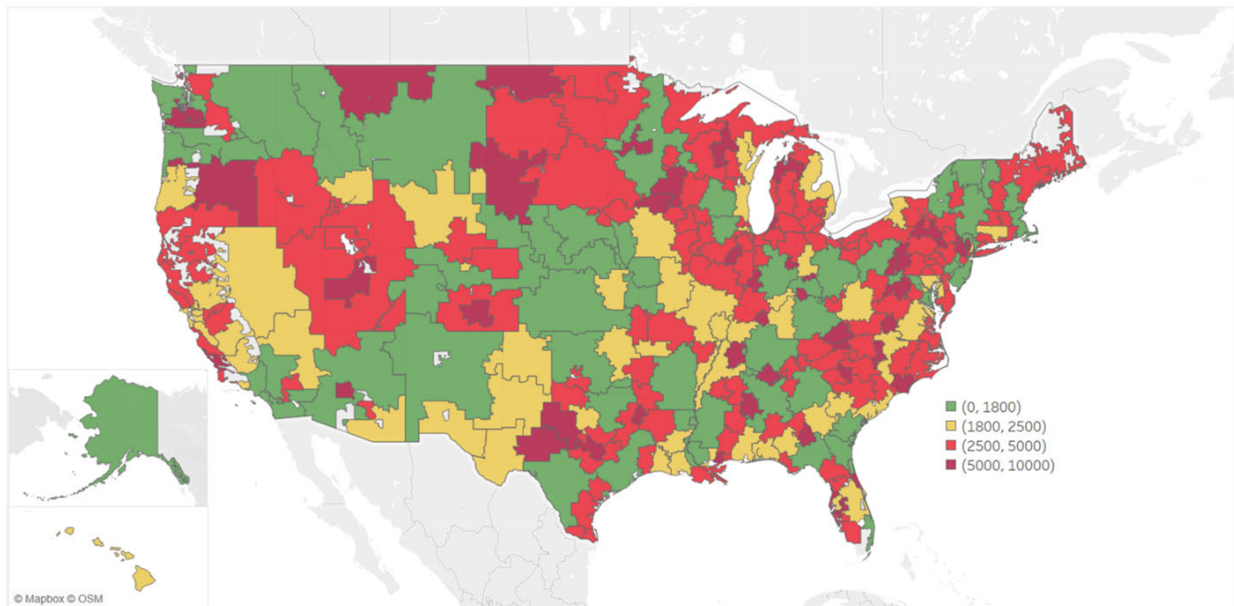
[18] The increase in remote work and telehealth due to the COVID-19 pandemic may also influence the construction of relevant markets.

Figure 2-6 - Hospital Referral Region (HRR) Level Herfindahl-Hirschman Index (HHI) Scores For Adjusted Admissions, 2008 and 2021

2008



2021



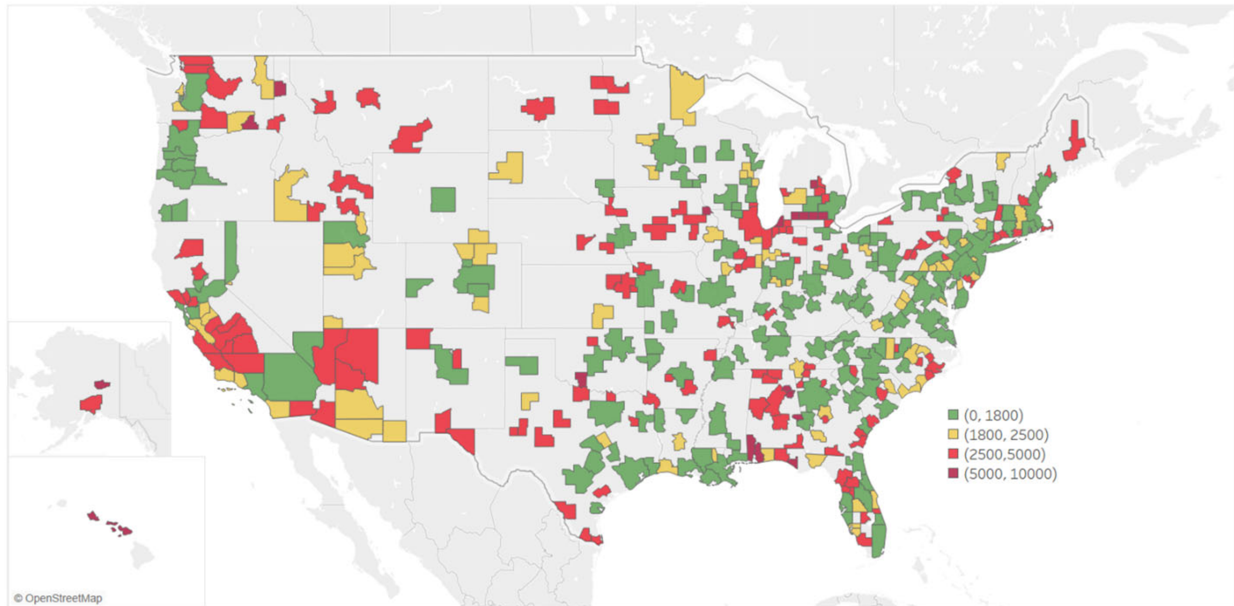
Source: ASPE Anaylsis of AHA Data

In Figure 2-7, health insurance HHI scores are calculated using Clarivate Managed Market Surveyor[19] 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 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).

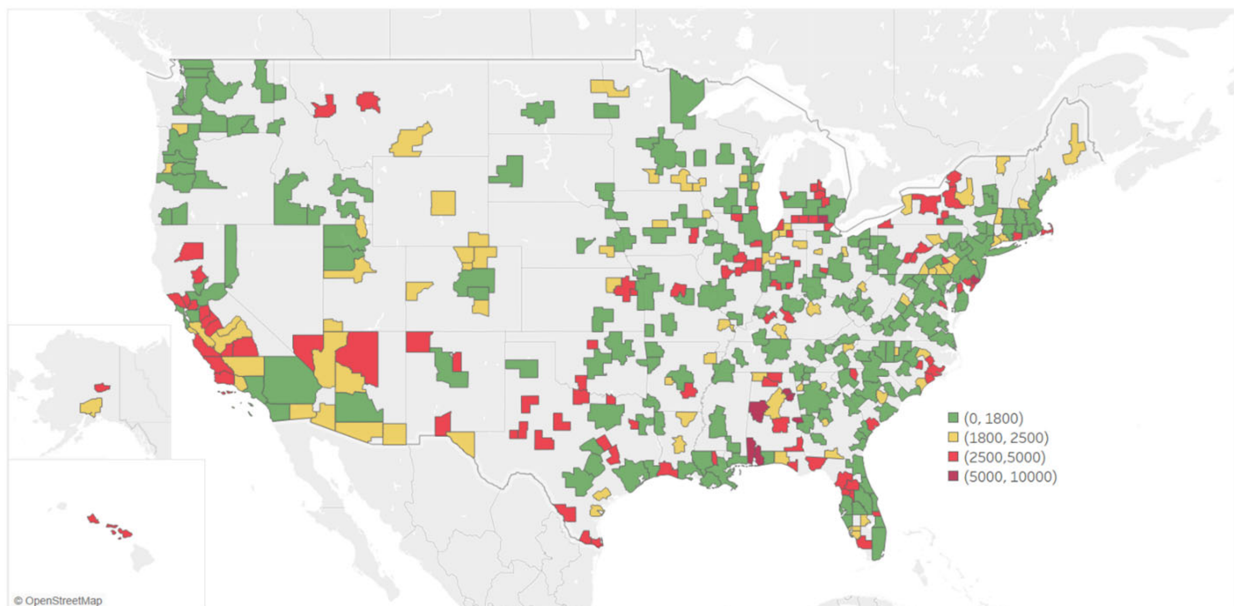
[19] Clarivate Managed Market Surveyor captures enrollment of health lives and affiliations by payer and geography.

Figure 2-7 - Core-based Statistical Area (CBSA) Level Herfindahl-Hirschman Index (HHI) Scores for Commercial Health Insurance Membership, 2008 and 2023

2008



2023



Source: ASPE Anaylsis of Clarivate|Clarivate Managed Market Surveyor

As shown above, in the years preceding NSA implementation, many markets for hospitals, physicians, and private health plans and issuers were highly concentrated. Many of these markets are also becoming even more concentrated. Vertical integration of physician practices by health systems has also become more common. Because the NSA may influence the dynamics of negotiation between providers and private health plans or issuers, each side may feel pressure to further consolidate beyond these

baseline trends. However, isolating specific marginal impacts of the NSA on these consolidation trends may be challenging.

Chapter 3. Descriptive Analysis of Trends in OON Billing

Updated Data on the Pre-NSA Implementation Period

This section describes trends in OON billing in the United States in the period before the NSA was enacted using the Health Care Cost Institute (HCCI) 2.0 data. The HCCI 2.0 data contain claim and enrollment information for 55 million individuals insured through employer-sponsored coverage per year between 2012 and 2021. The data are from three national issuers – Aetna, Humana, and Kaiser Permanente – as well as data from Blue Health Intelligence.[20] Together, the data constitute roughly one-third of enrollees with employer-sponsored insurance in the United States, covering all 50 states and the District of Columbia. It does not include any data from individual health insurance coverage, so we were unable to assess surprise billing in the individual insurance market.

The HCCI 2.0 data include a network status flag that indicates whether the claim was paid in-network or OON. Figure 3-1 presents the share of all professional claims[21] that were OON from 2012 to 2021. This analysis focuses on professional claims since surprise billing often occurs for physician or other professional services furnished by an OON provider at an in-network facility.

We consider claims to be "potential surprise bills" if they are either (1) OON professional claims for emergency services, or (2) OON professional claims furnished with respect to a visit to an in-network facility.

When there is not an emergency, the network status of facilities can be verified in advance more easily than the network status of providers who provide care at a given facility. The network status for both facility and professional claims for emergency services can be unknown to the patient at the time of care, and an OON facility claim for an emergency service would typically be accompanied by OON professional claims as well. Additionally, in some circumstances, a patient may affirmatively choose to receive services from an OON provider, a decision that would not be captured by claims data if the patient chooses to finance the service out-of-pocket.

Overall Trends in OON Billing

The overall prevalence of professional claims that were OON was modestly lower in 2021 than 2012, decreasing from 6.0 percent to 5.4 percent (Figure 3-1), consistent with earlier work showing declining rates of potential surprise bills (Garmon and Chartock, 2017). The share of claims that were OON out of total payments declined consistently from 2012 to 2019, when 4.6 percent of payments were OON. However, beginning in 2020 and continuing in 2021, overall OON prevalence has increased. Still, in settings where surprise bills are a particular concern – emergency services and non-emergency services furnished by an OON provider with respect to a visit at an in-network facility – the rates of OON claims have steadily, if slowly, decreased since 2012 and do not show the same post-2019 reversal in trend.

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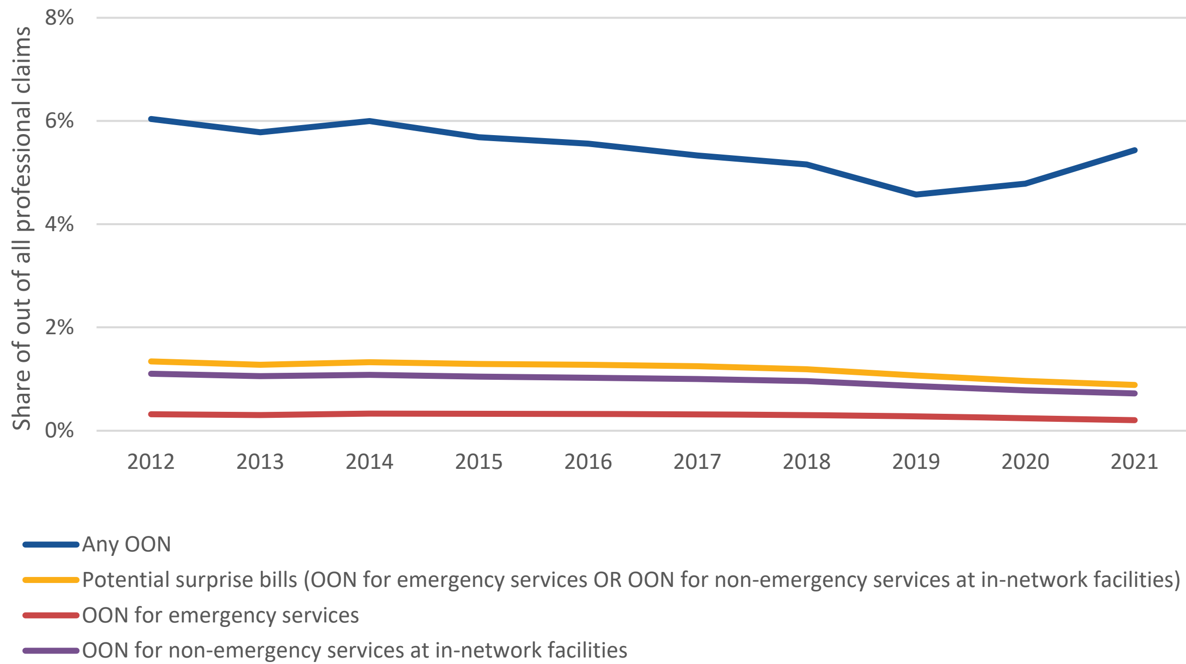
[20] Blue Health Intelligence is a data and analytics company that is a licensee of the Blue Cross Blue Shield Association and that collects and maintains claims data from independent Blue Cross Blue Shield licensee insurance companies.
[21] Professional claims (sometimes called non-facility claims) refer to bills that a physician or other medical professional submits to a patient's health plan or issuer for reimbursement. Professional claims are distinct from facility claims that are generated by hospitals or other medical facilities.

Figure 3-1 - Overall OON Prevalence and Potential Surprise Bills, 2012-2021

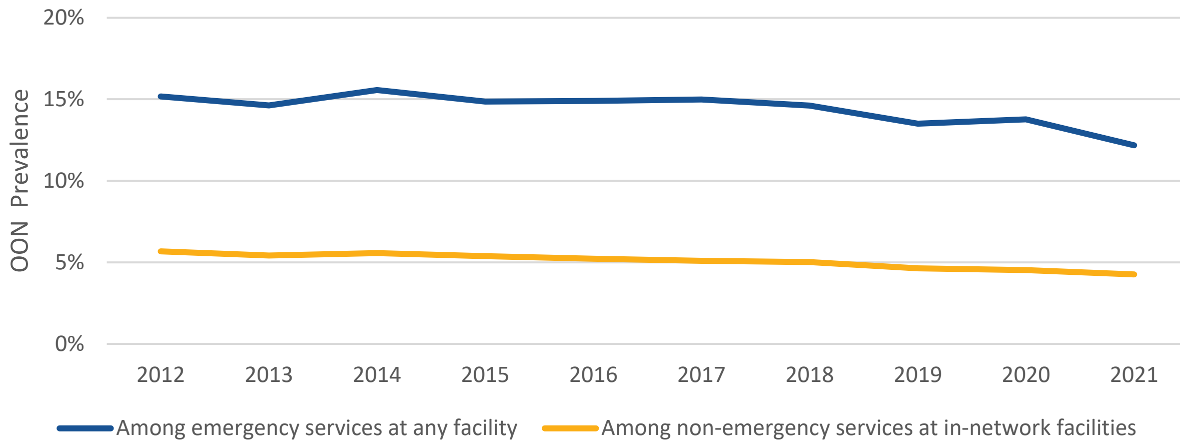


Source: Analysis of OON trends using Health Care Cost Institute 2.0 data

Trends in OON Billing by Care Setting

Figure 3-2 shows rates of OON prevalence in the two potential surprise billing settings: emergency services, and non-emergency services furnished by an OON provider with respect to a visit at an in-network facility. OON prevalence declined from 15.2 percent to 12.2 percent from 2012 to 2021 for emergency services and from 5.7 percent to 4.3 percent for non-emergency services at in-network settings.

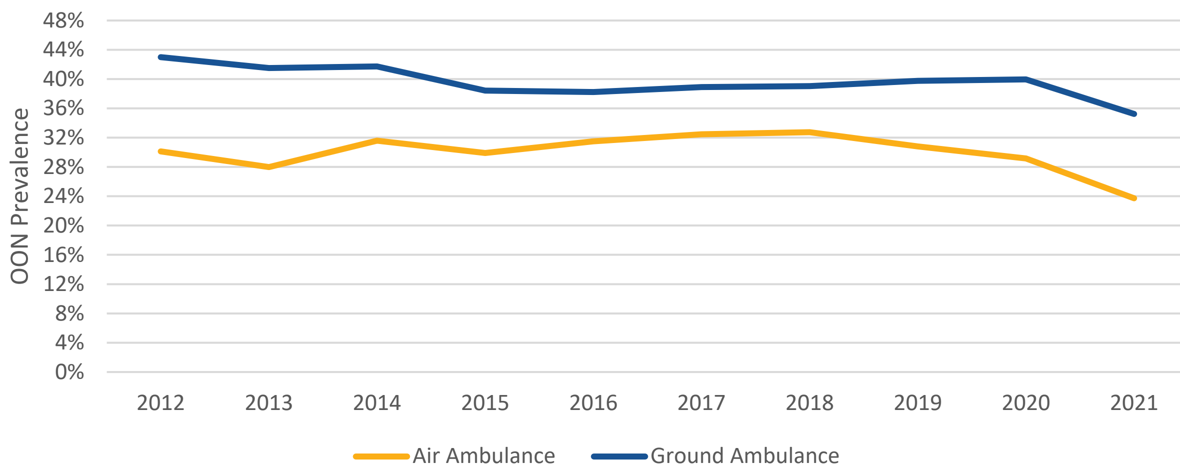
Figure 3-2 - OON Prevalence in Potential Surprise Bill Setting, 2012-2021



Source: Analysis of OON trends using Health Care Cost Institute 2.0 data

Figure 3-3 below shows OON prevalence for both air and ground ambulance services. For air ambulance, which is regulated by the NSA, OON prevalence stayed relatively stable at around 30 percent between 2012 and 2020 and declined to 23.7 percent in 2021. OON prevalence for ground ambulance services, which is not regulated by the NSA, declined slightly from 43 percent to 40 percent from 2012 to 2020 and then declined further to 35.3 percent in 2021.

Figure 3-3 - OON Prevalence for Ambulance Services, 2012-2021



Source: Analysis of OON trends using Health Care Cost Institute 2.0 data

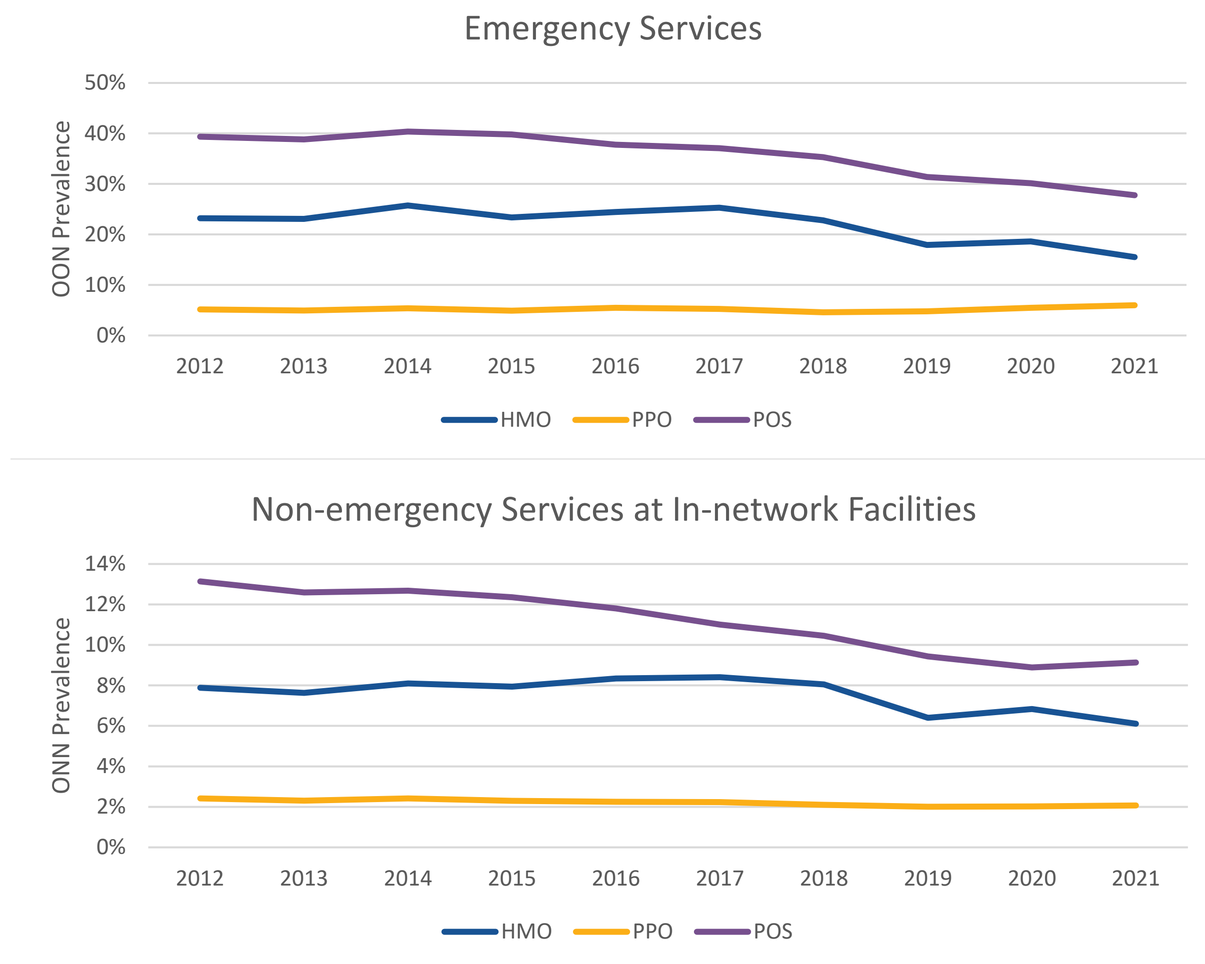
Variation in OON Prevalence by Insurance Plan

The number of in-network providers available to enrollees can vary depending on the type of insurance product. For example, in the individual market, health maintenance organization (HMO) plans were found by one research team to be over twice as likely to have small or extra small networks of physicians (Polsky

and Weiner, 2015). Enrollees with narrower networks may face higher rates of surprise bills because of their plans' network size.

Figure 3-4 shows OON claim prevalence by insurance type (point-of-service (POS), HMO, or preferred provider organization (PPO)) and service type. OON claim prevalence for emergency services for HMO plans declined from 23.2 percent to 15.5 percent in this period. PPO plans had the lowest OON claim prevalence for emergency services with little change in this period (ranging from 4.6 percent to 6.0 percent). For non-emergency services with respect to visits at in-network facilities, POS plans experienced the greatest decline in OON claim prevalence from 13.1 percent in 2012 to 9.1 percent in 2021. HMO plans declined from 7.9 percent to 6.1 percent, and PPO plans stayed low and largely stable, ranging from 2.0 percent to 2.4 percent.

Figure 3-4 - OON Prevalence by Insurance Type in Potential Surprise Bill Settings, 2012-2021



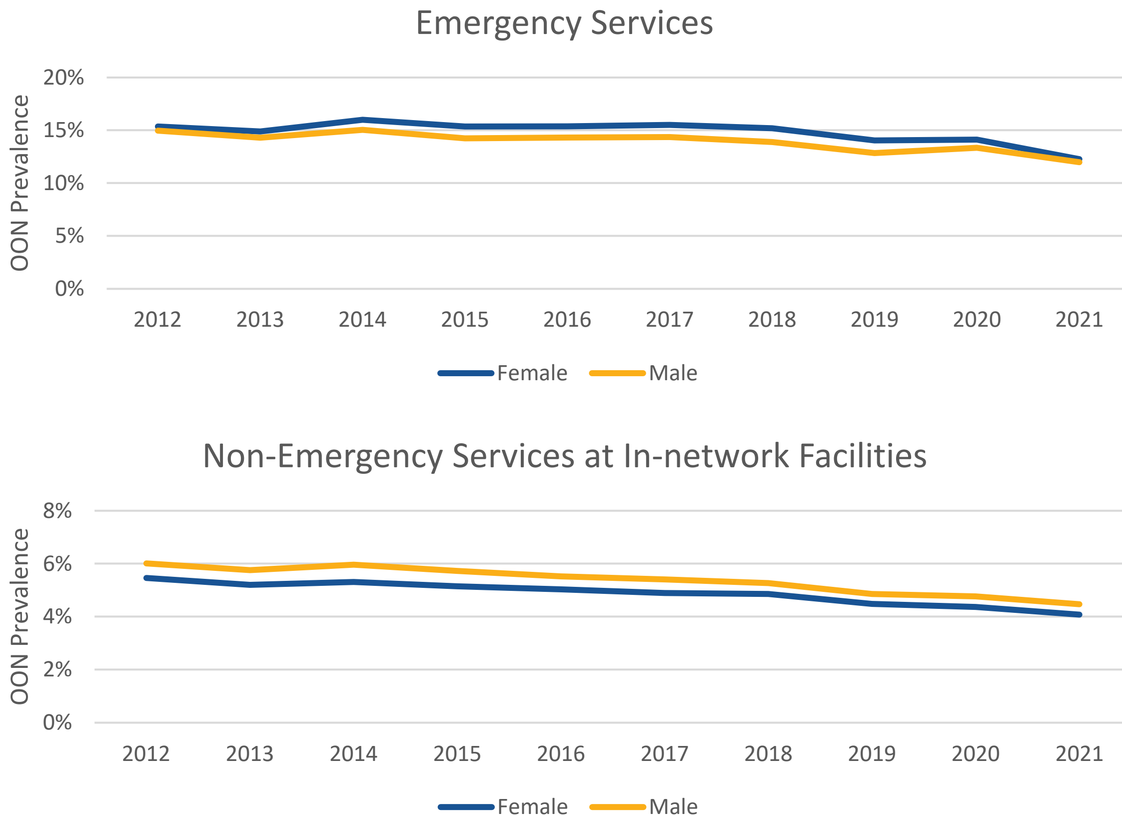
Source: Analysis of OON trends using Health Care Cost Institute 2.0 data

Variation in OON Prevalence by Patient Characteristics (Sex, Age, Urban/Rural)

This section explores trends in OON prevalence by selected demographic characteristics. Changes in trends by demographic could point to services commonly associated with those demographic groups being particularly affected by the NSA protections.

Female patients have slightly higher OON claim prevalence than male patients for emergency services, but the reverse is true for non-emergency services with respect to visits at in-network facilities. The differences are modest but persist throughout the period 2012-2021 (Figure 3-5).

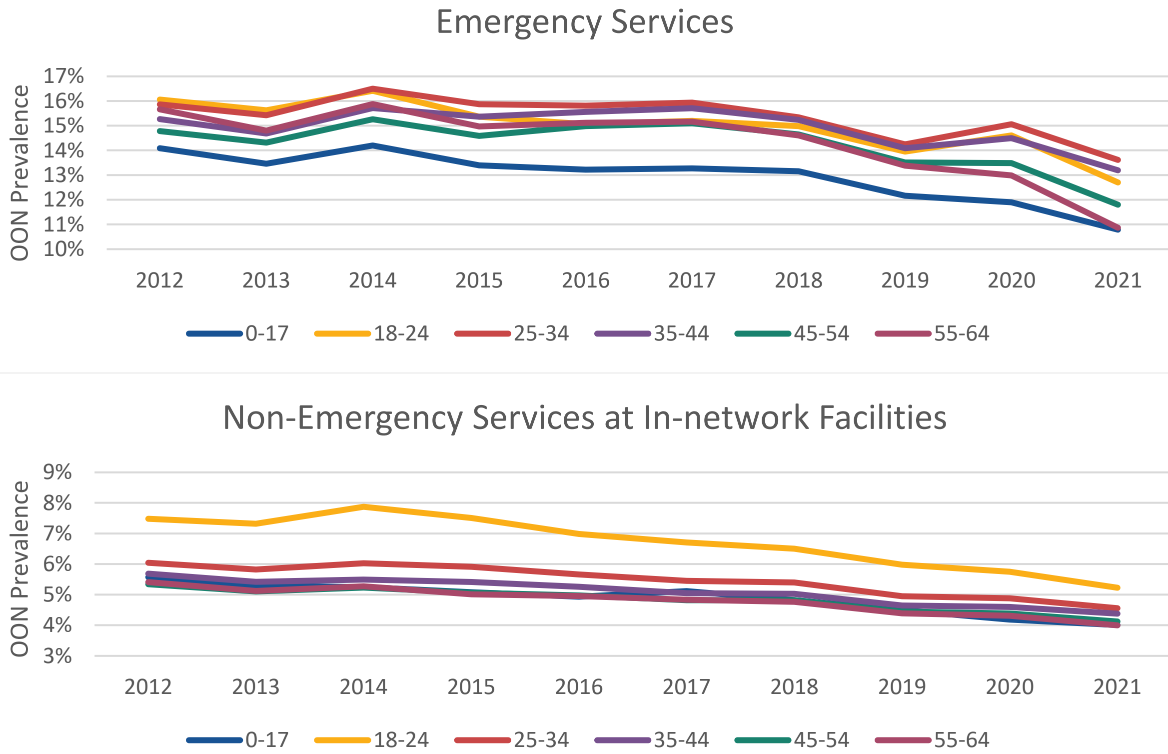
Figure 3-5 - OON Prevalence by Patient Sex in Potential Surprise Bill Settings, 2012-2021



Source: Analysis of OON trends using Health Care Cost Institute 2.0 data

All age groups saw OON claim prevalence decrease, on net, for both emergency services and non-emergency services at in-network facilities between 2012 and 2021. OON claim prevalence increased for younger adults (ages 18-24, 25-34, and 35-44) from 2019 to 2020 while OON claim prevalence for children (0-17) and older adults (45-54, 55-64) stayed even or declined only slightly. In 2021, there was a return to the broader trend as all age groups saw declines in OON prevalence for emergency services in 2021 relative to 2020. Young adults (18-24) had higher OON claim prevalence than all other groups for non-emergency services at in-network facilities throughout the 2012-21 period (Figure 3-6).

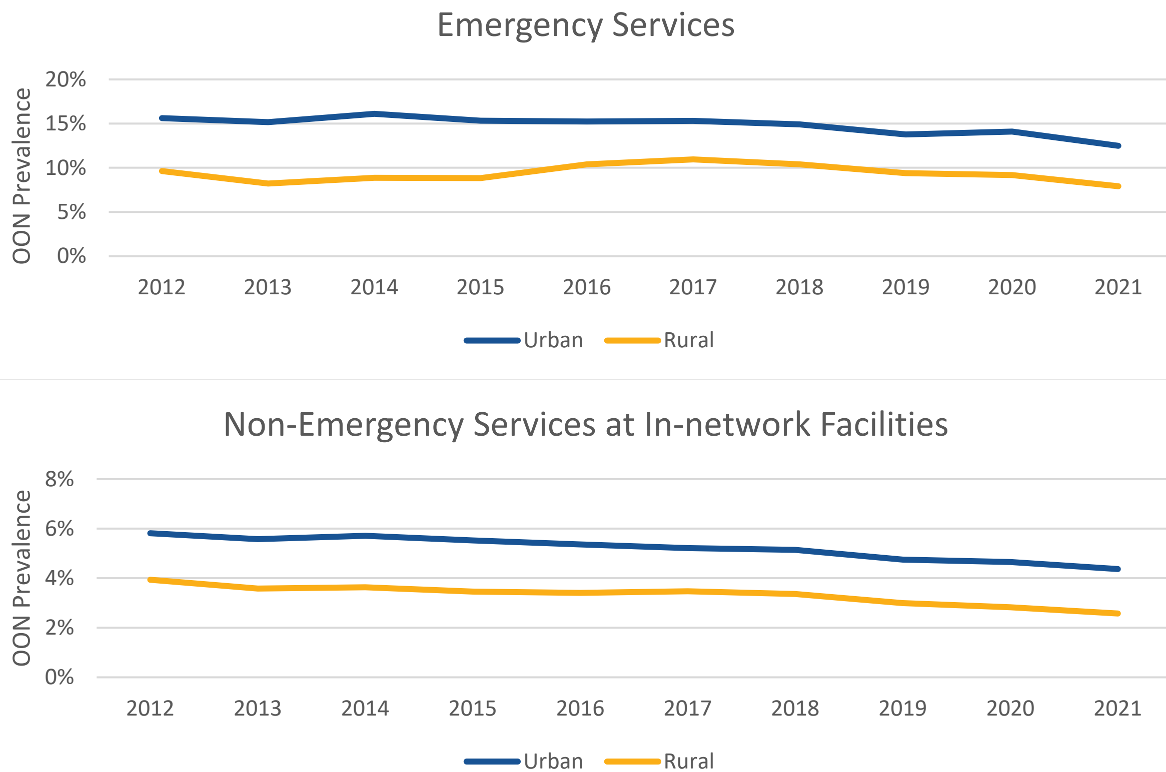
Figure 3-6 - OON Claim Prevalence by Patient Age in Potential Surprise Bill Settings, 2012-2021



Source: Analysis of OON trends using Health Care Cost Institute 2.0 data

OON claim prevalence was higher among patients from urban areas than rural areas for both emergency services and non-emergency services with respect to visits at in-network facilities (based on patient's residence ZIP code) (Figure 3-7).

Figure 3-7 - OON Claim Prevalence by Urban versus Rural Status in Potential Surprise Bill Settings, 2012-2021



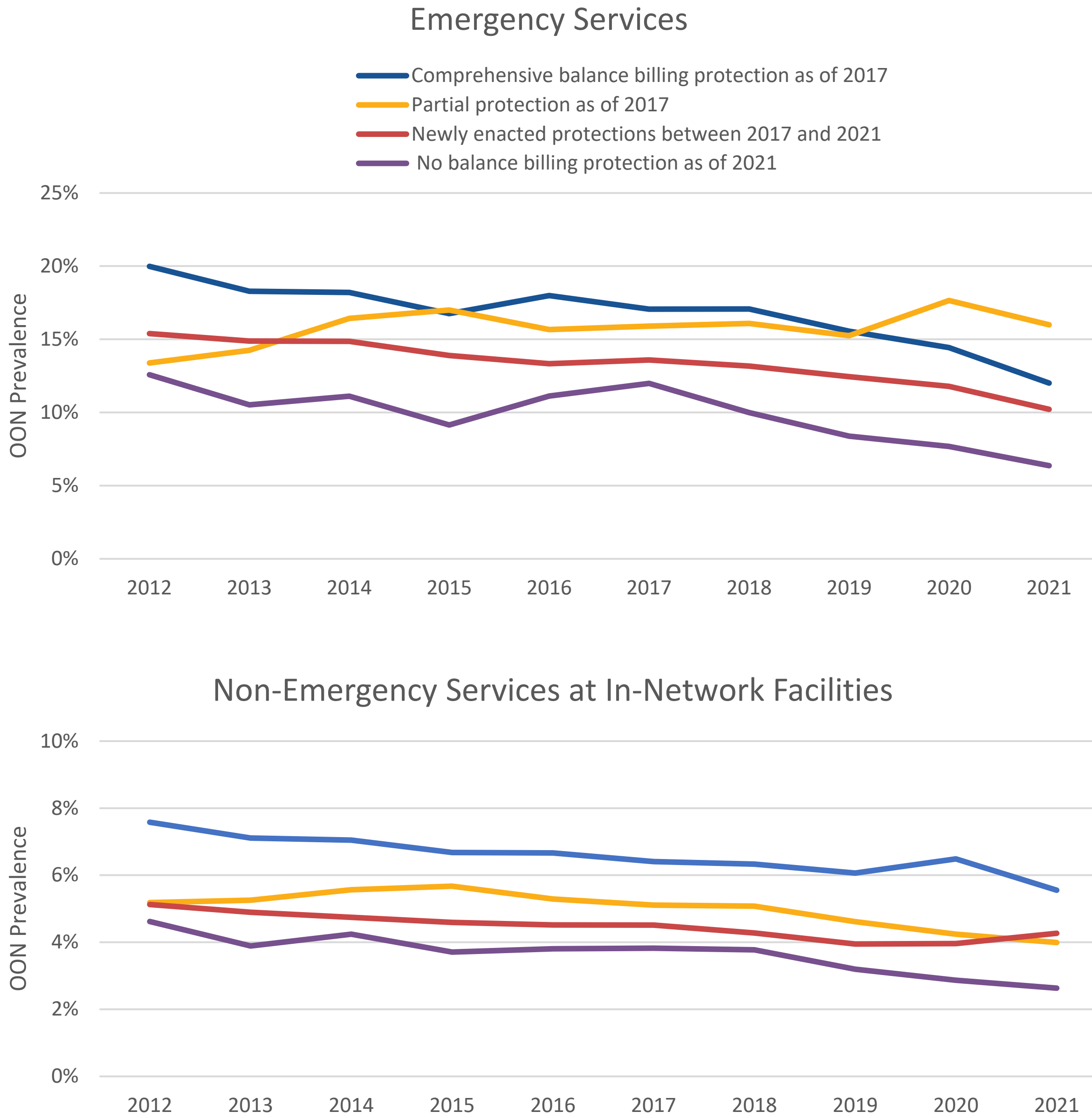
Source: Analysis of OON trends using Health Care Cost Institute 2.0 data

OON Prevalence by State Surprise Billing Laws

Figure 3-8 shows OON claim prevalence by timing and scope of state surprise billing protection laws (Hoadley et al, 2019, Kona, 2021).[22] Most states saw a gradual decline in OON claim prevalence for emergency services or non-emergency services with respect to visits at in-network facilities regardless of whether such protections were in place. However, states that had partial surprise billing protections in place as of 2017 (15 states) saw a slight increase in OON claim prevalence for emergency services. For non-emergency services in in-network facilities, trends in OON claim prevalence by state surprise billing protection largely moved in parallel, with a slight deviation in 2021 among states that enacted surprise billing protections between 2017 and 2021 that may be worth monitoring in future work.

[22] States are considered to have comprehensive protection if the laws protect against balance billing in both emergency department and nonemergency care in in-network hospitals and cover both HMO and PPO plans. More detail on how the authors categorized "comprehensive" and "partial" state protections available here: https://www.commonwealthfund.org/blog/2019/state-efforts-protect-consumers-balance-billing.

Figure 3-8 - OON Claim Prevalence in Potential Surprise Bill Settings by State Surprise Billing Protection, 2012 – 2021



Source: Analysis of Health Care Cost Institute 2.0 data

There are limitations to this analysis. It examines all types of OON billing, including OON bills incurred at in-network and OON facilities, not surprise billing specifically. One study found the share of total spending that occurred OON ranged from 6 to 8 percent in 2014 to 2017, which is similar to the results presented here (Song et al., 2020). In contrast, studies focused on OON bills incurred at in-network inpatient facilities from 2014 to 2016 found that about 15 percent of admissions had at least one associated OON professional claim (Garmon and Chartock, 2017). Additionally, while data on all states are included, the

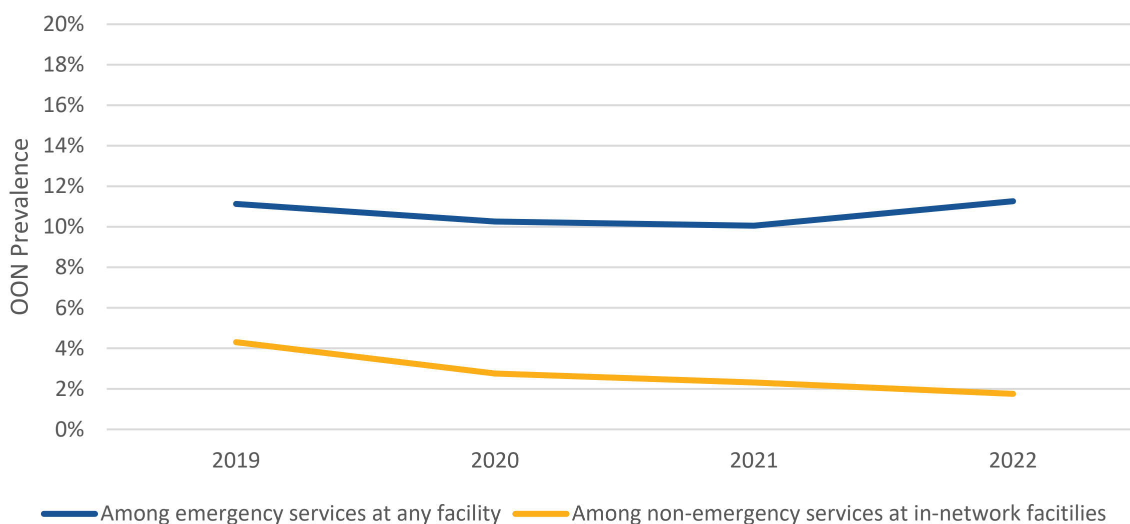
data may be less representative in states where the largest commercial issuers are not included in the HCCI data.

Colorado All Payer Claims Database (APCD)

As a supplement to the HCCI data that only includes employer-sponsored coverage, we analyzed data on OON claims from the Colorado All Payer Claims Database. These data include over 70 percent of covered lives in the state and are available through the end of 2022. They allow an early look at impacts of the period during and following implementation of the NSA while nationwide claims data are not yet available. Below are some of the same trends for the Colorado APCD data as presented above with HCCI data.

Similar to what is seen in national data (Figure 3-2), the Colorado data show that OON claim prevalence is more common among emergency services than non-emergency services at in-network facilities (Figure 3-9). The Colorado data also show that both trends declined between 2019 and 2021. However, the 2022 data show an increase in the OON claim prevalence among emergency services.

Figure 3-9 - OON Claim Prevalence in Potential Surprise Bill Setting in Colorado, 2019-2022



Source: Analysis of OON trends using Colorado APCD data.

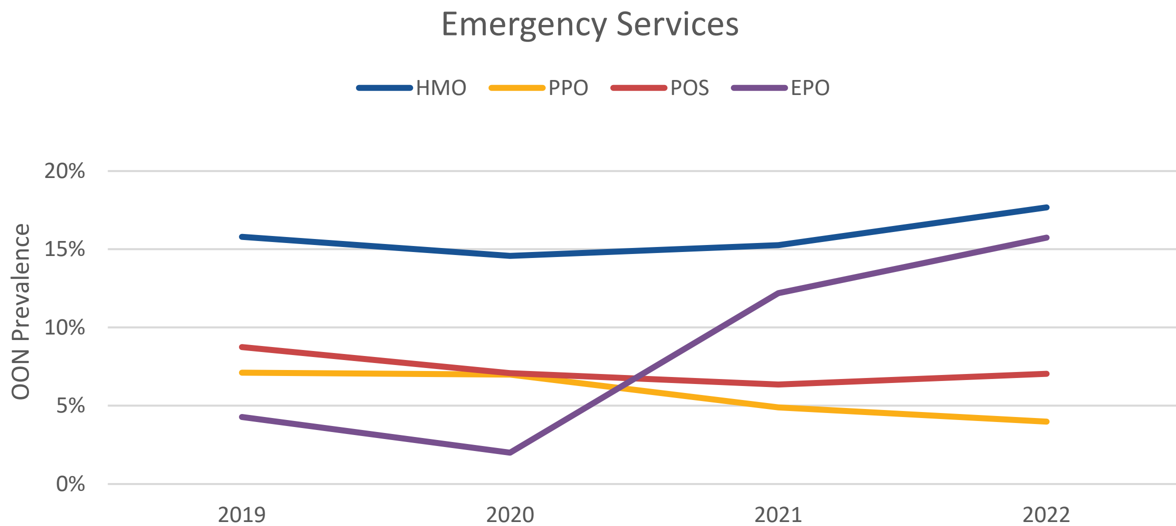
The Colorado APCD data show some patterns of OON prevalence by insurance type and patient demographics that differ from those in the HCCI data.[23] For example, in the Colorado data, POS plans had OON claim prevalence much closer to that for PPO plans for both emergency services and non-emergency services at in-network settings (Figure 3-10), whereas in the HCCI data, the prevalence for POS plans was 5 to 6 times that of PPO plans. Also, unlike the decline in OON claim prevalence for emergency services in HMO plans in the HCCI data, the Colorado APCD shows an increasing prevalence.

[23] In addition to the same insurance types found in the HCCI data, the Colorado APCD data also includes Exclusive Provider Organizations (EPOs), a type of plan that has no non-emergency OON coverage, like an HMO, but is otherwise less restrictive than an HMO.

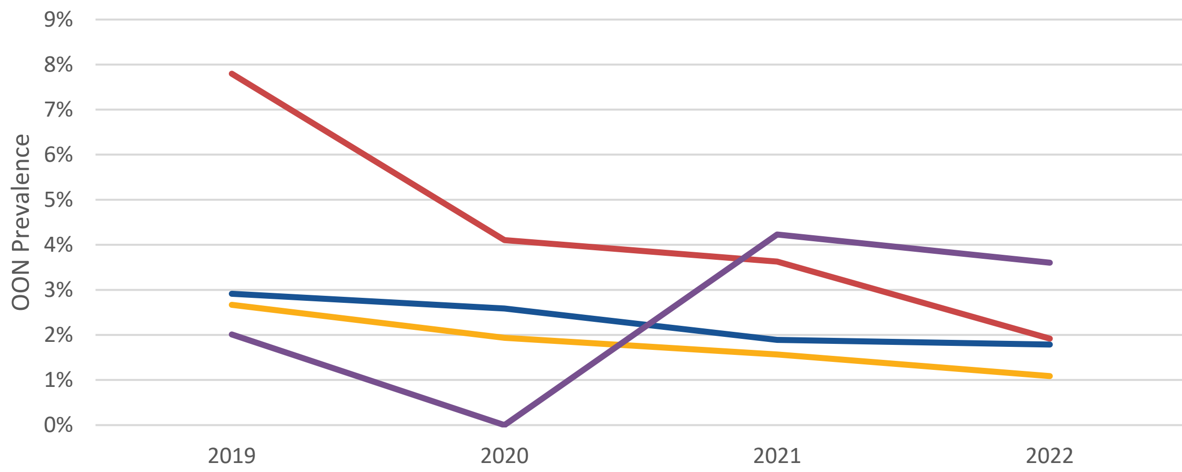
Unlike the HCCI data, urban residents in Colorado did not have higher OON claim prevalence than rural or frontier residents (Figure 3-11). OON claim prevalence for in-network facilities was virtually identical in urban, rural and frontier counties[24] between 2019 and 2022.

Some of these differences may be particular to the health insurance markets in Colorado and may not be generalizable to other states. Other states would likely have their own unique patterns. Continuing to analyze specific states and markets will be important as 2022 data become available nationally.

Figure 3-10 - OON Claim Prevalence by Insurance Type in Potential Surprise Bill Settings in Colorado, 2019-2022

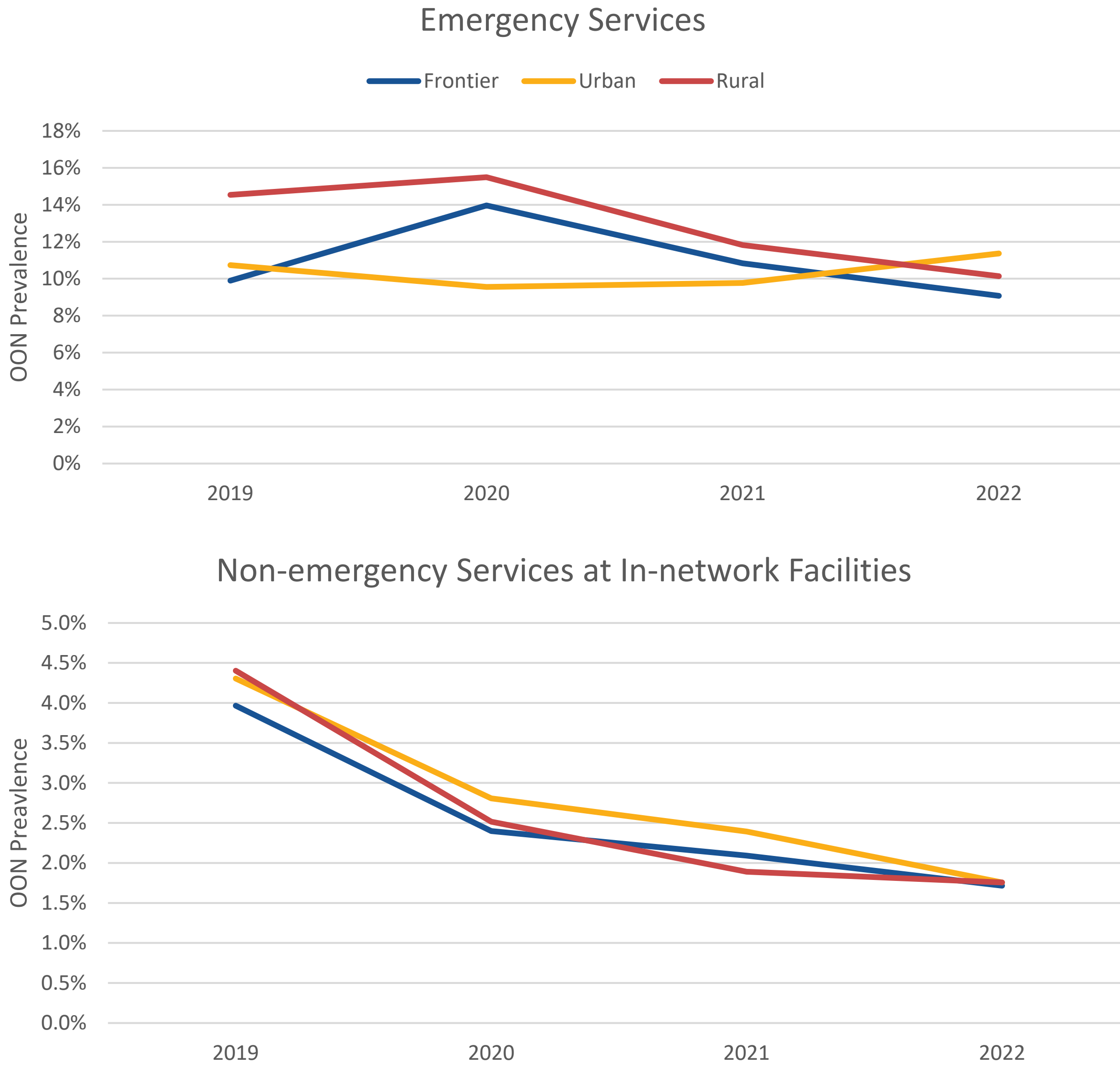


[24] Colorado frontier counties are particularly low population density rural counties. The Colorado Rural Health Center defines frontier counties as those counties with a population density of six or fewer persons per square mile.



Source: Analysis of OON trends using Colorado APCD data.

Figure 3-11 - OON Claim Prevalence by Urban versus Rural Status in Potential Surprise Bill Settings in Colorado, 2012-2021



Source: Analysis of OON trends using Colorado APCD data.

Chapter 4. Interested-Party Discussions of NSA Impacts

In this section, we discuss the series of interviews conducted with interested parties regarding the NSA. The goal of this qualitative study was to engage in wide-ranging discussions surrounding surprise medical billing and the NSA.

These interviews were conducted in two stages. First, we conducted a virtual focus group with nine individuals who were enrolled in private health plans and coverage who responded to screening questions indicating they had ever received a surprise bill. Participants were aged 19-62 and varied by gender, race, and geography.[25] Of the nine individuals, four had received a potential surprise bill either before or after January 1, 2022 (the date the NSA took effect) and the other five indicated they had received a potential surprise bill after the date the NSA took effect in a setting that would have been likely to generate a surprise bill before NSA implementation (ED visit or in-network hospital visit). As participants were not selected randomly, the focus group should not be considered representative of the U.S. population as a whole. In particular, rates of surprise billing among the focus group cannot be extrapolated to the national level, as individuals were screened based on ever having received a surprise bill or having had an experience that could have resulted in a surprise bill before implementation of the NSA.

Second, we engaged in virtual discussions with representatives of 32 professional organizations, including: hospitals and health systems, physician groups and provider coalitions, employer benefit consultants, and employer coalitions; national issuers, regional health plans, and insurance coalitions; state regulators from two states with pre-NSA surprise billing laws; and attorneys who participated in the NSA's IDR process. These representatives are described in Table 4-1, below. As with the patient participants, the professional organization participants were selected non-randomly and cannot be considered representative of the national health care provider or payer markets.

Table 4-1 – Professional Organization Participants

Stakeholder Group	Participants
Hospitals/Health Systems (6)	Health system (multi-state, for-profit, publicly traded) Health system (multi-state, for-profit, privately held) Health system (multi-state, non-profit) Health system (regional, non-profit) Health system (regional, non-profit) Academic medical center
Physician Groups (7)	Emergency medicine staffing firm (private equity-owned) Multi-specialty staffing firm (private equity-owned) Emergency medicine group (physician-owned) Multi-specialty group (physician-owned) Anesthesiology group (physician-owned)

[25] Patient panel participants included four men and five women; four who identified as White or Caucasian, two who identified as Hispanic, two who identified as Black or African American, and one who identified as American Indian/Alaska Native. The nine participants ranged in age from 19 to 62, and five were residents of states with pre-NSA surprise billing laws.

	National organization representing provider specialties National organization representing medical practices
Employers & Employer Groups (7)	Fortune 500 company (multi-state, multi-industry) Fortune 500 company (multi-state, industrial) Large public employer International insurance consultant Business coalition (representing large employers) Business coalition (representing small employers) Business coalition (regional)
Insurers (7)	Regional health plan Regional health plan Fortune 500 health insurer Fortune 500 health insurer Fortune 500 health insurer National organization representing insurers National organization representing insurers
State Regulators (2)	State regulatory body that handles surprise billing disputes State regulatory body that handles surprise billing disputes
3rd Party IDR Participants (3)	Attorney representing physician-owned provider group Attorney representing professional services firm Attorney representing third-party billing company

In both the patient focus group and organizational discussions, we discussed a wide variety of questions. The following section discusses key findings from the conversations as well as potential next steps for future research.

Focus Group with Patients

Interviews conducted during the patient focus group revealed that most patients felt that the problem of unexpected medical billing has not been resolved by the January 1, 2022 implementation of the NSA's prohibition on surprise bills. Of the nine patients interviewed, two said they had experienced a potential surprise bill after January 1, 2022. One of these potential surprise bills was from an OON anesthesiologist for care at an in-network hospital, and the other was for OON emergency care. While we could not verify that the bills received after NSA implementation were bills that should have been prohibited by the law, the descriptions given by the two patients who received them were consistent with an NSA-prohibited surprise bill. Other patients in the focus group reported receiving unexpectedly high medical bills that were not prohibited by the NSA. In general, the patients who had experienced an unexpectedly high

medical bill before or after January 1, 2022 reported that the experience was anxiety provoking and time consuming to resolve—it took approximately four to six months to work out a solution with the provider, such as paying the bill in full, settling with the provider for a lower amount, getting the bill revoked, or otherwise resolving the billing issue.

Prior to the focus group discussion, most of these patients were unaware of the NSA, and those who lived in states with state surprise billing laws were also unaware of those laws. Once they were given an explanation about the law, most agreed that the NSA was a good thing, but felt that it had not solved all issues of unexpected medical billing, as some reported they were still experiencing issues with unexpected bills. One patient expressed doubt that the law would fully protect them, feeling that they would still bear the responsibility to protect themselves against surprise bills. Additionally, there was some concern among patients that other issues will arise, particularly in how the law's "consent to balance bill" provision is handled in situations where providers are permitted to ask patients to waive the protections granted by the NSA. Patient participants also reported that consent forms for balance billing (which is permitted under the NSA in limited circumstances) were apparently presented to them among piles of health care paperwork, despite requirements that these forms be given separately from other forms and not attached to any other documents.

A few patients also expressed concern that the NSA might reduce their access to care and limit their choice of a health care provider. One patient was concerned that the law might affect the general availability of physicians in their state and deter physicians from accepting insurance. Most patients also expressed the belief that the NSA would not affect insurance premiums, with one stating, "Insurance companies are not going to lose money—they're going to get their money somehow."

How Prevalent is Surprise Billing Following Implementation of the NSA?

As discussed above, following NSA implementation, some patients are still reporting that they experienced unexpectedly high medical bills. It is unclear, however, if these bills are surprise bills prohibited under the NSA. Providers reported in discussions that it is extremely common for patients to be unaware of the cost-sharing provisions of their coverage. In particular, providers stated that patients often do not understand that enrolling in a high-deductible health plan may require them to pay a significant amount out of pocket for medical care before their health plan or coverage would start to pay. Additionally, focus group participants felt that they were still at risk for unexpectedly high medical bills.

The Centers for Medicare & Medicaid Services (CMS) has been able to verify reports of only a small number of prohibited surprise bills sent to patients after January 1, 2022. CMS maintains a No Surprises Help Desk (NSHD) for consumers and others to get answers to questions and report complaints regarding violations of the law, including surprise bills. As of December 31, 2023, the NSHD had received 8,096 complaints against providers, a subset of which related to potential violations of the law's surprise medical

billing prohibition.[26] When CMS receives complaints of surprise bills within its jurisdiction, CMS engages directly with the relevant provider. Of the complaints investigated by CMS, CMS reports that 43 have been found to be violations of the NSA's prohibition against surprise bills.[27] In the 43 cases found to be violations, CMS has been able to work with the providers to correct the patient's medical bill and assist the provider to come into compliance with all NSA provider requirements.

While cases can be resolved once the government becomes aware of them, the conversations with the patient focus group revealed that most of them had not heard of the NSA or of their own state's surprise billing law, if they lived in a state that had one. For patients to report violations, they must know that a law preventing such violations exists and that there is a way for them to report suspected violations. Overall, the results presented here suggest that some prohibited surprise billing may still be taking place (in part due to patients not being fully aware of the law and its requirements and protections).

Interviews with Other Interested Parties

In interviews with interested parties other than patients, we found that most believed that the NSA had solved the problem of surprise billing for patients. Representatives of physician groups stated that the law "makes [patient] out-of-pocket expenses more predictable." One leader of an employer coalition also confirmed they had not heard of their members receiving surprise bills after NSA prohibitions on surprise billing took effect.

In general, interested parties all agreed that patient knowledge of the protections in place from the NSA was low, echoing sentiments expressed in the patient focus group. Employers stated that communication of the law to employees was an issue, while physician groups pointed to inadequate communication of health plan cost structures to patients, leading to frequent confusion among patients regarding whether a bill was a surprise bill or, alternatively, a bill that was unexpectedly large, but consistent with their insurance plan's cost-sharing.

Both providers and private health plans and issuers reported that the biggest challenge of implementation was the Federal IDR processes, which they described as a "major lift." Both reported that participating in the process was expensive, and physician groups reported it caused financial stress for small and medium-sized physician practices. Providers reported that the implementation of the Federal IDR process required hiring additional staff to process additional claims reviews and to submit disputes to IDR entities. They also reported that additional staff were needed to produce GFEs, as required under a separate provision of the NSA. One attorney we interviewed reported that their provider organization required eight additional full-time-equivalent staff to handle the volume of the IDR process. In addition to staffing changes, physician groups noted that additional staff training about the law and new software for their

[26] Most complaints against providers are within CMS' enforcement jurisdiction. However, in some instances, state agencies have primary enforcement jurisdiction or have a collaborative enforcement agreement with CMS in which the state seeks to achieve voluntary compliance. If CMS does not have jurisdiction, the NSHD refers consumers to the appropriate authorities. Surprise billing complaints directed to states are not included in the total number of complaints against providers received by NSHD.

[27] The CMS Provider Enforcement team investigated 6,113 of these complaints. Of these, 1,983 fell outside its jurisdiction and were sent to states for investigation. 43 were found to be violations.

billing system required substantial investment. Some physician groups estimated that the administrative cost to implement these changes was around $100,000 to $200,000. Hospitals, health systems, and private health plans and issuers faced similar challenges regarding additional staffing and updates to their IT systems.

Providers expressed concerns about the QPA, which is often the basis for calculating patient cost-sharing amounts for many services covered by the NSA and frequently serves as a benchmark for negotiating out-of-network rates.[28] Physician groups said that they mistrusted the QPA calculations in cases when (1) the QPA is lower than Medicare rates, (2) the QPA offered is significantly lower than what was previously paid, (3) they are given two different QPAs from the same health plan or issuer for the same service at the same facility by the same doctor, and (4) what they are being paid as an in-network provider by a different health plan or issuer is significantly higher than the QPA. In contrast, private health plans and issuers viewed the QPA as an integral part of the NSA and the IDR process. They cited its important role as a benchmark in the negotiating process which, prior to the NSA, could get stalled over disagreements on what data source to use as a standard for a reasonable payment rate.

In addition, both hospital and health systems reported that the NSA has changed the dynamics of provider network contract negotiations. Providers reported feeling as though they have no leverage to negotiate with private health plans and issuers because they can no longer threaten to balance bill patients if private health plans and issuers do not agree to pay a higher rate. Meanwhile, private health plans and issuers noted that practices backed by private equity brought the largest volume of IDR claims, with one issuer stating that as many as 71 percent of disputes were brought by just four practices under one private equity group. This finding that a small number of organizations file a majority of the cases is consistent with the IDR public use files (PUFs) released on February 15, 2024 and June 12, 2024 (Hoadley and Lucia, 2024). Physician group coalitions expressed concerns that the high cost of the Federal IDR process and increased administrative costs might incentivize more consolidation and take-up of physician practices by private equity.

The impact of the NSA on health care access, quality, and prices are major questions. Among interested parties, the opinions on these issues were mixed. Insurance companies noted that, if the NSA leads to reductions in provider network participation, this could make issuer-driven quality improvement initiatives harder. Both health systems and providers expressed concern that the NSA could worsen conditions regarding network adequacy, as insurance companies might stop contracting with providers and instead rely on QPAs as a method of setting payment rates. In addition, physician groups, health systems, and attorneys worried about the increase in administration costs due to the NSA and how that might result in potential spillover costs to patients, although to date, no providers reported that they were billing patients more due to the costs of NSA administration.

This qualitative study provides useful insight into the impact of the NSA before commercial health insurance data are available to assess the impact of the law quantitatively. While the majority of interested parties expressed that the NSA solved the problem of surprise billing for patients, patients

[28] See footnote 5 above explaining when the QPA is used to calculate patient cost sharing amounts.

themselves expressed uncertainty regarding the effects of the law. In addition, interested parties expressed concerns regarding potential spillover effects of the NSA. These outcomes and spillover effects will be the subject of analysis and evaluation in future reports.

Chapter 5. Conclusion

A primary goal of the NSA is to provide protections for patients against the financial consequences of surprise bills. Surprise bills occur when individuals with a private health plan or coverage receive unexpectedly high 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' exposures to surprise bills.

Discussions conducted with interested parties for this report suggest that, from the perspective of providers and private health plans and issuers, the intended effect of the NSA – removing patients from OON payment disputes between providers and private health plans and issuers – has largely been accomplished. Discussions with a select group of patients reveal, however, that they are still concerned about unexpected high medical bills and still seem to be having some experience with them. It is unclear, however, whether the bills patients are experiencing are surprise bills prohibited by the NSA or bills that are not prohibited by the NSA (for example, in cases where patients are enrolled in health plans with high cost sharing).

While the primary intended effect of the NSA's surprise billing provisions is to prohibit surprise bills and the associated adverse financial consequences for patients, there are several potential health care market impacts that may also occur. The first report to Congress described a conceptual model of how the NSA may affect several related outcomes such as in-network and OON pricing, insurance and health plan premiums, and quality of care. Negotiations between providers and private health plans and issuers affect both in-network and OON prices, as well as network participation by providers. To the extent that these dynamics, impacted by the NSA, lead to more market power for private health plans and issuers, health plans and issuers may be able to negotiate lower in-network prices, reduce premiums, or limit overall health spending. In such a case, one possible response to the increase in issuer market power is providers seeking to consolidate to increase their own market power and strengthen their bargaining positions. This can have its own negative consequences for consumers such as lesser competition for providers and in the quality and price of their services. Private health plan and issuer claims data for items and services furnished after the implementation of NSA became available during 2024 and will be used for evaluating key outcomes such as consumer complaints, prices, spending, quality, access to health care, and market consolidation in the next report due January 2025.

There will be significant challenges for estimating these NSA effects relative to other important influences on trends in the outcomes of interest. In beginning to address these challenges, the first and second Reports to Congress reviewed baseline information on OON billing, market consolidation and concentration, and current state surprise billing laws already in effect. Subsequent reports will employ a variety of methodological approaches to examine changes in these trends that may be attributable to the implementation of the NSA. Future reports may also include recommendations with respect to potential challenges addressing 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.