AMERICANS FOR FAIR HEALTH CARE

No Surprises Act (NSA) Impact Analysis

2024

About AFHC

Americans for Fair Health Care (AFHC) is a national healthcare coalition representing 50,000 physicians and advanced practice clinicians who are dedicated to protecting medical practices and the patients they serve by advocating for reasonable and sustainable health insurance coverage. Insurer abuse takes many forms but has one common impact: it strains the ability of America's medical community to deliver the care patients need. As a result, AFHC members are working with community partners and concerned policymakers to combat insurer abuse and secure targeted action that protects practices, patients, and their communities.

The NSA Impact Analysis

The No Surprises Act (NSA) was developed by Congress to shield patients from unexpected gaps in their health insurance coverage while preserving their access to care. Towards that end, the law established a balanced process for dispute resolution for out-of-network care that removes patients from reimbursement disputes between insurance companies and medical providers. America's medical community applauded the NSA's passage and expected that all parties involved would abide by the legislation's letter and spirit. The evidence shows that some insurance companies continue to be acting in bad faith, however, further manipulating the NSA in the following ways:

- **Corporate health insurers are depriving patients of access to in-network care by terminating provider contracts, slashing reimbursement, imposing patient cost sharing, denying NSA-covered services, and dodging compliance with the Independent Dispute Resolution (IDR) and Open Negotiations processes.**

- **These actions are directly undermining Congress' intent in passing the NSA, which prioritized the protection of patients from surprise bills and preserving their access to in-network providers and treatment.**

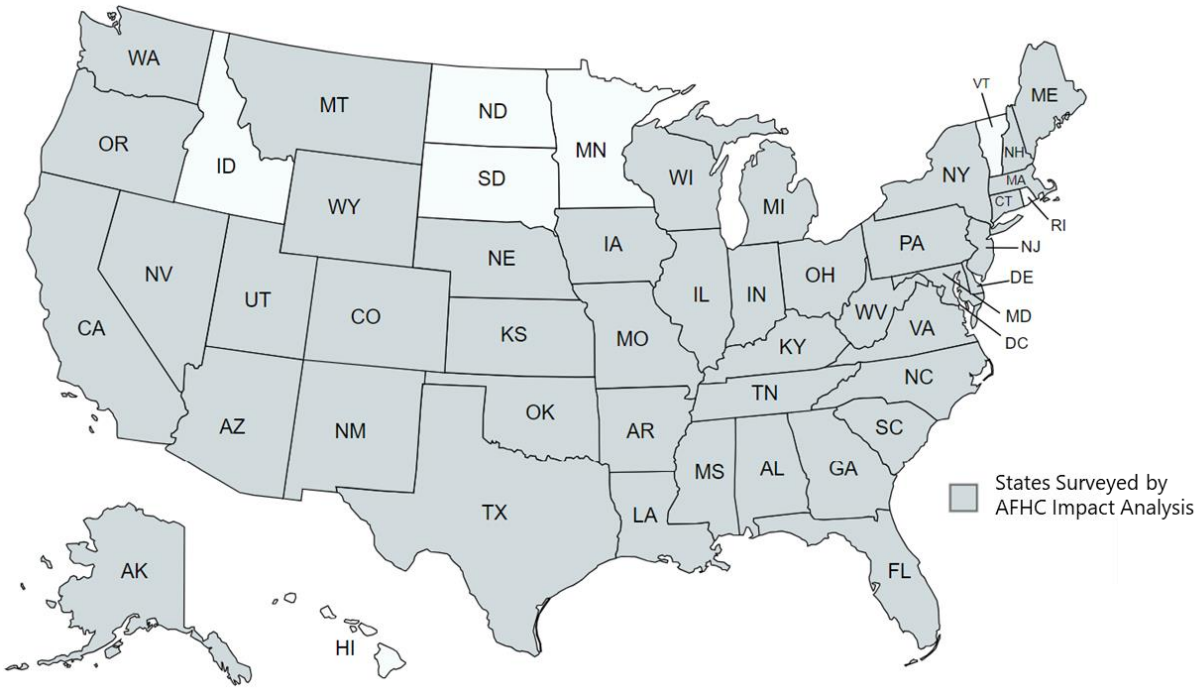
- **As a result, insurers are reaping enormous profits and stock market gains by paying out a smaller share of enrollees' premiums to providers, reducing payment amounts, delaying their disbursement, and engaging in the "shared savings" kickback scheme for billions of dollars in additional profit.**

Survey Scope

Due to the seriousness of these concerns, AFHC launched a nationwide survey to document the abuses and aid decision-makers in their analysis. The NSA Impact Analysis collected 2023 data from clinicians between March 20-July 10, 2024. The scope of this survey is as follows:

Specialties: Anesthesia, Critical Care, Emergency Medicine, Hospital Medicine, Interventional Radiology, Neonatology, Obstetrics, Post-Acute Care, Radiation Oncology, Radiology, Surgery, Telemedicine, Urgent Care

States: 45 States



Survey Findings

AFHC's second annual NSA Impact Analysis survey reveals that NSA manipulation continues to be committed by corporate health insurance companies, as revealed by the comparative stats below:

Payers Are Continuing to Shred Patient Access to In-Network Care

- In 2022, **100%** of providers were threatened with contract termination. This outrageous practice persists, with **53%** of providers threatened with contract termination in 2023.
- In 2022, **81%** of providers had **at least 1 contract** terminated by an insurer. This practice is continuing, too, with **24%** of providers having **at least 1 contract** terminated in 2023.
- **100%** of providers received take-it-or-leave unilateral contract amendments in 2022. This practice is continuing, with **24%** of providers unilateral contract amendments in 2023.
- Likewise, insurers made take-it-or-leave demands **11 times** to providers in 2022. Insurers continued to make such demands in 2023 at an average rate of **4 times** per provider.

This Enables Payments to Continue to be Sharply Cut, Delayed, or Not Made At All

- On average, 2022 payments were cut **52%** after insurers terminated in-network contracts. This abuse is continuing, with 2023 payments being cut **51%** after in-network termination.
- In 2022, **94%** of providers received QPA payments priced at or below Medicare. This practice was unchanged in 2023, with **94%** of providers still receiving Medicare-level QPA payments.
- **52%** of payments determined by IDREs in 2022 were not made at all (zero payments). Not yet deterred, insurers failed to make **22%** of payments determined by IDREs in 2023.
- Following Independent Dispute Resolution, **49%** of 2022 payments were not made in the required 30 days and **33%** were incorrect. In 2023, those rates were **35%** and **19%**.

Insurers Also Continue to Undermine the Resolution Mechanisms Intended by Congress

- Only **5%** of disputes, on average, were resolved during Open Negotiations in 2022. That abysmal rate edged up only slightly in 2023, to **7%** of disputes.
- Similarly, insurers made an Open Negotiations counteroffer only **26%** of the time in 2022. The Open Negotiations counteroffer rate rose to just **29%** in 2023.

- In 2022, insurers disclosed which claims were federal IDR-eligible only **33%** of the time. Insurers continue to "hide the ball," making this disclosure just **43%** of the time in 2023.
- Once in the IDR process, it took an average of **119 days** to resolve disputes in 2022. Providers continue to wait too long, with resolution delayed **88 days** in 2023.
- In 2022, Qualified Payment Amounts (QPAs) were machine-readable only **64%** of the time. Little progress has been made so far, with QPAs machine-readable **69%** of the time in 2023.
- On average, it took **236 days** overall for a payment dispute to be resolved and paid in 2022. In 2023, providers had to wait nearly 4½ months due to insurers' **132-day** payment delay.
- Only **24%** of IDR submissions were completed in 2022, with an average of **67%** pending. In 2023, **36%** of IDR submissions were completed, leaving an average of **46%** pending.

In Addition to These Continuing Problems, Other Forms of NSA Abuse Plague Providers

- Survey respondents reported that insurers rejected IDRE determinations **121 times** in 2023 and increased patients' cost sharing following IDR determinations **4,899 times** last year.
- **87.5%** of providers experienced insurers denying NSA-covered services to a patient in 2023 and reported that this unlawful activity occurred **5,024 times** last year.
- Also in 2023, providers were compelled to make an Open Negotiation offer that was less than their medical practice's originally submitted payment amount **88%** of the time.
- Insurers made an Open Negotiation counteroffer above the initial amount only **29%** of the time in 2023. More often, they made no counteroffer (**34%**) or didn't even reply (**37%**).
- In 2023, few (**18%**) of IDR disputes filed were decided fewer than 60 days. Instead, many more were decided in 61-120 days (**28%**), 120-180 days (**24%**), and 181 or more days (**29%**).
- Many providers were unable to file IDR disputes in 2023 due to: the IDR fee threshold (**35%**), lack of staff or other operational resources (**27%**), and lack of eligibility information (**14%**).
- Finally, nearly **1-in-5** respondents reported they experienced the "shared savings" payment scheme and the imposition of electronic payment processing fees in 2023.

For More Information: Please visit AFHC at www.AmericansForFairHealthCare.org or call 804-405-7600 to learn more about AFHC and the NSA Impact Analysis.