

# **CBO's Approach to Estimating the Budgetary Effects of the No Surprises Act of 2021**

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McCourt School of Public Policy, Georgetown University

Daria Pelech

Health Analysis Division

Congressional Budget Office

# The No Surprises Act

The stated aim of the No Surprises Act was to protect patients from surprise billing. The law:

- Established protections for patients receiving out-of-network care,
- Established an arbitration process for resolving payment disputes, and
- Directed arbiters to consider the qualifying payment amount (QPA), defined as the median in-network rate, as the benchmark for payment (with other factors).

CBO projected that reductions in prices paid to providers would reduce insurers' costs, in turn reducing premiums by roughly 1 percent and reducing federal deficits from 2021 to 2030 by a total of \$17 billion.

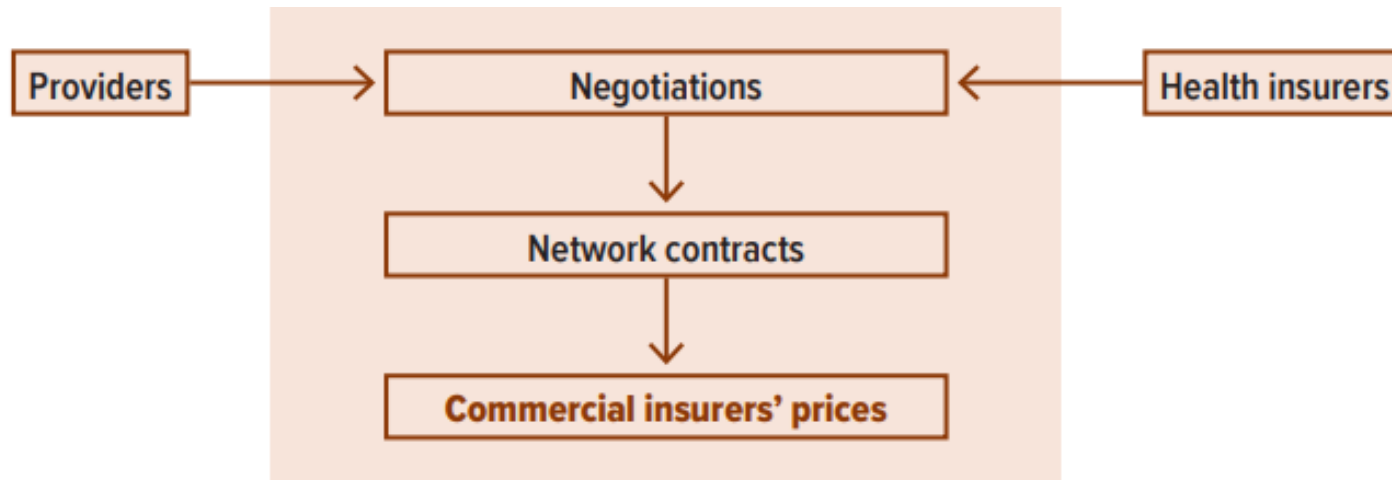
# Legislative Process

CBO provided Congressional staff with roughly 150 informal estimates in 2019 and 2020.

Estimates ranged from deficit reductions of about \$20 billion to *increases* of about \$50 billion.

That range of estimates was driven by the variation in payment resolutions, which affected the federal budget by changing providers' and insurers' bargaining power and in-network prices.

# How In-Network Commercial Prices Are Determined

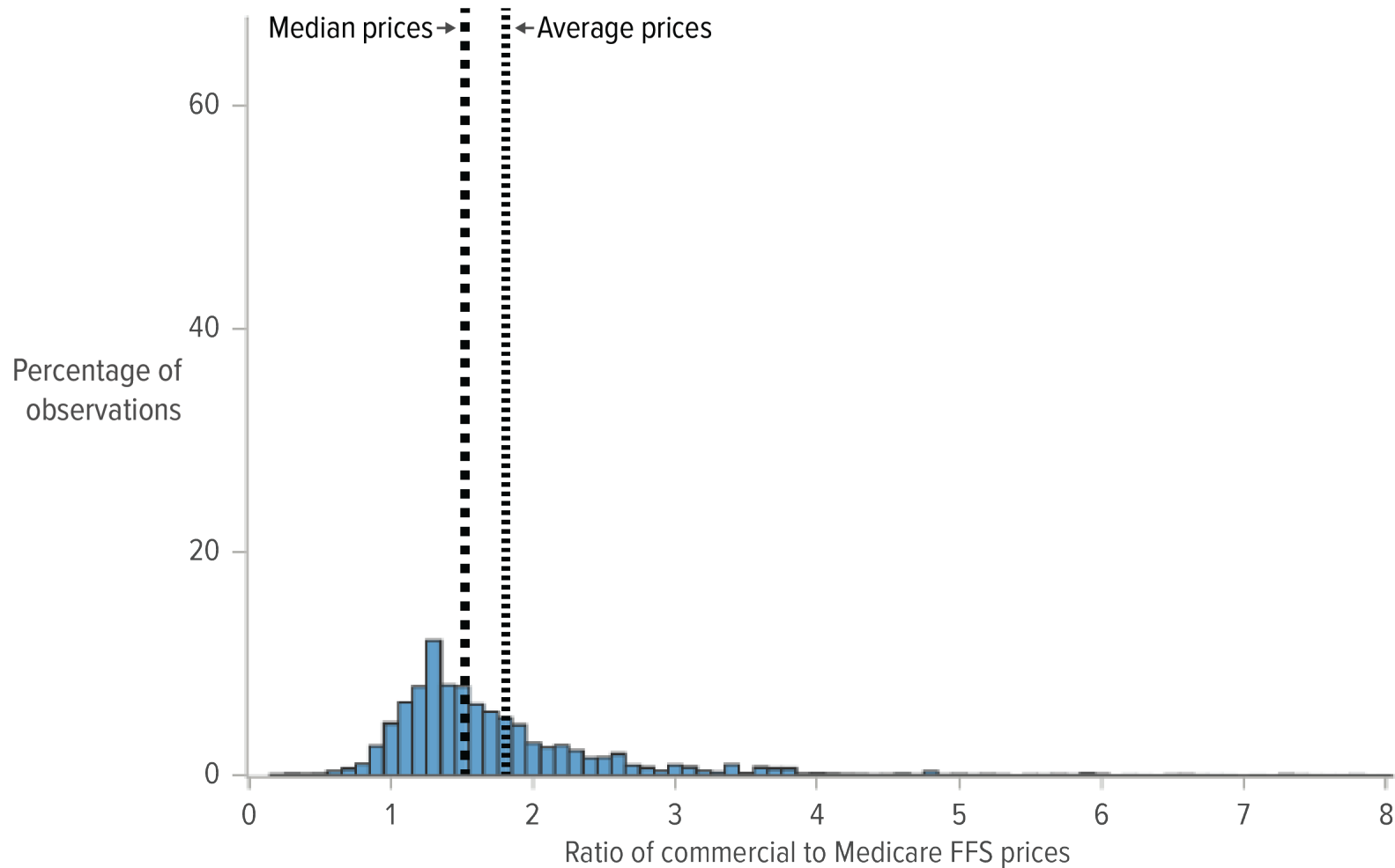


The prices paid by commercial insurers are determined through confidential negotiations between individual insurers and individual providers or groups of providers.

## Some Key Facts About Surprise Billing

- Although prices for out-of-network care are substantially higher than in-network amounts, most care happens in-network, even for specialties prone to surprise billing.
- Out-of-network prices influence in-network prices. If providers can credibly threaten to stay out-of-network, they can bargain for higher prices.
- Conversely, if insurers can credibly threaten to exclude providers from networks without leaving patients vulnerable to balance billing, they can bargain for lower prices.
- A benchmark of *median* in-network rates reduces spending, because average prices for in-network care are 15 percent to 20 percent higher than median prices for in-network care.

# Illustration of Variation in Prices in the Absence of an Out-of-Network Payment Standard: Knee Replacements

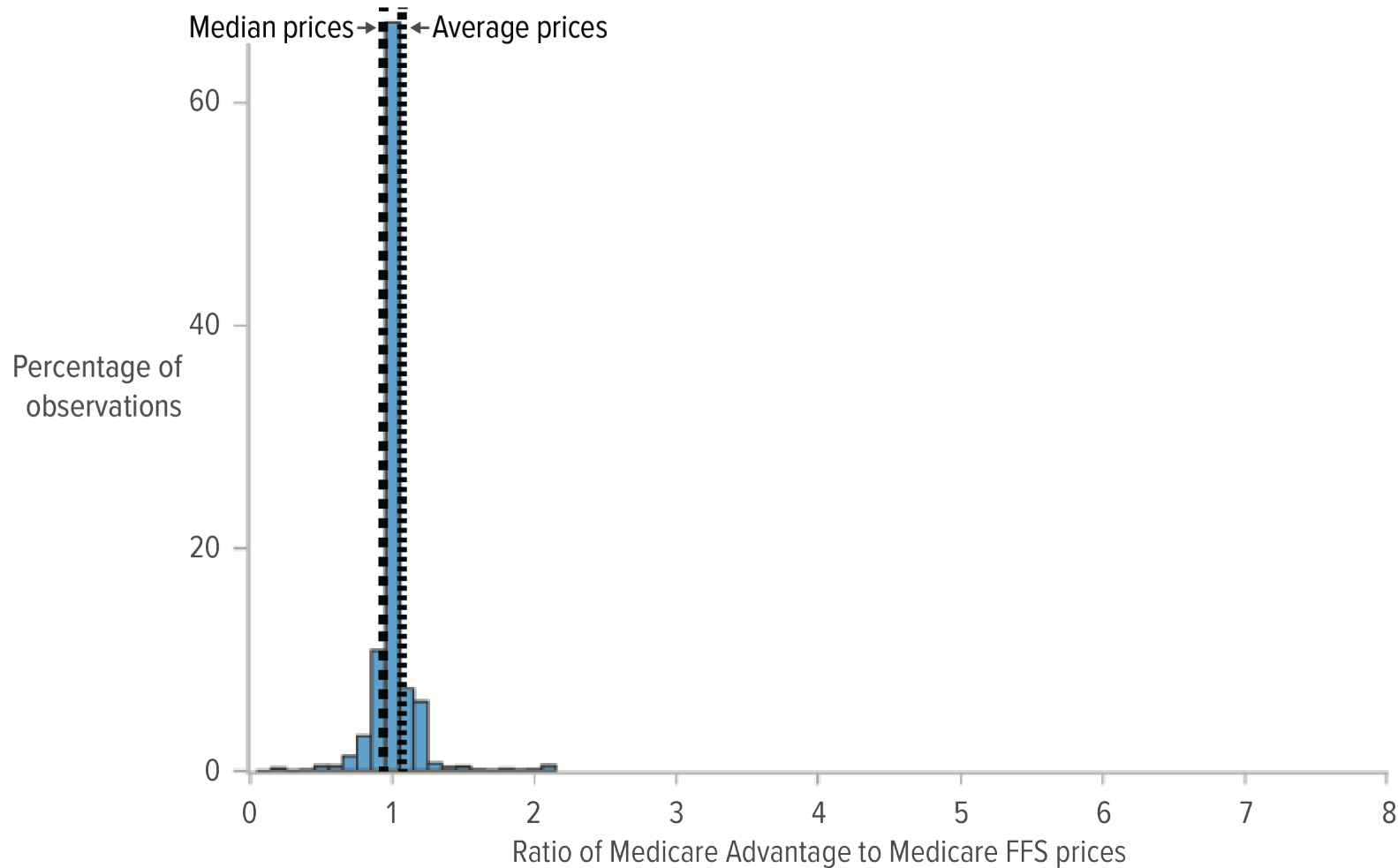


Commercial health care prices tend to have a higher mean than median.

In this example, average prices were 1.8 times Medicare fee-for-service (FFS) prices.

Median prices were 1.5 times Medicare FFS prices.

# Illustration of Variation in Prices With an Out-of-Network Payment Standard: Knee Replacements



In markets with explicit limits on out-of-network payments, such as Medicare Advantage, we see price compression around the out-of-network payment standard.

# Key Components of CBO's Analysis of the Effects of the NSA

In CBO's estimation, prohibiting surprise billing:

- Reduces insurers' spending for previously covered out-of-network care;
- Increases spending on previously uncovered out-of-network services—both directly (by increasing what is covered) and indirectly (because patients consume more care); and
- Reduces negotiated prices for all *in-network* care. Setting the benchmark amount for payment disputes at the median in-network rate reduces in-network prices.



Roughly 80 percent of the net budgetary effect



# Alternative Benchmarks

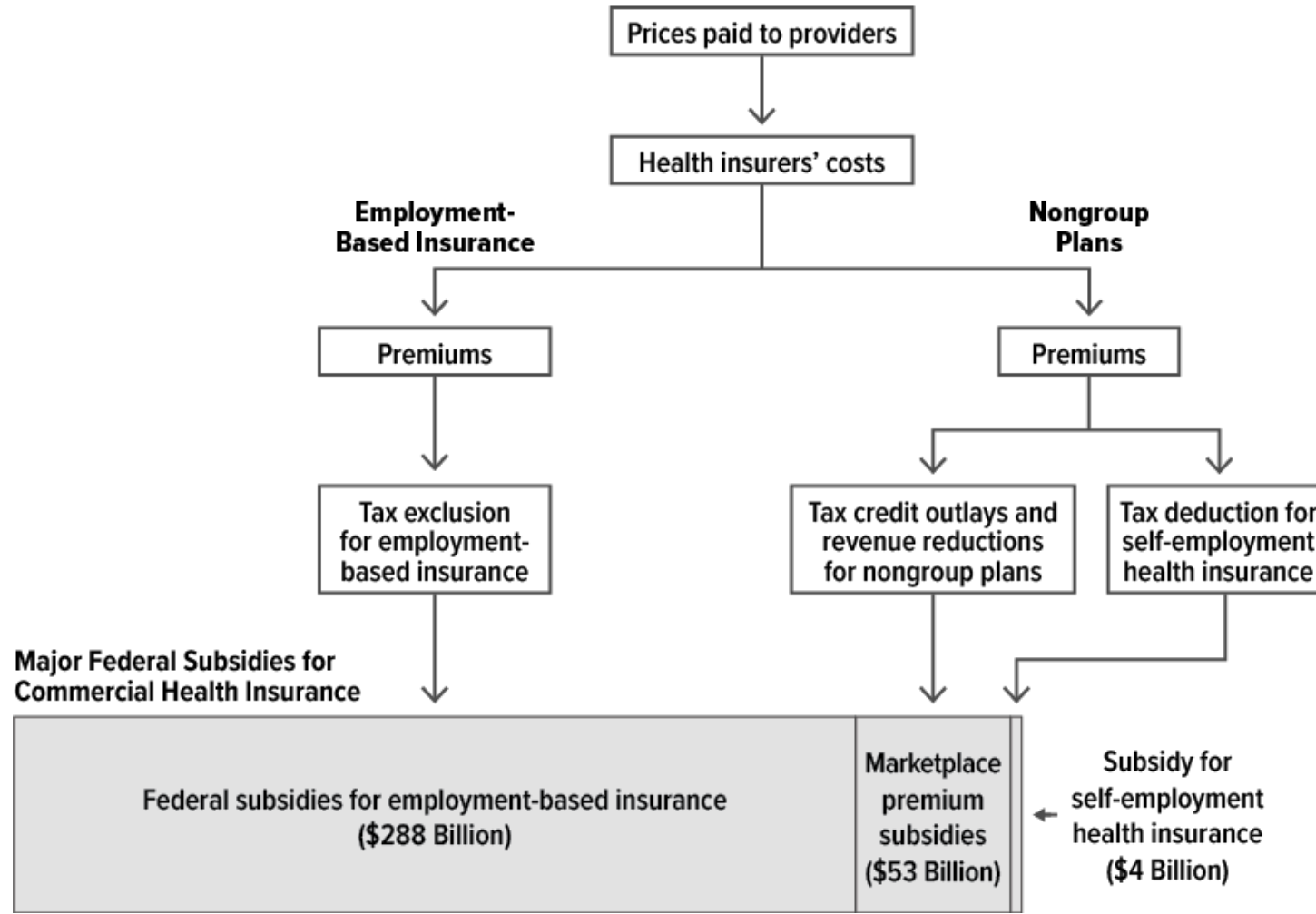
Many other benchmark amounts were considered:

- Benchmarks set *above* average in-network payments tend to increase spending.
- Benchmarks set *at* the average usually increase spending because insurers must expand coverage and increase administrative spending—but it's close.
- Evidence from states suggests that laws that do not specify a payment standard are generally inflationary.

## Additional Considerations in CBO's Analysis

- Using arbitration rather than setting an explicit benchmark reduces savings by introducing uncertainty about payment outcomes.
- Insurers incur additional administrative costs (for example, for providing additional explanations of benefits and participating in the arbitration process).
- Payment benchmarks were fixed in 2019 and indexed to inflation thereafter; the choice of inflation rate was consequential for CBO's projections.
- Additional rules on arbitration—such as allowing providers to batch claims or having a dollar threshold on claims that can be brought—have small upward or downward effects depending on whether they favor providers or insurers.

# How Do Changes in Providers' Prices Filter Through to the Budget?



Prices paid by commercial insurers to providers affect federal subsidies for health care because of the tax preferences for employment-based insurance and premium subsidies for nongroup coverage.

## Developments Since 2021

CBO's estimates of the budgetary effects of a proposal are based on the legislative language and other information available at the time of analysis.

CBO anticipated that arbitration would reduce savings by increasing uncertainty, but there have been more implementation challenges than anticipated.

Initial data from independent dispute resolution (IDR) entities suggest that prevailing party offers have been much higher than the QPA. Two considerations are relevant for interpreting that information:

- Cases that go to IDR are those that fail in open negotiation; they probably account for a small fraction of out-of-network care and insurance spending.
- The primary budgetary effects in CBO's cost estimate were driven by changes in in-network prices; it is not yet clear how those prices have been affected by prohibitions on surprise billing.

# About This Presentation

CBO's original estimates were developed with:

- Alice Burns (formerly of CBO, now at KFF),
- Chad Chirico (CBO), and
- Philippa Haven (formerly of CBO, now at the Department of the Treasury).

The estimates and slides were reviewed by many people at CBO. Graphics were developed with Casey Labrack.

Additional support came from Jessica Hale (CBO).