AMERICANS FOR FAIR HEALTH CARE

Myth vs. Fact

WHAT THEY'RE SAYING ABOUT THE NO SURPRISES ACT (NSA)

MYTH #1: Large Provider Groups are "Abusing the IDR Process." A handful of large provider groups are abusing the Independent Dispute Resolution (IDR) process and are responsible for the vast majority of IDR disputes. These large private groups are responsible for 71% of all disputes. Small provider practices aren't using IDR.

> **FACT:** 71% of disputes have been initiated by 10 provider organizations; however, only 6 of those organizations are large provider groups. The other 4 (see Appendix I) are revenue cycle management companies that manage billing and coding operations for medical groups of all sizes – including small practices.
>
> **FACT:** Conversely, 85% of disputes are initiated against just 10 health insurance companies. These insurers are driving high IDR use by underpaying for care. (Source: CMS report)

MYTH #2: 9 out of 10 Times, Providers Accept Initial Payments Based on QPAs without Dispute. The fact that most out-of-network payments are never disputed shows insurers are making fair initial payments based on QPAs that reflect appropriate market rates.

> **FACT:** Initiating disputes is costly and time consuming. What's more, restrictive batching rules and a 7-fold increase in administrative fees (both of which were eventually struck down by a federal court) made it impossible to dispute a significant proportion of underpaid claims.
>
> **FACT:** When providers do go forward with the IDR process, they win 77% of the time.

MYTH #3: The IDR Process is Biased Toward Providers. Providers win during dispute resolution 77% of the time, demonstrating how biased the process is against insurers. Arbitration results should be closer to 50/50. Arbiters need better guidance to decrease the provider win rate or the IDR process should be removed.

> **FACT:** Providers are successful in 77% of IDR disputes because their disputes are valid and well-founded. Several large payers are knowingly reimbursing for care at a rate well below what is fair and reasonable – in many cases even below the Medicare rate.

MYTH #4: Providers Are Filing Frivolous Disputes in the IDR Process. Providers are misusing the IDR process, filing disputes that are frivolous and without merit – all to gum up the works and prevent the IDR process for working the way it was intended.

> **FACT:** The extraordinary success rate – *77% of all decisions* – at which providers are winning is proof the insurers are wrong. After all, if the disputes filed by providers were in fact frivolous or without merit, providers would not be winning.

MYTH #5: Insurers are Doing Their Best to Make Payments on Time. The NSA requires arbitration award payments to be made within 30 days. While there have been some delays, insurers are making progress and trying to pay in a timely manner. Insurers have every incentive to pay quickly and no reason to delay.

> **FACT:** More than 50% of the time, insurers make arbitration award payments late or not at all. One large provider group's data shows an on-time payment rate of only 31% and a past-due unpaid rate of 43.4%. A survey of 48,000 providers by Americans for Fair Healthcare found similarly concerning rates of late and non-payment.

> **FACT:** Insurers have huge incentives to delay payment (or not pay at all). Income from invested premiums represents a significant portion of insurer profit, responsible for 30% of insurer net income in 2022. Net investment income made by insurers increased 38.3% for calendar year 2022, the first year the NSA (and associated payment delays from insurers) went into effect. (Source: National Association of Insurance Commissioners (NAIC) Report; see Appendix II)

MYTH #6: Insurers Hold Patients Harmless for Out-of-Network Care Under the NSA. Insurers apply in-network benefits for NSA covered care and have taken patients out of the middle of payment disputes.

FACT: Insurers often refuse to apply in-network benefits for out-of-network care provided at an in-network facility. These insurers incorrectly argue patients enrolled in plans without out-of-network benefits aren't protected by the NSA. (See Department of Labor FAQ 55, Q6)

FACT: After losing in arbitration, insurers have also tried to pass the responsibility for IDR awards on to patients. The statute and regulations require insurers to pay arbitration awards – they are never the patient's responsibility, even if they have an unmet deductible or co-insurance. (See AFHC Report at www.AmericansForFairHealthCare.org)

MYTH #7: Insurance Networks have Grown or Remained the Same Under the NSA. Respondents to a survey of health insurance plans released by America's Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association reported that none of their networks have experienced reductions.

FACT: The AHIP/BCBSA survey and underlying methodology are extremely opaque. The survey relies on self-reported information and uses only "number of participating health care providers" to assess network size. Under this methodology, an insurer could remove 10,000 radiologists from their network and still report an overall increase in networking if they added 10,001 pediatricians. Considering the rate at which insurers are buying out clinical practices, the survey should disclose how much of their alleged network growth can be attributed to insurers employing more and more healthcare providers.

Appendix I: Myth #1 (CMS Report)

Top 10 initiating parties and total volume of disputes (71% of all disputes). Revenue cycle management companies representing provider groups of all sizes, highlighted.

Initiating Party or their Representative	2022 Q2	2022 Q3	Overall	Percent of All Emergency and Non-Emergency Services Disputes
SCP Health	2,134	26,062	28,196	32%
R1 Revenue Cycle Management	1,563	8,304	9,867	11%
LogixHealth	2,987	3,750	6,737	8%
Roundtable Medical Consultants	1,611	3,178	4,789	6%
TEAMHealth	204	3,365	3,569	4%
Envision Healthcare	466	2,332	2,798	3%
Providence Anesthesiology	740	1,993	2,733	3%
Singleton Associates, P.A.	670	1,454	2,124	2%
Gryphon Healthcare	1,078	952	2,030	2%
HCA Healthcare	1,021	850	1,871	2%

Top 10 non-initiating parties and total volume of disputes (85% of all disputes)

Non-Initiating Party or their Representative	2022 Q2	2022 Q3	Overall	Percent of All Disputes Involving Emergency and Non-Emergency Items or Services
United Healthcare	4,170	16,880	21,050	24%
Aetna	3,070	9,220	12,290	14%
MultiPlan	1,013	8,283	9,296	11%
Anthem	488	7,863	8,351	10%
Cigna	1,800	6,329	8,129	9%
BlueCross BlueShield of Texas	1,764	3,000	4,764	5%
Clear Health Strategies	492	2,946	3,438	4%
Florida Blue	15	3,386	3,401	4%
BlueCross BlueShield of Illinois	140	1,991	2,131	2%
BlueCross BlueShield of Tennessee	1,000	935	1,935	2%

Appendix II: Myth #5 (NAIC Report)

There has been a *38.3%* increase in insurer net investment income in 2022.

Health Entities as of December 31, 2022

(In Millions, Except PMPM)	Chg.	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013
Operations											
Direct Written Premium	12.1%	$1,017,744	$908,225	$834,702	$761,738	$716,190	$668,521	$638,259	$593,403	$533,083	$459,274
Net Earned Premium	11.4%	$1,000,738	$898,044	$826,190	$734,993	$708,473	$664,107	$631,656	$587,374	$526,852	$450,737
Net Investment Income Earned	38.3%	$7,305	$5,282	$5,026	$6,083	$5,146	$4,798	$3,331	$3,250	$3,229	$3,152
Underwriting Gain/(Loss)	61.8%	$25,054	$15,480	$33,094	$17,656	$21,423	$18,836	$9,918	$6,438	$6,618	$9,637
Net Income/Loss	29.3%	$23,946	$18,526	$31,465	$22,168	$23,142	$16,060	$7,194	$3,672	$5,661	$9,978
Total Hospital & Medical Exp	10.3%	$863,057	$782,708	$683,646	$632,412	$598,130	$568,576	$541,886	$505,506	$450,823	$389,206
Loss Ratio	(1.1) Pts.	85.7%	86.8%	82.7%	85.8%	84.0%	85.4%	85.4%	85.6%	85.3%	85.8%
Administrative Expenses	14.5%	$118,564	$103,572	$110,770	$87,596	$92,628	$78,499	$82,633	$78,712	$71,538	$54,705
Admin Expense Ratio	0.3 Pts.	11.8%	11.5%	13.4%	11.9%	13.0%	11.8%	13.0%	13.3%	13.5%	12.1%
Combined Ratio	(0.8) Pts.	97.5%	98.3%	96.0%	97.6%	97.0%	97.2%	98.4%	98.9%	98.8%	97.9%
Profit Margin	0.4 Pts.	2.4%	2.0%	3.8%	3.0%	3.2%	2.4%	1.1%	0.6%	1.1%	2.2%
Net Premium PMPM	6.7%	$316	$296	$286	$268	$261	$248	$241	$232	$221	$212
Claims PMPM	5.3%	$273	$259	$238	$231	$220	$213	$207	$199	$189	$183
Cash Flow from Operations	106.9%	$38,359	$18,538	$55,830	$24,674	$17,046	$25,435	$12,266	$6,600	$6,273	$8,120
Enrollment	5.7%	271	256	242	231	225	221	218	213	204	178
Capital and Surplus											
Capital & Surplus	5.1%	$213,536	$203,141	$186,797	$165,965	$151,795	$137,686	$122,392	$115,561	$112,150	$111,140
Return on Equity (ROE)	2.6 Pts.	12.2%	9.6%	17.4%	14.0%	15.8%	11.9%	6.1%	3.7%	5.7%	10.0%
Assets											
Net Invested Assets	6.3%	$330,214	$310,703	$290,808	$238,116	$217,911	$210,825	$189,241	$177,180	$169,991	$163,439
Net Admitted Assets	7.0%	$455,238	$425,329	$388,228	$331,778	$305,220	$289,601	$268,386	$253,277	$238,913	$214,328
Net Inv Inc & Realized Gain/(Loss)	(35.6)%	$5,100	$7,915	$6,617	$7,718	$5,175	$5,438	$4,320	$4,165	$4,832	$4,479
Investment Yield	0.5 Pts.	2.3%	1.8%	1.9%	2.7%	2.4%	2.4%	1.8%	1.9%	1.9%	2.0%
Number of Companies Filed		1,160	1,125	1,118	1,031	1,010	981	967	958	943	926

In fact, the top 5 health plans have seen extraordinary stock valuation gains under the NSA.

#	NAME	MARKET CAP	5Y TOTAL RTN
1	UnitedHealth Group (UNH)	$465.977B	103.52%
2	Elevance Health (ELV)	$114.305B	71.56%
3	Cigna Group (CI)	$94.619B	81.65%
4	CVS Health (CVS)	$92.566B	27.58%
5	Humana (HUM)	$42.437B	23.27%

https://www.financecharts.com/compare/UNH,CVS,ELV,CI,HUM