

Policy Background

Health Care Costs and the No Surprises Act

The arbitration process under the No Surprises Act has grown far beyond expectations, to millions of cases each year. For businesses, particularly self-funded employers, the principal issue is whether they have sufficient visibility into the costs, payment decisions, and network effects of the system and the effects on their own costs.

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- The law appears to be protecting patients from surprise bills, but the arbitration process has become far larger and more costly than anticipated.
- High win rates for providers and awards above expected rates raise questions about whether the independent dispute resolution (IDR) is becoming a routine payment mechanism rather than a backstop for difficult cases.
- Evidence on costs and provider networks remains mixed, making the central policy challenge how to improve IDR without weakening patient protections or access to care.
- In 2025, self-funded plans covered 67% of workers with employer-sponsored insurance, including 80% at employers with at least 200 workers.
- Self-funded employers generally bear IDR costs directly, while fully insured employers may see higher costs and other effects through premiums, benefit changes, or narrower networks.

Protecting Patients and Shifting Payment Disputes

Congress enacted the No Surprises Act in 2020 with bipartisan support. Patients seeking emergency care, or using an in-network hospital, could be treated by an out-of-network clinician and billed for the difference between the provider's charge and the amount paid by the health plan. Patients generally could not select every emergency physician, anesthesiologist, or other clinician involved in their care and therefore had little practical ability to avoid or negotiate these charges. Effective January 1, 2022, the law generally limited patient cost sharing for covered out-of-network emergency and post-stabilization care to the in-network amount and prohibited providers from billing patients for the balance in situations where patients have little provider choice.¹

However, the law does not set a fixed payment rate for covered out-of-network services. After a plan pays or denies a claim, the parties have 30 business days to negotiate and, if no agreement is reached, four business days to initiate IDR. This “baseball-style” arbitration requires each side to propose a payment, with the arbitrator selecting one offer based on the “Qualifying Payment Amount” (QPA), generally the plan's median contracted rate for a comparable service, and factors such as care complexity, provider experience, market conditions, and prior contracting efforts. Applicable state payment rules take precedence over IDR.² The process keeps patients out of payment disputes and was designed to encourage reasonable offers and negotiated settlements. However, the volume and concentration of filings suggest that IDR has become a routine payment channel for some organizations rather than an occasional backstop.

From a Backstop to a High-Volume Payment System

Federal agencies originally projected approximately 22,000 disputes per year.³ By July 31, 2026, however 7,048,593 disputes had been initiated since April 2022. The pace continues to rise: 2,145,850 disputes were initiated from January through July 2026, compared with approximately 2.56 million during 2025.⁴

As the backlog of cases receded by the end of 2025, attention has shifted to who uses IDR and which claims enter the system.⁵ Filings and outcomes are highly concentrated. In the second half of 2025, the ten largest initiating parties or their representatives accounted for 66% of disputes, including 38% for the three largest. Providers prevailed in approximately 85% of payment determinations, and the selected offer exceeded the QPA in 87% of cases. These results do not establish abuse or inappropriate awards, but they raise questions about whether IDR is becoming a routine payment mechanism and how it affects incentives to negotiate and participate in networks. Eligibility adds another layer of cost and delay: non-initiating parties challenged 42% of filings, and IDR entities found 19% of closed disputes ineligible. Plans cite improper filings, while providers point to missing information and jurisdictional uncertainty.

Costs, Networks, and Competing Evidence

With this volume of cases, IDR is becoming a routine payment mechanism rather than a backstop for difficult cases. One analysis estimates that IDR generated \$22.4 billion in costs

from 2022 through 2025, including \$15.6 billion in payments above the QPA and \$6.9 billion in administrative costs and fees. Most of the estimated costs occurred in 2025 as dispute volume and awards increased sharply.

A central question is whether arbitration changes incentives to participate in provider networks. Evidence through 2023 found increased network participation in three of four specialties studied.⁶ A later study found that greater exposure to IDR under the Act was associated with lower network participation, increased premiums, and that a favorable arbitration decision was followed by a 6.8-percentage-point decline in participation with the relevant insurer.⁷ The studies differ in their methods and comparison groups, so they are not necessarily contradictory. Together, they suggest that IDR's effects vary by specialty and market.

A Changing Regulatory and Legal Framework

In response, the Administration is emphasizing operational reform rather than redesigning arbitration. A June 2026 final rule requires more information with initial payments and denials, strengthens eligibility review, standardizes claims data, and moves case management to a centralized IDR Gateway. It also reduced the administrative fee from \$115 to \$15 per party, lowering the cost of legitimate low-dollar claims but potentially encouraging additional filings.⁸ Implementation continues through January 2027. These changes may improve screening and reduce delays but do not directly address the incentives driving dispute volume or awards above the QPA.⁹

Litigation adds a separate source of uncertainty. In August 2026, the Fifth Circuit invalidated rules allowing plans to include rates for services a provider does not perform and exclude some bonus and incentive payments from the QPA, while upholding the exclusion of single-case agreements.¹⁰ As QPA affects patient cost sharing, negotiations, and arbitration, revised calculations could alter plan and provider economics.¹¹

Congress is considering a narrower response. The bipartisan No Surprises Act Enforcement Act would increase penalties for violations, including failure to make timely payments after an arbitration award, and require additional reporting.¹² The President's broader health plan instead asks Congress to require providers and insurers participating in Medicare or Medicaid to post prices and fees publicly, which reflects the Administration's emphasis on transparency and insurer accountability.¹³

Business Implications

The No Surprises Act protects employees from unexpected bills, but it does not eliminate the underlying payment. It shifts the dispute to providers and health plans. For employers, the central questions are who ultimately bears the cost and controls the decisions that produce it.

Self-funded employers have the greatest direct exposure. If an IDR payment is higher than the plan's initial payment, then plan pays the difference. For self-funded plans, that usually means

the employer bears the added cost, though stop-loss insurance can limit risk. This is true even when an insurer or third-party administrator controls the QPA, initial payment, negotiation, and processing, which separates financial risk from operational control.

In 2025, self-funded plans covered 67% of workers with employer-sponsored insurance, including 80% at employers with at least 200 workers. Stop-loss coverage may limit high-cost or aggregate exposure, but coverage of individual awards and administrative fees depends on the contract.¹⁴ Fully insured employers face less immediate exposure because the insurer pays claims and administers IDR, although costs may later appear through premiums, employee contributions, or benefit changes. Pooled claims experience can make it difficult to isolate IDR's contribution to those changes. For self-funded plans, limited visibility also creates a governance concern: employers and plan committees exercising authority over plan administration or assets may have ERISA fiduciary responsibilities, and delegating claims administration does not eliminate the obligation to prudently select and monitor service providers and plan expenses.¹⁵

Employers may therefore want increased reporting on dispute volume, awards, administrative fees, amounts paid above the QPA, eligibility challenges, missed deadlines, repeat filers, and changes in network participation. Breaking these measures down by provider, specialty, facility, and market can help distinguish isolated disputes from recurring sources of exposure. Service agreements will determine whether employers have access to claim-level data, audit rights, settlement authority, and information about vendor fees or shared-savings arrangements that could influence payment decisions.

Exposure is not uniform. Employers with workers concentrated in markets with limited emergency, anesthesia, radiology, or other specialist capacity may be more sensitive to higher awards or network disruption. National employers must also account for differences between state payment rules and IDR under the Act. The practical effect will depend on plan funding, administrator practices, workforce geography, provider concentration, and forthcoming guidance on QPA calculations. For business leaders, IDR under the Act has significant implications not only for the workforce and benefits, but also for oversight of vendors and potentially for fiduciary responsibilities as well – concerns that will only grow with the growth of IDR and the volume of cases under the Act.



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Endnotes

- ¹ <https://www.cms.gov/files/document/nsa-keyprotections.pdf>
- ² <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-73>
- ³ <https://www.federalregister.gov/documents/2026/06/04/2026-11140/federal-independent-dispute-resolution-operations>
- ⁴ <https://www.cms.gov/initiatives/no-surprise-billing/overview/policies-resources/independent-dispute-resolution-reports>
- ⁵ <https://www.cms.gov/priorities/innovation/data-and-reports/2026/federal-idr-supplemental-background-2025-q3-2025-q4>
- ⁶ <https://www.gao.gov/products/gao-26-107169>
- ⁷ <https://www.nber.org/papers/w35717>
- ⁸ <https://www.cms.gov/newsroom/press-releases/federal-rule-takes-aim-health-care-bureaucracy-reducing-dispute-fees-boosting-transparency>
- ⁹ <https://www.cms.gov/files/document/Federal-IDR-Operations-Implementation-Timeline.pdf>
- ¹⁰ <https://www.ca5.uscourts.gov/opinions/pub/23/23-40605-CV1.pdf>
- ¹¹ <https://www.cms.gov/initiatives/no-surprise-billing/overview/notices>
- ¹² <https://www.govinfo.gov/app/details/BILLS-119hr4710ih>
- ¹³ : <https://www.whitehouse.gov/fact-sheets/2026/01/fact-sheet-president-donald-j-trump-calls-on-congress-to-enact-the-great-healthcare-plan/>
- ¹⁴ <https://www.kff.org/health-costs/2025-employer-health-benefits-survey/>
- ¹⁵ <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/publications/understanding-your-fiduciary-responsibilities-under-a-group-health-plan>