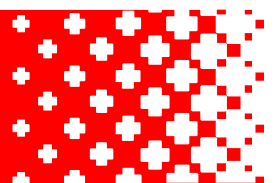




No Surprises Act (NSA) Impact Analysis

2025



FAST FACTS: Insurer Abuse in 2024

Corporate Health Insurers Continue Shredding Patient Access to Care

- **19%** of providers received take-it-or-leave unilateral contract amendments.
- **1-in-5** providers experienced **insurer-driven contract termination** in 2024.

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

- Payments were cut **~one-third** after insurers terminated in-network contracts.
- **93%** of respondents received QPAs at or below antiquated Medicare rates.
- After Independent Dispute Resolution (IDR), **50%** of payments were not made in the required 30 days, and insurers didn't make **any** payment **11%** of the time.

Payers Also Continue to Undermine the NSA's Resolution Mechanisms

- Insurers made an Open Negotiations counter-offer only **30%** of the time.
- **50%** of the time, insurers didn't even reply to Open Negotiations requests.
- Only **1%** of disputes, on average, were resolved during Open Negotiations.
- Insurers disclosed which claims were IDR-eligible only **30%** of the time.
- After a claim was filed, insurers delayed payment an average of **194 days**.

Other Forms of Payer Abuse Plagued Providers – and Patients – in 2024

- **87%** reported that insurers increased patient cost sharing last year.
 - This unlawful activity was reported to have occurred **7,258 times**.
- **86%** also reported insurers denied payment for NSA-covered services.
 - This unlawful activity was reported to have occurred **42,404 times**.

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:

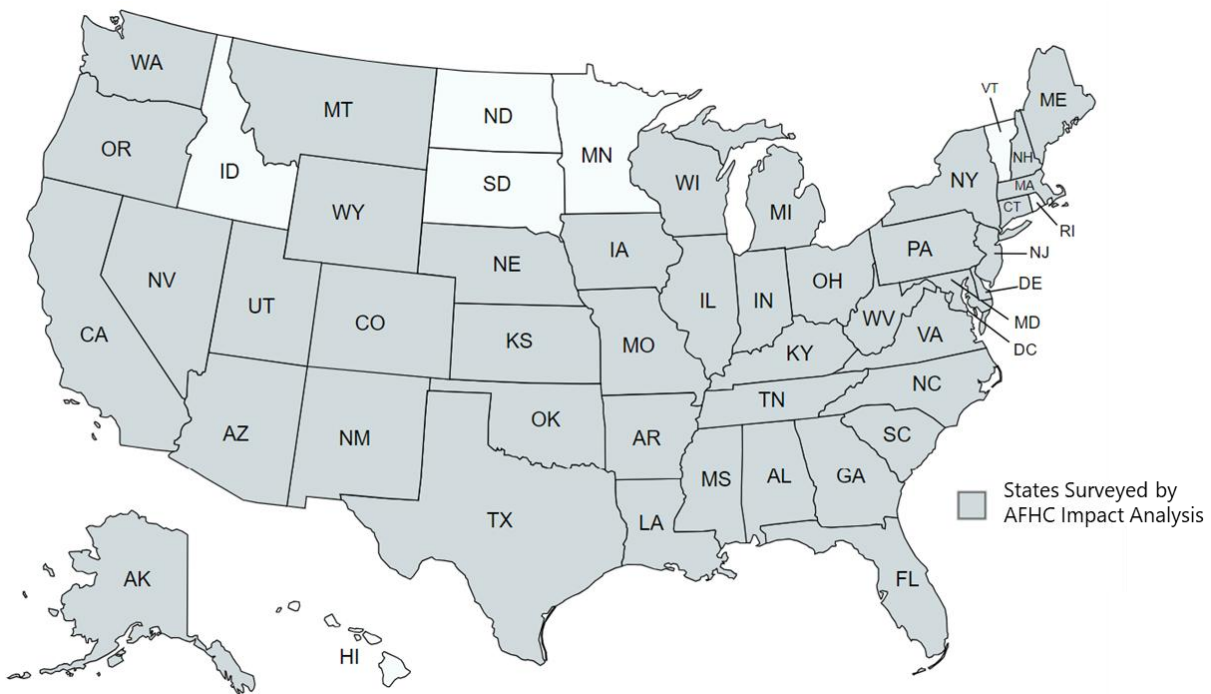
- **Corporate health insurers are depriving patients of access to in-network care by terminating provider contracts, slashing reimbursement, imposing patient cost sharing, denying NSA-covered services, and dodging compliance with the Independent Dispute Resolution (IDR) and Open Negotiations processes.**
- **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 care.**
- **As a result, insurers are reaping enormous profits by 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 2024 data from clinicians between May 7-July 11, 2025. 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 NSA Impact Analysis survey reveals that NSA manipulation continues to be committed by corporate health insurance companies, as revealed by the comparative stats below. What is driving this abusive behavior? See AFHC's [Impact Alerts](#) for details on insurer abuse and profiteering. 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.

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

- In 2023, **53%** of providers were threatened with contract termination. This outrageous practice persists, with **1-in-5** providers threatened with contract termination in 2024.
- In 2023, **24%** of providers had **at least 1 contract** terminated by an insurer. This practice continued in 2024 as **19%** of providers experienced **insurer-driven contract termination**.
- Meanwhile, **24%** of providers received take-it-or-leave unilateral contract amendments in 2023, and **19%** of providers continued receiving unilateral contract amendments in 2024.

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

- On average, 2023 payments were cut **51%** after insurers terminated in-network contracts. This abuse is continuing, with 2024 payments being cut **32%** after in-network termination.
- In 2023, **94%** of providers received QPA payments priced at or below Medicare. This practice persisted in 2024, with **93%** of providers still receiving Medicare-level QPA payments.
- **22%** of payments determined by IDREs in 2023 were not made at all (zero payments). Not yet deterred, insurers failed to make **11%** of payments determined by IDREs in 2024.
- Following Independent Dispute Resolution, **35%** of 2023 payments were not made in the required 30 days and **19%** were incorrect. In 2024, those values were **50%** and **15%**.

Insurers Also Continue to Undermine the Resolution Mechanisms Intended by Congress

- Only **7%** of disputes, on average, were resolved (meaning, payment received) during Open Negotiations in 2023. In 2024, that abysmal rate dropped to a shocking **1%** of disputes.
- Insurers made an Open Negotiations counteroffer only **29%** of the time in 2023. This rate edged up to just **30%** and insurers didn't even reply to offers **50%** of the time in 2024.
- Also in 2024, only **38%** of IDR disputes were decided in fewer than 60 days. Instead, many more were decided in 61-120 days (**22%**), 120-180 days (**17%**), and 181 or more days (**23%**).
- Many providers were unable to file IDR disputes in 2024 due to: the IDR fee threshold (**48%**), lack of staff or other operational resources (**14%**), and lack of eligibility information (**14%**).
- In 2023, insurers disclosed which claims were federal IDR-eligible only **43%** of the time. In 2024, insurers ramped up efforts to "hide the ball," disclosing it just **30%** of the time.
- Once a claim was filed, it took an average of **132 days** in 2023 before payment was made. This problem significantly worsened in 2024, with payment delayed an average of **194 days**.
- Once in the IDR process, it took an average of **88 days** to resolve disputes in 2023. This delay also lengthened in 2024, with resolution taking an average of **140 days**.
- Only **36%** of IDR submissions were completed in 2023, with an average of **46%** pending. In 2024, **74%** of IDR submissions were completed, leaving an average of **21%** pending.

In Addition to the Above, Other Forms of NSA Abuse Plague Providers – and Patients

- **87%** of providers experienced insurers hiking patient cost sharing after IDR determination. As detailed by survey respondents, this unlawful activity occurred **7,258 times** in 2024 alone.
- Just as concerning, **86%** of providers reported insurers denied payment for NSA-covered services to a patient. Shockingly, this unlawful activity occurred a **42,404 times** last year.