MILLIMAN REPORT

Impacts of Regulatory Options in Independent Dispute Resolution on Costs Under the No Surprises Act

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I. EXECUTIVE SUMMARY

In late 2020, the United States Congress passed the No Surprises Act (NSA)[1], which provided patient protections regarding certain "surprise billing" activities in private market health coverage. For select settings and service categories with a historically high incidence of surprise bills, new processes were enacted to create more predictable patient out-of-pocket costs and assist issuers / health plans (payers) and providers without a payment contract to reach an agreement regarding payment.[2] The NSA eliminates balance bills for most emergency services, services obtained from out-of-network providers at in-network facilities, and out-of-network air ambulance services. If payers and providers cannot agree on acceptable payment for a protected service, independent dispute resolution (IDR) is used to determine payment for the service. The protections in the NSA revolve around the qualifying payment amount (QPA). As defined in a July 2021 Interim Final Rule[3] the QPA is the median of the contracted rates recognized by the insurer or plan for the same or a similar item or service provided by a provider in a same or similar specialty in the same geographic region. The QPA is used to adjudicate member cost sharing and is the key benchmark used in the independent dispute resolution (IDR) process available for providers and payers who cannot reach agreement on payment through direct negotiations. In an October 2021 Interim Final Rule (the IDR IFR),[4] CMS further outlined key parameters of the IDR process.

The basic parameters of independent dispute resolution are outlined in the statute. However, the statute does not provide clear guidance on how different elements are to be evaluated or what weights to apply to the QPA and other service characteristics when evaluating offers. The IDR IFR provides some additional clarity, but still leaves room for some subjectivity in IDR determinations. We reviewed the federal statute and compared it to existing state IDR programs to help understand the range of potential outcomes. Additionally, we simulated QPA calculations using our proprietary data asset with over 78 million member life years and determined several payment cost measures to evaluate the potential financial effect of various prevailing IDR payment awards. In our analysis, we identified the following major themes:

- **The direct costs of independent dispute resolution have the potential to be material.**

  We observed a wide variation in arbitration fees in states with existing IDR processes and fees published by national arbitration associations. IDR costs could run into the $1,000s per case when factoring in the formal costs of the IDR process and informal costs required to support IDR cases. On an annual basis, 1 in 10 insured adults received an unexpected out of network bill[5], paving the way for up to $100 or more in additional health-related spending per adult each year if all of these claims were processed through IDR, or about 1.5% of average healthcare expenditures for employer sponsored coverage.[6] While it is unlikely that all out-of-network bills will proceed to IDR, an IDR program that increases IDR utilization could meaningfully increase national healthcare spending.

- **While federal IDR considerations are similar to existing state IDR considerations, the exclusion of billed charges has the potential to produce a narrower range of smaller determinations relative to state results to date.**

  State surprise bill reforms with IDR components tend to address similar considerations in the IDR – service characteristics, provider characteristics, and service cost. While there are minor variations, states tend to incorporate provider billed charges both in aggregate and for the specific provider. This appears to be a key element of the favorable results providers have seen in these states, as well as the high payment determination levels. However, federal IDR explicitly excludes consideration of billed charges – the only explicitly referenced cost benchmark is the QPA, which could provide greater stability to IDR determinations if IDR entities center their review around the QPA.

[1] The No Surprises Act is Title I of Division BB of H.R. 133. Full text of the legislation can be downloaded from Text - H.R.133 - 116th Congress (2019-2020): Consolidated Appropriations Act, 2021 | Congress.gov | Library of Congress at https://www.congress.gov/bill/116th-congress/house-bill/133/text.

[2] The No Surprises Act does not pre-empt state regulation of payment amounts under existing state surprise bill.

[3] 86 FR 36872

[4] 86 FR 55980

[5] Pollitz K, Lopes L, Kearney A, et al. US Statistics on Surprise Medical Billing. *JAMA*. 2020;323(6):498. doi:10.1001/jama.2020.0065 https://jamanetwork.com/journals/jama/fullarticle/2760721

[6] 2019 plan spending on employer sponsored health care was projected to be $5,927. https://www.cms.gov/files/document/highlights.pdf

- **If IDR pushes payments higher than the QPA, savings that arise from the QPA could be eroded or eliminated.**

  Savings from surprise billing reforms take two forms – the level of payment from the plan (including member cost-sharing) to the provider and the elimination of balance bills. The elimination of surprise bills represents a significant reduction in healthcare costs, and on a standalone basis would require IDR determinations to be around the 75th percentile of allowed charges before health spending on surprise billed services would begin to increase. However, if IDR results are predictable enough to become a de facto target contracted rate in settings where surprise bills occur, the effects of IDR determinations gain much broader reach. If IDR determinations cause contracted rates in settings where surprise bills occur to settle 10% above current average contracted rates, national health spending in the commercial market could increase by almost 2% in addition to the direct costs of IDR.

- **The degree of subjectivity available to IDR entities with regards to service and provider characteristics could be a key determining factor in how often IDR is utilized and how IDR awards settle.**

  The NSA lists several factors which IDR entities can consider in their review, affording them significant latitude in regard to settlements. The QPA is the primary cost metric, and, as a median, represents a middle ground in terms of the nature of the service and the qualifications of the provider. IDR can reflect higher payment determinations for high quality providers and / or complex cases, but the degree of reliance on provider or plan assertion in lieu of demonstrable / quantifiable relations to the median case / provider could open IDR to a wider range of potential outcomes for each case and correspondingly greater utilization. The statutory language clearly allows for payment determinations above the middle ground of the QPA, but is not similarly explicit about lower payment determinations, so regulators should consider the degree to which awards below the QPA are also appropriate. Ultimately the degree of subjectivity available to IDR entities could influence the level of utilization of IDR, thus, the direct costs that IDR may increase overall health system costs.

With the publication of the IDR IFR by HHS at the beginning of October as required by the NSA, stakeholders have more insight to how the IDR process will function. While the market dynamics associated with these protections are likely to take a while to reach an equilibrium, the potential for either health expenditure savings or increased spending will depend strongly on how IDR entities manage the resulting IDR process, both in the degree to which they focus IDR determinations on the QPA and whether they favor plans or providers in its practical administration.

II. BACKGROUND

On July 1, 2021, the Department of Health and Human Services (HHS) released an interim final rule outlining the parameters related to the determination of the No Surprises Act's (NSA) qualifying payment amount (QPA).[7] Notably absent from the interim final rule was guidance on Independent Dispute Resolution (IDR), a critical component of the regulation. On September 30, 2021, HHS released a second interim final rule (the IDR IFR) addressing parameters and considerations of IDR and implementing statutory provisions of the NSA.

OVERVIEW OF THE INDEPENDENT DISPUTE RESOLUTION PROCESS IN THE NO SURPRISES ACT

The key statutory elements of IDR are outlined in section 103 of the NSA and its role in determining final payment from the payer to the provider. Before IDR can be invoked, payers and providers must make certain efforts to settle the claim. Following receipt of a clean claim[8], the payer has 30 days to submit an offer of payment or else deny payment for the service. This communication must include the QPA. Within the 30-day period beginning with receipt or denial of payment, both parties have the option to initiate open negotiations. During open negotiations, both parties have up to 30 days to settle on a final payment amount. If no agreement is reached by the end of the 30-day period, either party has the option to begin the IDR process within four days after the failed open negotiation period. At this time the other party and HHS will be notified by the initiating party that the IDR process is required. Various components of the IDR process are summarized below.

Arbitrators

The statute requires that IDR entities meet certain requirements to obtain federal certification, such as possessing sufficient expertise and staffing to make a timely determination and lack of apparent or actual conflicts of interest. Certified IDR entities must agree to maintain confidentiality of personal health information (PHI) and follow the rules as defined in the statutes. Both parties can jointly select an arbitrator within six days of the initiation of the IDR process. Otherwise, an arbitrator will be assigned by HHS.

Timing

Within 10 business days of selection of an arbitrator, both parties must submit offers for payment, along with any supporting information related to the offer and any information requested by the certified IDR entity. The certified IDR entity must select one of the two offers within 30 business days of being appointed. Following this determination, the payer has 30 business days to remit payment to the provider.

Considerations

The statute outlines certain considerations for certified IDR entities. The QPA is the first IDR consideration mentioned in the statutory text, and is the only cost measure explicitly permitted. The statute prohibits certified IDR entities from considering other common amounts, such as payments by public health programs[9], billed charges, or usual and customary charges.

In addition to the QPA, certified IDR entities shall also consider certain information:

- Any information submitted by the payer or the provider as part of their offer (subject to the common amount prohibitions discussed above)
- The level of training, experience, quality, and outcomes of the provider or facility
- The market share of the provider, facility, plan, or issuer in the relevant geographic region
- The acuity and complexity of the service
- Teaching status, case mix, and scope of services of the facility
- Demonstrations of good faith efforts (or lack thereof) in establishing a contract between the parties in the previous four plan years

[7] The qualifying payment amount is the median contracted rate for the same or similar service provided by a provider in the same or similar specialty in the same region. For more information on this, please refer to our July 16, 2021 report.
[8] A clean claim is claim for which all information necessary to determine payment for the service has been submitted to the payer by the provider.
[9] The statute explicitly references Medicare, Medicaid, and TRICARE, but is not limited in scope to these programs.

The statute does not indicate how much weight IDR entities should give to any one of these factors when making a determination, nor does it indicate any specific direction or magnitude of adjustment relative to the QPA as the appropriate outcome for any single factor under consideration in an IDR determination. However, the IDR IFR indicates that the QPA should be the anchor of IDR determinations unless there is credible evidence that one of these factors results in a material difference between the QPA and a reasonable rate. The determination of what evidence counts as credible and what magnitude of difference is material are currently left to the IDR entity, though HHS intends to release further guidance at a future date.

Settlement

After the initiation of arbitration, payers and providers may still settle on a final amount. This amount supersedes the IDR amount.

IDR Process Funding

The IDR process is funded via two mechanisms.

- Certified IDR entities will charge fees for their services[10]
- HHS will determine a user fee to be paid by all providers and payers who participate in IDR[11]

The party whose offer is not selected by the certified IDR entity is responsible for the certified IDR entity's fee. In the case that a settlement is reached after IDR is initiated, then both parties pay half of the certified IDR entity's fee (unless they agree on another split as part of their settlement). The statute does not provide guidance on the amount to be charged by the certified IDR entity, but does specify that the user fee will be calibrated to offset costs incurred by HHS to carry out the IDR process.

Batching of disputed claims

IDR can represent more than one claim. In order for multiple services to be bundled into one IDR filing, the services must be:

- Furnished by the same facility or provider
- Paid by the same group health plan or individual insurance coverage
- Related to treatment of the same condition
- Provided in the same 30-day window

Each service in a batched submission receives its own offer from the payer and from the provider, and the IDR entity is not required to select all offers from one party or the other. For example, a final determination for a batch of five services could reflect two services at the payer's final offer and three services at the provider's final offer.

Reporting

The Secretary will release a report on the Department of Treasury website information for each calendar quarter on:

- The number of IDR requests
- The size of the provider practices and size of facilities that submit IDR requests
- The number of IDR requests that result in an IDR determination
- Number of times the final payment exceeds the QPA
- The costs to the Secretary in operating the IDR process
- The total amount of administrative fees
- The total payment to certified IDR entities

For each service where a determination is made, the Secretary is also required to publish:

- The service / item, region, and specialty
- The amount of each payer and provider offer, as a percentage of the QPA
- Which offer was selected, as a percentage of the QPA
- The identity of the payer and of the provider
- The time taken to complete the determination

[10] CMS published guidance that outlines reasonable fee ranges for single service and batched service IDR filings. IDR entities are permitted to charge rates outside of these ranges, but must justify these rates to CMS. See Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act (cms.gov).

[11] CMS published guidance that establishes a user fee of $50 per IDR party per filing, per Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act (cms.gov).

- The amount paid to the certified IDR entity for the claim

CURRENT STATE SURPRISE BILLING REGULATION EFFORTS

Of the 33 states that currently have legislation in place to address balance billing, 15 utilize IDR processes[12] to provide arbitration between carriers and providers / health systems that are covered under state law. Many of these IDR processes have similar core structures, but can be quite dissimilar in their utilization and outcomes. Figure 1 provides a snapshot of the IDR process and structure in five prominent states: New York[13], New Jersey[14], Texas[15], Washington[16], and California[17]. Items shaded green are specifically included in statute, items shaded orange can reasonably be inferred from statute, and items shaded pink are specifically prohibited by statute. With the exception of New Jersey, significant alignment in criteria is shown across the states shown in Figure 1 and the NSA. However, the No Surprise Act meaningfully departs from state examples by not incorporating billed charges into the dispute resolution process. If implemented as described, this may limit the degree to which awards in states with established IDR processes for surprises bills serve as predictor of awards generated under federal IDR.

[12] The Commonwealth Fund frequently publishes information on surprise bills, including this survey of state surprise billing protections. State Balance-Billing Protections | Commonwealth Fund

[13] Parameters of New York's surprise billing independent dispute resolution procedure are outlined in Article 6 of the Financial Services Law. The New York Senate maintains a copy of the text of this law at https://www.nysenate.gov/legislation/laws/FIS/A6.

[14] New Jersey's surprise billing protections were passed in 2018, and key characteristics of the IDR process are contained in Section 26:2SS-10 of the New Jersey Statutes at https://lis.njleg.state.nj.us/nxt/gateway.dll/statutes/1/21816/23378.

[15] Texas incorporated Independent Dispute Resolution in 2019's State Bill 1264, which eliminated surprise billing for certain health plans. The state maintains a copy of the legislative text at https://capitol.texas.gov/tlodocs/86R/billtext/html/SB01264F.htm.

[16] Washington included surprise billing protections in their 2019, and regulations implementing the Balance Billing Protection Act are maintained at https://www.insurance.wa.gov/media/8671.

[17] California's IDR process is outlined in Uniform Written Procedures and Guidelines published by MAXIMUS, the state's selected vendor. Current rules are outlined at https://ab72idrp.maximus.com/idrpportal/public/docs/AB72_Uniform_Written_Procedures_and_Guidelines.pdf.

FIGURE 1: IDR CHARACTERISTICS IN FIVE PROMINENT STATES WITH IDR FOR SURPRISE BILLS

	Federal	New York	New Jersey	Texas	Washington	California
IDR CHARACTERISTICS						
Decision Type	Baseball Style†	Baseball Style†	Baseball Style†	Baseball Style†	Baseball Style†	Baseball Style†
Qualification and selection of IDR entities	Determined by HHS	Certified by the state. Reviewers must have experience in medical billing and UCR. Reviewers must consult active licensed physicians in a same or similar specialty.	Selected by the state.	Certified by the state or an outside individual agreed upon by both parties.	Trained by the American Health Lawyers Association (AHLA) or the American Arbitration Association. The two parties must agree on the arbitrator from Office of Insurance Commissioner's list.	Selected by the state.
Payment of IDR Entity Costs	Unsuccessful party pays, if a settlement is reached the health plan and the provider split the cost.	Unsuccessful party pays, if a settlement is reached the health plan and the provider split the cost.	Shared equally, unless the carrier is not acting in good faith.	Shared equally.	Shared equally.	Shared equally.
Request batching	Permitted	Not permitted	Not Permitted	Up to $5,000	Permitted	Permitted
KEY FACTORS USED IN IDR DETERMINATIONS						
Relationship of service-specific fees to typical fees	?	Specified	Implied		Implied	Implied
Provider training / education / experience	Specified	Specified	Implied	Specified	Implied	Specified
Other relative provider economic circumstances	?		Implied	Specified	Implied	Specified
Payer network capacity	?		Implied	Specified	Implied	Implied
Nature of services	?		Implied	Specified	Implied	Specified
Case complexity and circumstances	Specified	Specified	Implied	Specified	Specified	Implied
Patient characteristics	Specified	Specified	Implied	Specified	Specified	Specified
Contracting history	Specified		Implied		Implied	Specified
Other items	Provider Market Share Teaching Hospital / etc.		Any submitted	Relevant factors	Relevant factors Evidence and methodology	Other unusual factors Other relevant information
PAYMENT BENCHMARKS REFERENCED						
Contracted Rates	Median	Median	Any	Median	Median	Average
Billed Charges	Prohibited	80th Percentile	Any	80th Percentile	80th Percentile	Prevailing
Provider-specific usual charge	Prohibited	X	Any	X	X	X

† *In baseball-style arbitration, the arbitrator must select one of the two party's offer based on which is most reasonable.*

OUTCOMES ACROSS SELECT STATE SURPRISE BILLING IDR PROCESSES

We reviewed publicly reports from the five states in Figure 1. Three of these states have seen significant utilization of IDR (New Jersey, New York, and Texas), while two have not (Washington and California). In states with limited utilization of IDR, anesthesia is the most common specialty involved. While anesthesia IDR volume remains significant in other states, emergency services, and surgical services (including cosmetic surgery) are more prevalent in states with greater IDR utilization. State publications regarding their IDR processes vary widely in the time frames covered and the level of detail provided. Figure 2 illustrates select IDR outcomes data that have been published by states.

FIGURE 2: KEY OUTCOMES IN STATE IDR PROCESSES TO DATE

	New York[18]	New Jersey[19,20]	Texas[21]	Washington[22]	California[23]
Claims Dates	2015 – 2018	2019 – 2020	Jan 2020 – July 2021	2020	Jan 2018 – Jun 2021
IDR Filings	3,736	8,446	112,577	71	114
IDR Rulings	2,175	6,280	22,876††	29	33
Payer Success %†	49%	38%		7%	

† Amongst claims which are won by a single party. Batch filings with multiple service may have split settlements, with some services settled in favor of the provider and some in favor of the payer.
†† Includes estimated settlements for November 2020 and December 2020 consistent with settlement rate for January 2020 through October 2020 submissions.

Data in both New York and New Jersey indicates increasing rates of settlements in favor of the provider over time. There is somewhat less data regarding actual payments across multiple states, but available data reveals several interesting details:

- Provider offers are typically much higher than payer offers. In New Jersey, final offers from providers have been about five times higher than final offers from payers on average, while the average provider offer in Texas typically ranges from 500% to almost 2,500% of the original plan offer depending on setting.

- Final payments can be quite high, even when factoring in successful payer offers. Final payments under surprise billing protections in Texas and New Jersey average about 300% of the payer's offer. Meanwhile, New York features arbitration decisions averaging 8 percent higher than the 80th percentile of charges – the higher benchmark rate mentioned in the regulation.[24]

While these values may be extreme, it can be argued that they are features of the mixed payment benchmark specification in state surprise billing laws – if IDR entities can consider billed charges, they very well may do so.[25] This reinforces the need for federal regulators to be clear in how different considerations ought to be reflected in the IDR process under the NSA.

[18] NEW YORK'S SURPRISE OUT-OF-NETWORK PROTECTION LAW: Report on the Independent Dispute Resolution Process. https://www.dfs.ny.gov/system/files/documents/2019/09/dfs_oon_idr.pdf
[19] The Out-of-network Consumer Protection, Transparency, Cost Containment, and Accountability Act (P.L. 2018, c. 32) Data Reporting. https://www.state.nj.us/dobi/division_insurance/oonarbitration/data/200131report.html
[20], The Out-of-network Consumer Protection, Transparency, Cost Containment, and Accountability Act (P.L. 2018, c. 32) Data Reporting. https://www.state.nj.us/dobi/division_insurance/oonarbitration/data/210131report.html .
[21] Balance billing protections: Senate Bill 1264 2021 midyear report. https://www.tdi.texas.gov/reports/documents/SB1264-2021-midyear-update.pdf
[22] Balance Billing Protection Act Arbitration Proceedings Annual Report. https://www.insurance.wa.gov/sites/default/files/documents/bbpa-annual-arbitration-report-2021_0.pdf
[23] AB 72 Independent Dispute Resolution Process Quarterly Report. https://www.dmhc.ca.gov/Portals/0/Docs/HC/PCU/AB72%20Quarterly%20Report%202021-%202nd%20Quarter.pdf
[24] Experience with New York's arbitration process for surprise out-of-network bills - Brookings
[25] As an example, if a payer offers median in network charges while a provider offers 10% above the 80th percentile of billed charges and the arbitrator believes billed charges are the more appropriate benchmark, the provider offer could reasonably be called the better "best" offer.

III. THE COSTS OF THE IDR PROCESS

One of the anticipated outcomes of focus on a median payment rate is a reduction in overall health spending – depending on choices made, the potential impact of the QPA could be as high as $15 billion to $40 billion in savings per year in the commercial market.[26] However, the availability of IDR to settle claims where the payer and the provider do not agree on final payment affects this dynamic. The existence of an IDR process on its own does not guarantee that health spending will increase – changes in spending will primarily be driven by the overall payment level of IDR determinations. However, IDR itself comes with its own formal and informal costs that are likely to reduce any savings obtained from these surprise billing reforms.

THE FORMAL COSTS OF IDR

One consideration of the implementation of IDR on a federal level is the direct costs associated with the process. Currently, the interim final rule states that the unsuccessful party will pay all fees associated with arbitration, apart from the administrative fees which are spread across all parties utilizing arbitration. This is a departure from the practice of most states examined in the previous section as outlined in Figure 1, which more often split costs between the payer and the provider. While the statute does not establish the amount to be charged by the certified IDR entity, costs related to other forms of arbitration may serve as a good starting point. Limited information is available about the arbitration filing fees and expenses in states with established IDR processes. However, we do have a few data points from out-of-network IDR proceedings in select states:

- Texas: Arbitrators establish their own fixed fees for cases. In the first six months of 2021, these fees ranged from $350 to $5,000, with a median value of $1,000, though the average fee was over $2,000.[27]
- California: IDR filing fees vary from $315 to $415 depending on the number of claims submitted and whether procedure coding is being evaluated.[28]
- New Jersey: State vendor charges $445.[29]

Other states do not specify IDR entity fees, but may utilize established arbitration organizations, such as the American Arbitration Association (AAA).[30] Filing fees can vary from $1,725 to upwards of $10,000[31] for extremely high-value claims. Arbitrator time may be charged on a per hour basis ($290 to $550 per hour is typical for the AAA) or a per case basis ($1,500 per case for a document only filing, including up to seven hours of arbitrator time), while hearings may come with a separate daily schedule of charges (the AAA charges $2,500 per day) and potentially their own separate filing fees.[32]

Hourly costs may vary based on arbitrator qualifications, with the highest-profile arbitrators in legal settings drawing fees similar to those of high-powered law firms.[33] The results in Texas and public arbitration fee schedules suggest that IDR costs will represent a sizeable proportion of the $6,516 average annual healthcare cost per person.[34] As such, regulatory decisions around IDR process could have material cost implications on US spending on healthcare.

HHS published guidance outlining reasonable fee ranges for federally certified IDR entities.[35] In general, final fees per IDR case for certified IDR entities are fixed and must fall between $200 and $500 for single service filings and $268 and $670 for batched service filings. IDR entities can request a waiver to charge a fixed fee outside of this range, but

[26] Development of this amount is outlined in our previous report, "Impacts of Regulatory Options in Determination of Qualifying Payment Amounts Under the No Surprises Act", available at https://www.milliman.com/en/insight/Impacts-regulatory-options-determination-qualifying-payment-amounts-under-No-Surprises-Act

[27] These fees are outlined in quarterly reporting on IDR published by the Texas Department of Insurance at https://www.tdi.texas.gov/reports/documents/SB1264-2021-midyear-update.pdf

[28] These fees represent current rates as of August 2021. The schedule of fees is published by the California Department of Managed Health Care at https://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan/NonEmergencyServicesIndependentDisputeResolutionProcess.aspx.

[29] Half of the fee is paid by the filer at time of filing of the IDR request, with amounts shown at https://njpicpa.maximus.com/njportal/public/c32.xhtml

[30] The AAA maintains rules for healthcare payer-provider disputes, including a discussion of expenses associated with arbitration of payer-provider disputes at https://www.adr.org/sites/default/files/AAA_Healthcare_Payor_Provider_Arbitration_Rules_and_Mediation_Procedures.pdf .

[31] The AAA utilizes a sliding fee schedule for the administrative fee associated with arbitration of payer-provider payment disputes, which ranges from $1,725 for a dispute with a total dollar value under $75,000 up to $24,750 to $68,750 for disputes in excess of $10,000,000. This amount excludes compensation for the arbitrator. https://go.adr.org/feeschedule

[32] Values are outlined in the American Arbitration Association's November 1, 2020 consumer fee schedule which is generally intended for arbitration as a replacement for other legal proceedings but provides illustrative examples of how arbitrator compensation may be determined and what may be charged. https://www.adr.org/sites/default/files/Consumer_Fee_Schedule_2.pdf .

[33] Rothman, Deborah (Spring 2017). Trends in Arbitrator Compensation. https://www.americanbar.org/content/dam/aba/publications/dispute_resolution_magazine/spring2017/3_rothman_trends_in_arbitrator.authcheckdam.pdf

[34] As estimated by the 2021 Milliman Medical Index, found at https://us.milliman.com/-/media/milliman/pdfs/2021-articles/2021-milliman-medical-index.ashx .

[35] Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act (cms.gov)

must provide a justification that includes a description of the circumstances that justify the alternative fixed fee and how the alternative fixed fee addresses those circumstances. These fees are expected to be in line with fees in states that publish their own fee schedules, but it remains to be seen how much flexibility HHS may grant to IDR entities with regards to waivers of the established range limits.

In addition to amounts paid to certified IDR entities, IDR participants (both the provider and the plan) must each also pay a user fee to HHS to cover federal costs associated with resolving surprise bills.[36]

THE INFORMAL COSTS OF IDR

In addition to the direct filing fees associated with a claim that goes to IDR, both payers and providers will have to do additional legwork to support their IDR filing. Tasks to support an IDR filing can broadly be classified into two categories – understanding relevant service cost benchmarks and identifying unusual service / provider characteristics.

Perhaps the most important feature of any IDR offer is the amount requested. The inclusion of the QPA as the sole referenced cost benchmark in the statute simplifies this to some degree – payers calculate the QPA, and providers receive the QPA as part of the payer's offer for payment earlier in the process. However payers have significantly more information, notably including the range of contracted rates surrounding the QPA, which may give them an advantage in understanding and articulating the relative value that may be assignable to other provider or case characteristics. While providers may understand the relationship of their charges between payers and perhaps how other payers have valued specific case characteristics, they have less directly relevant data given the focus of the NSA on the payer's specific contracted rates.[37]

Both payers and providers will also have to evaluate the characteristics of the service and the provider. Providers may be in a better position to describe specifics of the case, such as the complexity of the service and acuity of the patient. However, much of this information may be transmitted to the payer as part of the payment processing. Depending on the degree of contemporary chart review performed by the payer in the act of processing the claim, this may require some additional review by the payer. A payer may have better insight into the typical range of complexities associated with a given procedure code, though the provider is likely to have more insight into the overall scale of complexities as it applies to the specific service. Similarly, providers are likely to be well-versed in their own distinguishing features. However, individual providers may be less aware of how their education, training, and experience compare to the providers with which the payer does contract. Compared to service cost benchmarks, service and provider characteristics are generally likely to be less directly quantifiable as compared to service cost evaluation, which lend themselves to more subjectivity. This topic is discussed in more detail in the next section of this paper.

The informal costs of IDR also come in terms of cash flows. Assuming the process functions according to statutory timelines, receiving payment under the IDR process can take four months from submission of a clean claim. Providers routinely involved in surprise bill settings today are likely to see this as a reduction from more drawn-out payment timeframes associated with the lack of a binding non-judicial pathway to payment of surprise bills, but providers for whom this is not standard practice may see the additional delay in service payment as a deterrent to initiation of the process. From a payer side, extensive use of IDR could create two avenues of increased uncertainty in financial reporting. The payment timing delay associated with IDR may meaningfully alter patterns of claims payment, complicating reserve calculations. Additionally, uncertainty about IDR outcomes could create more volatility in reserve levels relative to actual claims paid.

KEY DRIVERS OF IDR UTILIZATION

The overall cost level associated with IDR filings remains uncertain, but it has the potential to be significant. This magnitude has the potential to influence how likely either party may be to initiate the IDR process in the first place. The essential calculation that underlies initiation of IDR is that the potential gain is more valuable than the potential cost. Since IDR fees are paid by the unsuccessful party, the difference in financial outcomes based on which offer is selected includes both the difference between the two final offers and the filing fees associated with the IDR process. The larger fees are relative to the difference between payer and plan's position in negotiation, the more reluctant parties will be to initiate IDR. This dynamic has the potential to be more impactful for federal negotiations than it has been in existing state reforms which permit use of billed charges.[38] One factor which has the potential to limit the impact of fees on initiation of IDR is the ability for providers to bundle sufficiently similar claims together[39] and submit these claims in a

[36] This fee is set at $50 for calendar year 2022 in this CMS guidance: Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act (cms.gov)

[37] While the Transparency in Coverage rule (85 FR 72158) will require publication of nominally similar data, the QPA is based on 2019 data which is not required to be published under these provisions, limiting the relevance of these data sets.

[38] Milliman analysis shows that the 80th percentile of billed charges for surprise billed service is frequently in excess of five times the median allowed charge, which may in part explain why IDR process costs have not been a particular barrier to IDR utilization in states.

[39] The IDR IFR defines batched items and services must be provided by the same provider to enrollees of the same group health plan or health insurance issuer and be for the same or similar service (as defined for purposes of calculating the QPA). See 86 FR 55994.

batch. Batching can increase the total volume of claims in a single arbitration filing, spreading out the somewhat higher formal IDR costs across a number of claims. This may increase the likelihood providers and payers initiate the IDR process rather than negotiate.

IDR utilization will also be driven to some extent by the predictability of outcomes under the IDR process. If IDR entities demonstrate a clear pattern in their evaluation of payment offers, then frequent participants, such as providers routinely involved in surprise bills and payers are likely to shift their offers to align with those patterns. This dynamic would be expected to filter down to offers during the open negotiation phase – IDR is an inefficient process, and removal of the formal and informal costs associated with IDR can put both providers and payers in a relatively better financial position assuming both payer and provider agree on what level of offer an IDR entity will approve.

Eventually, contracted rates are likely to converge towards the payment levels that come out of IDR, whether this is higher or lower than the QPA remains to be seen. On the other hand, if the parties do not agree on the payment that will be approved by the IDR entity, then IDR becomes more likely. As the magnitude of the disagreement as to the value of the service increases, the chances that IDR will be initiated also increase as the potential gains from a winning bid become more extreme and increasingly outweigh the direct costs of filing an IDR request.

IV. SUBJECTIVITY IN IDR

The discretion left to the certified IDR entity in the IDR process will significantly shape the overall financial effects of the NSA. The NSA outlines two primary considerations for the certified IDR entity when determining payment, the QPA and "additional circumstances." The IDR IFR provides a clear definition of the role of the QPA in the IDR process, and establishes how different factors should be evaluated in IDR, with a goal of creating a more "predictable, fair, and equitable"[40] IDR system. In this section, we focus on some of the challenges certified IDR entities may face as they evaluate payer and provider offers, as well as the potential economic effects of various IDR payment outcome levels.

WEIGHTING THE QPA RELATIVE TO ADDITIONAL CONSIDERATIONS

The core cost metric of the NSA is the QPA, and it holds primacy of place in the list of IDR considerations. However, the statute does not specify how much weight should be given to the QPA relative to other permissible non-QPA considerations in the evaluation of offers in the IDR process. The IDR IFR referred to this preferential placement and determined the QPA should be the "presumptive factor" in any IDR award.[41] As a median, the QPA represents a middle point for the price of a service. As such, it represents a mix of provider and service characteristics. Half of those with whom the payer has a contract would charge less than the QPA for the service, and half would charge more. As such, it seems reasonable to consider that IDR settlements could be both lower than and higher than the QPA, depending on how the specific provider and service characteristics compare to the provider and service that are the basis of the QPA. This is supported by the language of the IDR IFR, as the offer closest to the QPA – whether higher or lower – is to be selected absent credible and material evidence that the QPA is unreasonable. In the event that the QPA is deemed to be unreasonable, the IDR entity must first determine a reasonable rate and then choose the offer which lies closest to the determined reasonable rate. When the QPA (or the IDR entity-determined reasonable rate) falls exactly halfway between the two closest offers, the IDR entity must decide whether a higher or lower payment is more reasonable and select that offer.

CHALLENGES WHEN QUANTIFYING ELEMENTS OUTSIDE OF THE QPA

As mentioned in the background section, certified IDR entities may take into account additional information when deciding on a payment:

- Any information submitted by the payer or the provider as part of their offer (subject to the common amount prohibitions discussed above)
- The level of training, experience, quality, and outcomes of the provider or facility
- The market share of the provider, facility, plan, or issuer in the relevant geographic region
- The acuity and complexity of the service
- Teaching status, case mix, and scope of services of the facility
- Demonstrations of good faith efforts (or lack thereof) in establishing a contract between the parties in the previous four plan years

These considerations are reasonable potential sources of variation in provider payment. However, these were not included as distinguishing elements in the definition of the QPA, possibly since in-network contracts could not be easily classified across these dimensions. Furthermore, these factors are more difficult to quantify. The subjective nature of many of these items will add complexity to the certified IDR entities' processes. More subjective considerations take additional time to review, which is likely to add to the direct expenses to the IDR process potentially eroding some of the expected savings from the NSA. We provide some examples of the challenges of using these additional considerations in practice:

- Acuity level and case mix: Although standard practices exist for measuring patient acuity levels, they require significant technical expertise and rigorous validation efforts to make the information useful. Furthermore, quantification of acuity level typically relies heavily on the documentation of diagnosis codes. There remains significant variation in documentation and coding practices across providers and payers, which may complicate quantification of variation from the median.

[40] 86 FR 55997
[41] 86 FR 55996

- Provider level of training: It will be challenging to discern meaningful differences in training among providers. In the U.S., physicians are all highly trained specialists with post-graduate degrees. Roughly 90% of physicians are board certified. States typically require continuing medical education credits to maintain a medical license, though amounts vary significantly by state. As such, it is important to determine what levels of education and training support varying payments from the median. At the same time, it is unclear what criteria could reasonably be used to measure this variation, let alone how this criterion could be objectively translated into a dollar amount.

- The level of quality for a provider: Ease or difficulty in quantifying quality varies significantly across provider specialties and procedures. Almost certainly there will be some measures available to provide partial assessment of quality, such as those developed by established organizations like the U.S. Agency for Healthcare Research and Quality. The complexity of health care, as well as difficulties in isolating quality from other characteristics influencing outcomes (e.g., random fluctuation, social determinants of health, patient morbidity) has significant room for advancement.

- Provider market share: While this is listed as a consideration to be taken as IDR, it is not specified how this should be taken into account by the certified IDR entity. High market share may be an indication of patient preference and / or quality of a provider or facility. On the other hand, high market share may be a result of business practices, such as marketing and or mergers and acquisitions. Provider consolidation is typically associated with higher prices[42], and an IDR process that automatically rewards higher market share with higher IDR settlements could serve to further the ongoing trend in this area. The IDR IFR suggests that high provider market share may indicate that a QPA is too high, but does not require the certified IDR entity to reach this same conclusion.

- Payer market share: In addition to provider market share, the market share of a group health plan or health insurance issuer may also be considered. As with provider market share, directionality is not specified, but the IDR IFR notes that larger health plans may have lower payment rates, suggesting a QPA might be too low.

- Teaching hospital status:] This may be the least subjective of the considerations as identifying teaching hospitals is fairly straight-forward and objective. Teaching hospitals tend to have higher payment rates, which may be due to elements, such as the educational component of facility operations or higher quality outcomes. The more challenging aspect is translating that status to a specific enhancement in payment for a particular service or procedure. However, there have been some studies that conclude teaching hospitals tend to have better quality of care, and lower mortality rates for high-risk populations.[43] As such, there is some potential for interaction with provider quality considerations which should be taken into account to avoid any double benefit.

- Demonstration of good faith contracting efforts: Payer-provider contracts reflect a wide range of factors, including quality and service considerations, as well as, other elements more closely linked to market forces, such as whether a carrier has an adequate network and the desire of the provider to participate in plan networks. Aspects like this may impact one or both parties' approach to negotiations. In this regard, defining what constitutes a good faith effort may be challenging, and any evaluation of this criterion should reflect that negotiating in good faith is not the same thing as arriving at a mutually agreeable contract.

These challenges are exacerbated by the fundamental need to quantify the same considerations for the QPA benchmark, as well as the specific case in question. Higher (or lower) payment may be warranted for exceptional circumstances. However, provider networks are typically required to be able to cover a full range of services through meeting network adequacy standards, and so contracted rates used when calculating the QPA may already reflect consideration for services with exceptional circumstances. In order to document exceptionality of a single service, that service must be measured against this relevant baseline. The QPA is the median contracted rate, and so represents the rate that the median provider would accept as part of their mix of both simple and complex services across all patient circumstances in their scope of practice. IDR entities will produce the most consistent results if they are able to objectively evaluate how each case varies from the QPA. A lack of clear definitions and specifications of how these considerations should be measured and weighed in the final rule would likely result in significant variation in IDR results and uncertainty for IDR participants. The IDR IFR requires any variation from the QPA to be driven by credible information, and that the resulting effect of be a material difference between the QPA and a reasonable rate. The regulation does not specify what constitutes credible or material, but offers several examples that may assist IDR entities in evaluating the impact of the various criteria.

[42] The Kaiser Family Foundation has a useful summary of research related to provider consolidation at https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/ .

[43] Silber JH, Rosenbaum PR, Niknam BA, Ross RN, Reiter JG, Hill AS, Hochman LL, Brown SE, Arriaga AF, Kelz RR, Fleisher LA. Comparing Outcomes and Costs of Surgical Patients Treated at Major Teaching and Nonteaching Hospitals: A National Matched Analysis. Ann Surg. 2020 Mar;271(3):412-421. doi: 10.1097/SLA.0000000000003602. PMID: 31639108.

Evaluation of these considerations grows more complicated when multiple services are batched together, as many of these factors may take on a variety of values across the spectrum of services included in a batch submission. While submissions are limited to the same type of service, multiple patients may be reflected, and thus could represent a variety of acuity levels. The services themselves could be notably different – the provider may have exceptional training, excellent quality outcomes, or significant market share with regards to one of the services in the batch submission but not on others. Even contracting efforts and resulting reimbursement levels may vary for the different services. The only noted consideration that will not change is the teaching status of the hospital, but even that could reasonably have different impacts on different services in a batch submission. As a result, batching of claims could produce a variety of offsets, potentially in multiple directions. The IDR IFR requires payers and providers to submit individual offers for each service in the batch, and the IDR entity can select different offers for each service, which should limit the ability for a payer or provider to attempt to exploit baseball-style arbitration for the collection of services.

EVALUATING THE ECONOMIC EFFECTS OF IDR

The results of IDR proceedings will influence overall health costs, and be influenced by the degree of subjectivity in the IDR process. This influence will be especially pronounced if subjectivity produces results that are consistently higher than (or lower than) the QPA. Healthcare spending by health plans and individuals for health services under private health coverage exceeded $1.5 trillion in 2019, with about 18% of these services in settings regulated by the NSA.[44] Our analysis suggests almost $7 billion of this spending takes the form of services that are the subject of surprise bills.

Among healthcare claim costs, medians tend to be lower than averages, so the QPA as a median should put greater downward pressure on payment rates for out-of-network providers. Furthermore, the ability for plans and providers to engage in strategic contracting suggests that contracted payment rates are likely to converge towards prevailing IDR determinations as well. To understand the potential impact of IDR determination levels relative to the QPA we reviewed several different scenarios outlined in Figure 3. Each scenario represents an average rate of payment in IDR settlements. We have illustrated the relationship of this settlement to 2019 reimbursement levels to illustrate potential overall savings. We also illustrate the relationship of this settlement to the level of the QPA to illustrate the potential costs / savings of IDR on a standalone basis.

FIGURE 3 RELATIONSHIP OF VARIOUS LEVELS OF PROJECTED IDR AWARDS TO 2019 PAYMENTS AND THE QPA

	% OF CURRENT AVERAGE IN-NETWORK ALLOWED	% OF QUALIFYING PAYMENT AMOUNT
25th Percentile of in-network allowed	74%	80%
Qualifying Payment Amount	92%	100%
110% of average in-network allowed	110%	119%
75th Percentile of in-network allowed	136%	148%
Billed charges (overall)	234%	254%
Billed charges (surprise billed services)	318%	345%

In Figure 4 we analyze a range of potential economic impacts for these various prevailing levels of IDR determinations. We separately quantify effects for current surprise billed / out-of-network services and services performed in-network at contracted rates in settings where surprise bills occur (“surprise settings”) regulated by the NSA. The economic impact for surprise bills represents the cumulative impact of IDR relative to current allowed amounts for these services, as well as the elimination of all balance bills. The economic impact for surprise setting contracted rates assumes that contracted rates converge towards the payment levels that are assumed for IDR determinations. We also illustrate the total cost or savings assuming that contracted rates converge to these levels, and the percentage impact that each amount represents relative to the total charges in each category, as well as for all health expenditures under private health coverage.

[44] Based on an analysis of Milliman private market claims data and National Health Expenditure Accounts projections, as shown in Figure 4 in the Methodology section.

FIGURE 4: PROJECTED EFFECTS OF IDR SCENARIOS IN 2019 DOLLARS

AVERAGE AWARD UNDER INDEPENDENT DISPUTE RESOLUTION	RELATIVE TO STATUS QUO ($BILLIONS)			PERCENTAGE CHANGE IN HEALTH EXPENDITURES			
	SURPRISE BILLS	SURPRISE SETTING CONTRACTED RATES	SURPRISE SETTINGS TOTAL	SURPRISE BILLS*	SURPRISE SETTING CONTRACTED RATES	SURPRISE SETTINGS TOTAL	OVERALL HEALTH SPENDING
25th Percentile of in-network allowed	(3.2)	(85.3)	(88.6)	-47.3%	-31.9%	-32.3%	-5.8%
Qualifying Payment Amount	(2.0)	(21.1)	(23.0)	-28.7%	-7.9%	-8.4%	-1.5%
110% of average in-network allowed	(1.0)	26.7	25.7	-14.8%	10.0%	9.4%	1.7%
75th Percentile of in-network allowed	(0.2)	68.3	68.1	-2.8%	25.5%	24.8%	4.4%
Billed Charges**	9.9	353.5	363.4	145.9%	132.1%	132.5%	23.7%

** Includes both allowed amounts and balance billed amounts.*
** Assumes that surprise billed / out-of-network services settle at an amount equal to current billed charges for surprise billed services in Figure 3 (318%) average in-network allowed) and in-network contracted rates converge towards an amount equal to overall billed charge rate in Figure 3 (234% of averag network allowed).

As shown in Figure 4, most of these scenarios produce savings on surprise bills. A significant portion of this savings is attributable to elimination of the balance billed portion of surprise bills. However, the largest economic impacts are driven by indirect effects of the QPA and IDR settlements on contracted rates in settings regulated by the NSA (air ambulance services, emergency services, and services by out-of-network providers at in-network facilities). Figure 4 also clearly demonstrates that convergence of rates in IDR above the QPA can erode or even erase savings achieved through surprise billing reforms, and the potential influence of IDR settlements on contracted rates could have significantly larger effects than the direct impact on surprise bills alone. The actual effects are likely to be smaller than those shown. It is likely that only a portion of surprise bills will settle at any these rates via IDR, and contracted rates are unlikely to fully converge to the QPA due to the many considerations that influence provider-payer contracts, at least in the short term. Given the emphasis of the IDR IFR on the QPA in the IDR determination, the most likely outcome may be the second scenario, but this is highly dependent on how IDR entities interpret and act on the rules outlined in the regulation.

V. METHODOLOGY AND DATA SOURCES

All quantitative analysis in this report relied upon Milliman's Consolidated *Health Cost Guidelines*™ Sources Database (CHSD) as our primary data source. Analysis was limited to commercial group and individual experience for 2019 calendar year. Services with insufficient provider information to determine a provider location or specialty were excluded, as well as services that were unable to be adjudicated under any of the Medicare fee schedules. Finally, we excluded group contracts for which we could not identify group size or funding status. The resulting data set contains health plan claims services for approximately 59 million person years.

Surprise bills were identified from CHSD for services classified as air ambulances, ground ambulances, emergency room services, and for facility services with an in network facility component and at least one out-of-network component using a combination of network status, place of service, and procedure codes.

The medians calculated for this paper were based on the definitions for region, specialty, and service type found in the IFR. We used the data fields available in CHSD:

- Region: Metropolitan Statistical Areas and states
- Specialty grouping: CHSD's standard specialty codes with identification of specialties most associated with surprise bills.
- Service type: Medicare APCs, DRGs, and HCPCS from CHSD were used to identify service type

Each median was calculated on a provider ID weighted basis. The provider NPI weighted basis combines national provider identifier and total service payment to impute the number of distinct provider contracts.

Members were attributed to each of the four regulatory markets using contract information in CHSD. Claims were then assigned to the regulatory market based on the market of the member associated with the claim. For each cohort definition analyzed, claims were grouped by cohort and market and observations were aggregated to each of the three weighting levels. Medians were then calculated using percentage of Medicare payments (allowed amount / Medicare allowed amount). These values were then compared to the average value for the cohort to determine the QPA potential payment change. Aggregate impacts were determined by weighting the QPA potential payment change by in-network allowed amounts within the cohort.

We reviewed the relationship between various claims quantities in CHSD, such as contracted rate quartiles and billed charges relative to prevailing in-network payment rates.[45] We then incorporated data from the 2019-2028 National Health Expenditures projections to study potential economic effects of alternative scenarios for average outcomes of the IDR process under the NSA. We estimated the distribution of allowed health costs and surprise bills in the United States, as outlined in Figure 5.

FIGURE 5: ESTIMATED DISTRIBUTION OF PRIVATE MARKET HEALTH SPENDING BY SETTING

SETTING	COST	% OF TOTAL
Surprise Settings	272.8	17.8%
Surprise Bill Allowed (included above)	*5.3*	*0.3%*
Other Settings	1,257.3	82.1%
Total Allowed Charges	1,530.1	99.9%
Estimated Surprise Balance Bills	1.5	0.1%
Total Private Health Care Spending	1,531.6	100.0%
Surprise Bills including balance bills (included above)	*6.8*	*0.4%*

Sources: Milliman Analysis of private market health data, CMS projected 2019-2028 National Health Expenditures

[45] This measurement is similar to the potential payment change (PPC) metric outlines in our previous report, "Impacts of Regulatory Options in Determination of Qualifying Payment Amounts Under the No Surprises Act", available at https://www.milliman.com/en/insight/Impacts-regulatory-options-determination-qualifying-payment-amounts-under-No-Surprises-Act

VI. CAVEATS AND LIMITATIONS

The authors of this report are consulting actuaries for Milliman, Inc. Jason Karcher and Cory Gusland are members of the American Academy of Actuaries, and meet the qualification standards of the American Academy of Actuaries to perform the analysis supporting this report.

The material in this report represents the opinion of the authors and is not representative of the views of Milliman. As such, Milliman is not advocating for, or endorsing, any specific policy changes to the commercial market surprise billing regulations in this report.

This report was prepared for the internal use of UnitedHealth Group and should not be distributed, in whole or in part, to any external parties without the prior written permission of Milliman. We do not intend this information to benefit, or create a legal liability to, any third party, even if we grant permission to distribute this information to such third party.

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to illustrate the potential impacts of potential varying regulatory definitions under federal surprise billing reforms on service costs in the commercial market. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We have relied upon data contributed by a broad range of commercial health plan sponsors and accepted it without audit. We have reviewed this data for reasonableness. There is no single comprehensive source that estimates provider payment levels or health plan premiums in the commercial market. As such, we connected publicly available aggregate totals to plan and region-specific costs to determine median contract rates under a variety of scenarios. To the extent that the data and information relied upon is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

The figures presented in this report are designed to provide information regarding the estimated financial impact of various definitions of key terms in the NSA. Future healthcare costs are highly uncertain and will likely vary from our current estimates and will depend on market dynamics, a plan's regional makeup, and many other external factors.

This report is designed to assist UnitedHealth Group in better understanding the costs and dynamics of independent dispute resolution under the NSA related to key regulatory decisions to be made by HHS. This information may not be appropriate, and should not be used, for other purposes. The terms of the October 1, 2015 Master Services Agreement between Milliman and United HealthCare Services, Inc., an affiliate of UnitedHealth Group, apply to this report and its use.

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