U.S. CONGRESSMAN
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REPRESENTING THE 3RD DISTRICT OF NORTH CAROLINA

Myth vs. Fact: No Surprises Act Enforcement Act

The bipartisan *No Surprises Act* (NSA), passed in 2020, was intended to protect patients from surprise gaps in coverage and balance bills that resulted from care being unexpectedly provided by out-of-network clinicians. Despite Congress' clear intent, there is evidence that patients remain at risk of receiving inappropriate medical bills due to frequent insurance company non-compliance with the law. A new proposal aims to close enforcement gaps and create parity between penalties imposed against non-compliant insurers and providers, supporting the ultimate goal of reducing patient financial harm.

Proposed New Legislation: Parity in Non-Compliance Penalties. Apply the same financial penalty that already exists for providers who violate the balance billing protections to insurers that fail to apply a patient's in-network benefits to care protected by the NSA.

Myth: The NSA is new and complicated. Payers are working hard to comply, but they are experiencing growing pains and need time to build the systems that support compliance. They have every reason to comply and no reason to inappropriately deny coverage.

Fact: The NSA was passed in 2020 and went into effect in 2022. Insurers and clinicians have had ample time to familiarize themselves with the expectations of the law and implement changes to policies and procedures to ensure compliance. Clinicians, who currently face up to a $10,000 penalty each time they issue a bill to a patient for an inappropriate out-of-network balance, have generally been able to comply with the NSA. A comparable insurer penalty may create appropriate urgency in their compliance.

Myth: If additional enforcement mechanisms are created to penalize payer non-compliance, it will result in increased premiums for patients and drive-up out of pocket insurance costs.

Fact: Even without the imposition of fines, the threat of $10,000 Civil Monetary Penalties for clinicians that send surprise bills to patients has incentivized their compliance. If payers act responsibly, putting in place appropriate screening processes and showing intention for compliance with the law, payers should not experience any penalty. Without action however, patients will remain at risk of financial harm as a result of insurer non-compliance.

Myth: The existing law ensures patients are only responsible for their in-network cost-sharing amount when they need emergency care or when they receive non-emergency care from an out-of-network clinician at an in-network facility. $10,000 civil monetary penalties can already be applied if patients are billed inappropriately. Patients are protected from unavoidable out-of-network costs and disputes in rates of reimbursement under the *No Surprises Act* are between the provider and the payer.

Fact: The patient cannot be held harmless when payers consistently adjudicate claims incorrectly. According to the existing law, out-of-pocket maximums, deductible amounts, and co-insurance payments should always be applied to NSA covered care as if in-network. Clinicians only have the benefit information given to them by the insurers after they submit a claim. The complexity of in-network and out-of-network benefit design, deductibles, coinsurance amounts, and out-of-pocket cost accumulators mean that providers may unknowingly issue a bill for an incorrect amount due to incorrect claim adjudication by the insurer. Insurers should be held accountable for incorrect billing in the same way that providers are.

Proposed New Legislation: Enforcing On-Time Payment of Independent Dispute Resolution Decisions. Apply a late payment penalty and interest for failure to meet the 30-day statutory payment deadline after dispute resolution. Widespread non-compliance with this 30-day payment requirement has had substantial cash-flow implications for prevailing parties, as identified by the Ways & Means Committee's hearing in September, 2023.

Myth: While insurers will admit that they are often late in resolving payment after IDR, they argue that it is not intentional. Final dispute resolution documents are complex and non-descriptive, making it difficult to easily identify how much non-prevailing parties owe, who they owe it to, and what claims those payments apply to.

Fact: CMS made significant improvements to the post-IDR dispute resolution notices in April 2023, improving the dispute determination form and presenting the status of claims in IDR more comprehensively. Each completed form includes a reference to the standardized IDR dispute number and clearly identifies the prevailing party, the amount owed for each item within the dispute, and the claim number of each item within the dispute; **in other words, all of the informational necessary for the non-prevailing party to make payment.** However, despite these improvements, reports of late and non-payment persist. In 2023, a survey of clinicians from American's for Fair Health Care (AFHC) found that 49% of IDR payments were made after the 30-day deadline if they were made at all.[1] A more recent survey from April of 2024 by the Emergency Department Practice Management Association (EDPMA) shows the same concerns, with 24% of successful dispute payments being both late and unpaid.[2] Insurers have a perverse incentive to not pay on time. **According to an annual report by the National Association of Insurance Commissioners (NAIC) on sources of revenue for payers, in 2022 insurance companies saw a 30% increase in net investment revenue[3]. In 2023, insurer net investment revenue increased by an additional 74%[4].** This increase in investment revenue is likely a direct result of insurer's ability to hold onto payments they owe to clinicians for longer, keeping those dollars invested and generating a return.

Myth: IDREs do not consistently or correctly respond to each of the informational fields on the dispute determination form. This includes failing to complete the chart detailing which factors were considered by the IDRE and why the prevailing offer was selected. Without this information, the non-prevailing party is unable to cross-check the arbiter's decision to ensure they are not considering prohibited factors. This results in delays for some payments.

Fact: Arbitration decisions under the *No Surprises Act* are binding. **The statute does not allow the non-prevailing party to withhold payment just because they disagree or feel as though a decision's rationale was not sufficiently explained to them.** If a non-prevailing party believes prohibited factors may have been considered, they should submit a complaint to CMS through the complaint portal. The updated dispute determination form includes all the information necessary for the non-prevailing party to make timely payment, including the standardized dispute reference number, the name of the prevailing party, the amount owed for each item within the dispute, and the claim number of each item within the dispute.

Myth: Providers are flooding the IDR process with frivolous claims to make it more difficult for payers to comply with the mandated timelines. The volume of claims moving through IDR is substantially higher than was expected by CMS or insurers. This has created pressure on insurers to keep up with payment processing.

Fact: Providers do not have an incentive to use the IDR process frivolously. The tediousness of initial underpayment, the cost of accessing the IDR process, and IDR resolution and payment delays are extremely

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[1] https://www.americansforfairhealthcare.org/_files/ugd/11639b_a39a37a219aa40ee8d68a219ec2e84ed.pdf
[2] https://edpma.org/wp-content/uploads/2021/02/EDPMA-NSA-Implementation-and-Compliance-Data-Analysis-April-2024-1.pdf
[3] https://content.naic.org/sites/default/files/inline-files/Health%202022%20Annual%20Industry%20Report.pdf
[4] https://content.naic.org/sites/default/files/topics-industry-snapshot-analysis-reports-2023-annual-report-health.pdf

harmful to provider operations and sustainability. Providers are paid in arrears, floating the cost of care from the time that it is provided until it is reimbursed by the insurer. Alternatively, insurers are paid in advance, generating investment revenue from the time that a patient pays their premium until they reimburse for care.

Insurers are well equipped to process payments in extremely high volumes, with more than 3 billion claims processed annually.[5] Only about 200,000 disputes were resolved through the IDR process last year, less than 0.007% of total claims volume.

[5] https://onepercentsteps.com/policy-briefs/real-time-adjudication-for-health-insurance-claims/