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Big Surprise for The No Surprises Act:
Study Shows Insurer Benchmark Dangerously Lower Than In-Network Rate

Disputed QPAs Miss the Mark, with Median In-Network Rates 300 Percent Higher

Washington, D.C. — [DATE] — Americans for Fair Health Care (AFHC), a coalition representing more than 70,000 frontline clinicians and healthcare organizations, today released a first-of-its-kind analysis revealing that the Qualifying Payment Amounts (QPAs), the "benchmark" insurers calculate under the *No Surprises Act* (NSA), often dramatically understate actual median in-network payment rates.

The findings undercut assumptions about the cost of the NSA, which have treated the publicly reported QPAs as a neutral, data-grounded measure of market prices. Instead, the new study reveals that these opaque, insurer-calculated and insurer-reported QPAs are frequently inaccurate and are on average only a third of the payers' own contracted in-network rates.

"Our clinicians are fiercely supportive of the patient protections afforded under the NSA, but we continue to see insurers undermine the law. Using inaccurate QPAs drives use of the NSA's arbitration process and adds cost to the health care system," said Eric Berger, AFHC's Executive Director.

Key Findings

The study, conducted by NDP Analytics on behalf of AFHC, matched publicly reported QPA values to insurers' published median in-network contracted rates for the identical CPT code and geographic region. (see below for methodology) Through this process, researchers discovered that QPA values diverge sharply from median in-network rates. Other key findings of Q4 2024 data include:

- In 65% of disputes subject to the Independent Dispute Resolution (IDR) process, the reported QPA *lower than the median in-network contracted amount*. In those cases, networking rates were an average of 300% higher.
- In more than 60,000 disputes subject to the IDR process, the reported QPA is less than $20. There were also almost 1,000 instances of a reported QPA less than $1, and more than 20,000 instances of $0 offers, irrespective of the QPA.

In one case for a high-acuity emergency visit, the insurer set the QPA at $0.01 and offered to pay that amount. The Independent Dispute Resolution Entity (IDRE) rejected this, finding the accurate payment to be $1,196 instead. This 120,000% difference between the prevailing offer and the "benchmark" directly reflects an inaccurate QPA not, as insurers may claim, an inflated provider charge.

Why the Findings Matter

The *No Surprises Act* was designed to ensure fairness in out-of-network payment disputes. Instead, the statutory benchmark—calculated unilaterally by insurers and shielded from rigorous review—has distorted the entire process.

Unfortunately, CMS oversight remains minimal. Despite a statutory requirement for federal monitoring of QPA calculation and a promised 2025 report to Congress, CMS has released only one QPA audit since the NSA took effect in 2022.

Arbitration Isn't Driving Up Costs – Deceptive QPAs Are

The new study directly rebuts many myths regarding the NSA:

- **The QPA is not—and never has been—a verified measure of market rates.** Analysts have incorrectly assumed insurer-reported QPAs match the statutory definition, ("median in-network rate"). This study shows that is frequently untrue.
- **High provider win rates do not indicate inflation by providers.** Providers win more than 80% of arbitration disputes because insurers routinely tie their offer to an inaccurate QPA, not because providers submit unreasonable claims.
- **NSA cost trends cannot be quantified using a faulty benchmark.** Past work attempting to quantify the cost of the NSA falsely assumes the QPA is a typical in-network payment rate. In fact, that is usually not the case.

Methodology

The analysis compared insurer-reported Qualifying Payment Amounts (QPAs) from CMS' Q4 2024 Public Use Files against actual median in-network contracted rates published by major commercial insurers. Researchers matched each QPA to the corresponding payer, CPT code, and geographic rating area. Median in-network rates were calculated using publicly available payer fee schedules and contract data. The study conducted a line-by-line comparison across thousands of matched records to determine the variance between the reported QPA and the insurer's true median in-network rate.

About Americans for Fair Health Care

Americans for Fair Health Care (AFHC) is a national healthcare coalition representing 70,000 physicians and advanced practice clinicians dedicated to protecting medical practices and the patients they serve by advocating for reasonable and sustainable health insurance reimbursement. All of the physicians and clinicians represented by the group are supportive of and committed to the preservation of the patient protections in the NSA.

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