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Congress Must Act to Safeguard the No Surprises Act from Industry Gaming

Introduction

The No Surprises Act (NSA), signed into law in December 2020, represents a rare success story as one of the most significant bipartisan actions to address a pressing consumer concern. Prior to the NSA, surprise billing was a common problem when, through no fault of their own, families received medical treatment from an out-of-network provider working at an in-network facility. The surprise came in the form of medical bills for the difference between what a provider charged for those services and what the insurer paid that provider, often leaving consumers on the hook for unexpected and unforeseeable bills in the hundreds and thousands of dollars.

The NSA protects consumers by taking them out of the middle of payment disputes between insurers and uncontracted providers. To date, the NSA has prevented an estimated 50 million surprise medical bills from reaching consumers.[1] **Despite this clear success, the law includes a major loophole in determining how much these out-of-network providers should be paid by relying on a gameable independent dispute resolution (IDR) process** (see Appendix, page 8, for more detail on IDR). Certain provider groups backed by private equity and corporate middlemen have systematically exploited the IDR process to inflate their payments, which will ultimately increase premiums and health care costs for consumers and patients.[2]

By not setting a firm, evidence-based price benchmark to determine appropriate payment for disputed claims, the NSA has allowed a handful of private equity-backed staffing firms to flood the law's new arbitration system with millions of frivolous cases and turn the IDR process into a profit engine, winning 87% of disputes at rates between three and 10 times the median in-network rate in 2025.[3] As a result, hospitals and corporate provider groups have every incentive to try to drive up payment awards, and insurers are starting to pass those higher costs on to consumers through higher premiums.[4] **Abuse of IDR has incurred more than $22 billion in total costs since 2022 and increased year over year, including $16.5 billion in 2025 alone.**[5]

This is the foreseeable consequence of an IDR process that was designed to favor inflated rates driven by corporate-backed health care providers. Despite warnings from consumer advocates, employers and other key stakeholders, these corporate provider groups successfully lobbied

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Congress to enact a process they knew would be susceptible to gaming and now reap the rewards of abusing it.[6] Congress must act now to correct course and live up to the law's intent to protect consumers from the inflated costs of out-of-network surprise medical bills — both at the time consumers receive medical services and in the form of higher insurance premiums for everyone.

How we got here

Prior to passage of the No Surprises Act in 2020, surprise billing was rampant — a practice where patients would receive unexpected bills from out-of-network provider groups even when treated at in-network facilities. This dynamic was driven by a fundamental market failure in health care: Patients do not regularly select their own emergency and ancillary providers (for example, anesthesiologists, radiologists or ambulance companies) when seeking hospital care. Since those providers contract with health insurers independently from the hospital, staffing firms, including those backed by private equity, discovered they could stay out of insurance networks while still maintaining a high volume of patients when delivering care at in-network facilities.[7]

Firms like TeamHealth and Envision contracted with in-network hospitals to manage care delivery for entire hospital-based departments, such as emergency services and radiology,[8] and often purposely stayed out of network as a deliberate billing strategy. Leveraging the monopoly power they had in these instances, these large staffing firms charged inflated prices for lifesaving care that patients had no ability to shop for or decline, then balance billed (see Appendix, page 8, for more detail on balance billing) patients for any amount the insurer did not pay.[9]

Patients would regularly receive surprise bills in the hundreds or thousands of dollars, and sometimes in the tens of thousands of dollars, such as in the case of air ambulance bills, despite seeking care at in-network hospitals.[10] These large staffing firms also employed a second billing strategy: using the *threat* of staying out of network to gain leverage during contract negotiations with insurers to negotiate inflated in-network rates for services since they could credibly walk away and directly balance bill patients anyway.[11]

The direct impacts of this surprise billing strategy were staggering, inflationary and lucrative. For instance, compare the average in-network payment rates for internal medicine providers for standard office visits and orthopedists for knee replacements (158% and 164% of Medicare rates in 2015, respectively) to the in-network rates for the provider groups that could leverage the out-of-network billing threat, such as pathologists, emergency department physicians, anesthesiologists and radiologists (343%, 303%, 367% and 195% of Medicare rates in the same year, respectively).[12]

Before the No Surprises Act

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By the late 2010s, roughly 1 in 5 emergency department visits involved an out-of-network provider, and nearly 1 in 10 scheduled hospital stays at in-network facilities led to a surprise out-of-network bill.[13] As the chaos caused by rampant surprise bills came to a boiling point, Congress finally intervened. Thanks to the sustained efforts of health care advocates and a steady stream of outrageous patient stories highlighted in the media, members of Congress passed the bipartisan No Surprises Act, which was signed into law in December 2020.

Problem partially solved

The promise of the No Surprises Act was first and foremost to prevent patients from getting unexpected medical bills in the hundreds or thousands of dollars. But the NSA failed to establish a method for setting fair and reliable payments to out-of-network providers, which would protect consumers from rising health care premiums.

When designing the NSA, the vast majority of health care stakeholders, including consumer advocates, labor groups, employers and insurers, agreed on the best approach: **setting limits on out-of-network payments by using a fixed benchmark, either based on Medicare prices or a median in-network contracted rate.**[14] Such a concrete benchmark would have two important effects: 1) removing the financial incentive to stay out of network in the first place and 2) preventing out-of-network providers from using arbitration to generate inflated payments that exceed what competitive market negotiations would produce.[15]

Corporate provider groups, private equity-backed staffing firms and their allies fought this approach aggressively. They lobbied instead for third-party arbitration — a "baseball-style" process in which a neutral arbitrator chooses between the insurer's and the provider's proposed payment amounts, weighing a range of factors. Consumer advocates and other stakeholders meanwhile raised explicit concerns that arbitration without a strong, fixed benchmark would be easily manipulated, add enormous administrative complexity, and drive up costs.[16]

Congress ultimately enacted a final compromise that included the third-party arbitration process that industry groups spent millions of dollars in lobbying to support, but also included a key guardrail intended to help contain costs — consideration by the arbitrator of the qualifying payment amount (QPA) (see Appendix, page 8, for more detail on the QPA), essentially the median in-network rate.[17] The QPA was meant to be a grounding and primary

factor in IDR considerations, listed first in the statute, but was included as one factor among many, including providers' historically contracted rates, which were themselves inflated by the very surprise billing abuses the law was meant to stop.[18]

While interim final rulemaking from the Centers for Medicare & Medicaid Services initially directed arbitrators to use the QPA as a presumptive benchmark, this directive was challenged by industry almost immediately and an aggressive industry-led litigation strategy proved fatal to a balanced IDR process.[19] Large provider groups, private equity-backed staffing firms, air ambulance companies and professional physician associations filed more than 30 lawsuits aimed at weakening implementation of the NSA, including between 2022 and 2023, when the Texas Medical Association filed three successive lawsuits challenging the role of the QPA in the IDR process.[20] District and circuit courts ruled in the industry's favor each time, determining that the QPA could no longer be considered first nor weighted more heavily than other factors, gutting the only meaningful guardrail Congress enacted against inflated IDR payments.[21]

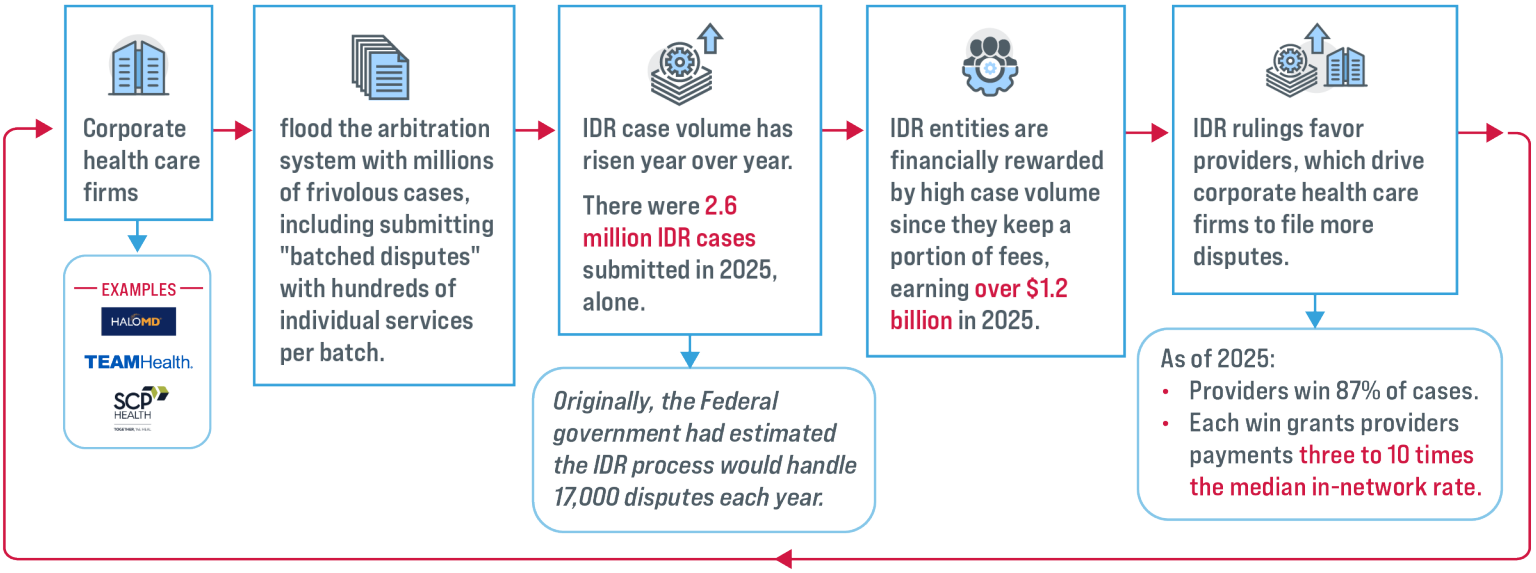
IDR's perilous loophole

Once the QPA guardrail fell, the economics of the IDR process became irresistible for private equity-backed providers. Without the QPA guardrail, large provider groups and their private equity-backed staffing firms won more than 83% of settled disputes in the IDR process in the fourth quarter of 2025.[22] Payment determinations for out-of-network providers in settled disputes far exceeded the median in-network rate for the same period: 334% of the median rate for emergency services, 398% for radiology services, and 361% in anesthesia.[23] With the IDR process now engineered to side with inflated out-of-network provider prices and profits consistently, the very same private equity-backed staffing firms that pioneered surprise billing as a business strategy were poised to reap the rewards of a significantly weakened IDR process.

The volume of claims exploded. The federal government originally estimated the IDR process would handle approximately 17,000 disputes per year.[24] Instead, 1.4 million cases were submitted to the IDR in 2024 alone, followed by a staggering 2.6 million cases in 2025 — roughly 150 times more than originally predicted.[25] **Notably, just four private equity-backed staffing firms and IDR middlemen are responsible for nearly half of this volume:** HaloMD, TeamHealth, SCP Health and Radiology Partners.[26] These corporate health care firms are the architects of the IDR abuse model.

To be clear, this volume was not driven solely by the number of eligible payment disputes. It was driven by a deliberate strategy to overwhelm the system and generate inflated payment determinations en masse. As large provider groups consistently won inflated payment determinations, it created a strong financial incentive to submit higher volumes of

A Vicious Cycle: Corporate Firms Abuse the IDR Process



cases to IDR, regardless of whether those disputes are eligible for the process.[27] For example, in the fourth quarter of 2025 alone, large staffing firms initiated more than 700,000 cases, with 134,000 cases declared ineligible and removed from the IDR process.[28]

One key strategy private equity-backed staffing firms and corporate middlemen use to abuse the IDR system is submitting "batched disputes."[29] Some providers are using batched disputes to submit hundreds of individual services for IDR consideration in a single batched submission.[30] According to one survey, **15% of all claims in 2024 should have been deemed ineligible but resulted in a payment determination anyway.**[31]

This massive increase in payment disputes serves to overwhelm IDR entities' ability to review the eligibility of each claim for review, resulting in payment determinations favoring providers. Many of these claims are not even subject to NSA regulations, including disputes submitted by providers for services paid by Medicare and Medicaid.[32] Because the reward for winning is so large and the cost of submitting an ineligible claim is so small, the perverse incentive is to submit ineligible claims. This business model has proved so lucrative that even specialists like plastic surgeons, who rarely balance billed prior to the NSA, have turned to the IDR process for profits.[33]

Conflicts of interest baked in

Further undermining the intent of the IDR process, IDR entities — the third-party arbitrators responsible for resolving disputes — are themselves incentivized to perpetuate this system given that they keep all the revenue generated by the IDR entity fees. In 2025, IDR entities earned more than $1.2 billion in IDR entity fees, which are paid by the loser of arbitration.[34] Because cases are almost exclusively brought to IDR by providers, IDR entities have some financial interest in providers winning cases, and continuing to bring additional volume of future cases

to arbitration. To make matters worse, some IDR entities themselves are backed by private equity firms, including at least one case of a private equity firm that backed both a provider firm and an IDR entity — a direct conflict of interest with no meaningful regulatory response.[35]

Rising costs for consumers

As dispute volume climbs year after year, insurers have felt the inflationary impact of the IDR process, paying more than $2 billion to providers between 2022 and 2024 in payment determinations.[36] Without changes, insurers are beginning to pass these excess costs along to consumers. For example, the United Service Workers Health Plan specifically raised premiums by 1.75% this year on top of other premium increases to offset increased costs associated with IDR processes.[37] As other plans follow suit, the promise of the No Surprises Act to contain costs and potentially yield health care savings, both to the system and to consumers across America, is undoubtedly broken.

The path forward

Federal policymakers must act now to put the No Surprises Act back on track. It is clear that private equity-backed provider staffing firms and corporate middlemen will continue to exploit key loopholes in the No Surprises Act to profit from the IDR process, which was not designed to support a large volume of disputes. After a series of provider-initiated lawsuits gutted the IDR guardrails in favor of provider payouts, insurers are now reporting in their rate filings that they are raising premiums in part to account for the high and rising volume of these payment decisions, impacting the cost of care for families across the country.

These issues are not inevitable, as evidenced by the fact that some states enacted surprise medical bill protection processes that are not being flooded with appeals and not having an inflationary impact. A companion Families USA paper, States Spotlight Promising Fixes to the No Surprises Act, details such state-specific solutions in California, Ohio and Virginia.

These are fixable issues if policymakers have the political will to act.

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CONGRESS MUST TAKE ACTION TO FIX THE NO SURPRISES ACT

1. **Establish a fixed benchmark for out-of-network services subject to No Surprises Act protections to prevent corporate provider groups from extracting billions of dollars of inflationary payment determinations from IDR — costs that will be passed onto everyone with private insurance.**

   - **Option 1:** Remove the current IDR process and instead set payments for out-of-network services subject to No Surprises Act protections with a statutorily defined benchmark price, either as a percentage of Medicare or based on a median contracted rate, as was originally proposed by diverse stakeholders for the No Surprises Act.[38]
     - In **California**, the state balance billing law requires insurers to offer providers an upfront benchmark price (either 125% of the Medicare rate or the average commercial rate). Additionally, providers must first utilize insurers' internal appeals process prior to accessing IDR.
       - **California's** IDR process has achieved a lower volume of disputes per capita, with payment determinations only slightly higher than the median in-network rate.[39]
   - **Option 2:** Require IDR entities to base their arbitration decisions primarily on median contracted rates or as a fixed percentage of the Medicare rate.
     - In **Virginia**, where state law ensures IDR entities can consider contracted rates from an all-payer claims database, payment determinations were more balanced, with providers winning 45% of settled disputes.[40]

2. **Include ground ambulance services under the No Surprises Act to protect patients from a common source of out-of-network bills.**

   - As of 2026, 22 states have already enacted legislation to ban ground ambulance surprise bills.[41]

3. **Address conflicts of interest among IDR entities by:**

   - Requiring IDR entities to publicly disclose ownership structures, compensation arrangements and outcomes data.
   - Strengthening the IDR entity certification process to impose meaningful consequences for IDR entities that disproportionately issue payment determinations on ineligible claims.[42]

In the almost six years since its passage, the No Surprises Act has protected millions of consumers from harmful surprise bills.[43] But as it becomes clearer that industry pressure has weakened the ability of the law to contain costs, policymakers should take action to center and protect consumers.

Appendix

Glossary

Balance bill / balance billing — A type of surprise medical bill. Prior to the No Surprises Act, when a patient received a bill for care from an out-of-network provider, the patient's insurer would cover only a portion of that charge, based on a "usual, customary, and reasonable rate" — an amount based on what providers in the area usually charge for the same or similar medical services. Providers could then bill patients for the difference (or remaining balance) between that rate and the full out-of-network charge. The No Surprises Act outlawed this practice.[44]

Open negotiation — When an insured patient receives services covered by the No Surprises Act from an out-of-network provider, the patient can no longer be issued a bill for that care. Instead, insurers and providers have a period of 30 days to negotiate a fair price for that service. If the two sides cannot come to an agreement, the dispute can be submitted to the independent dispute resolution process.

Independent dispute resolution (IDR) process — When providers and insurers cannot agree on a fair price during the open negotiation (see definition above) period for a service covered by the No Surprises Act, the dispute can be submitted to the IDR process. While the state statutes vary on the structure and standards of IDRs, under the federal No Surprises Act, these disputes are reviewed by a third-party arbitrator (called an IDR entity) in a "baseball-style" arbitration. Each side will submit a single offer for the price of that care alongside evidence to justify that offer. Then the IDR entity will review the evidence and determine which of the two offers will become the payment owed by the insurer to the provider. The IDR entity must choose one of the two offers exactly and cannot select an average of the two.

Qualifying payment amount (QPA) — The QPA is one factor that insurers submit alongside their offer during the independent dispute resolution process. It is a benchmark price defined in the No Surprises Act as the median rate paid to contracted providers in a local geographic area for a particular health care service. In effect, it is a representation of what an insurer pays providers to deliver that service for in-network patients.[45]

Endnotes

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