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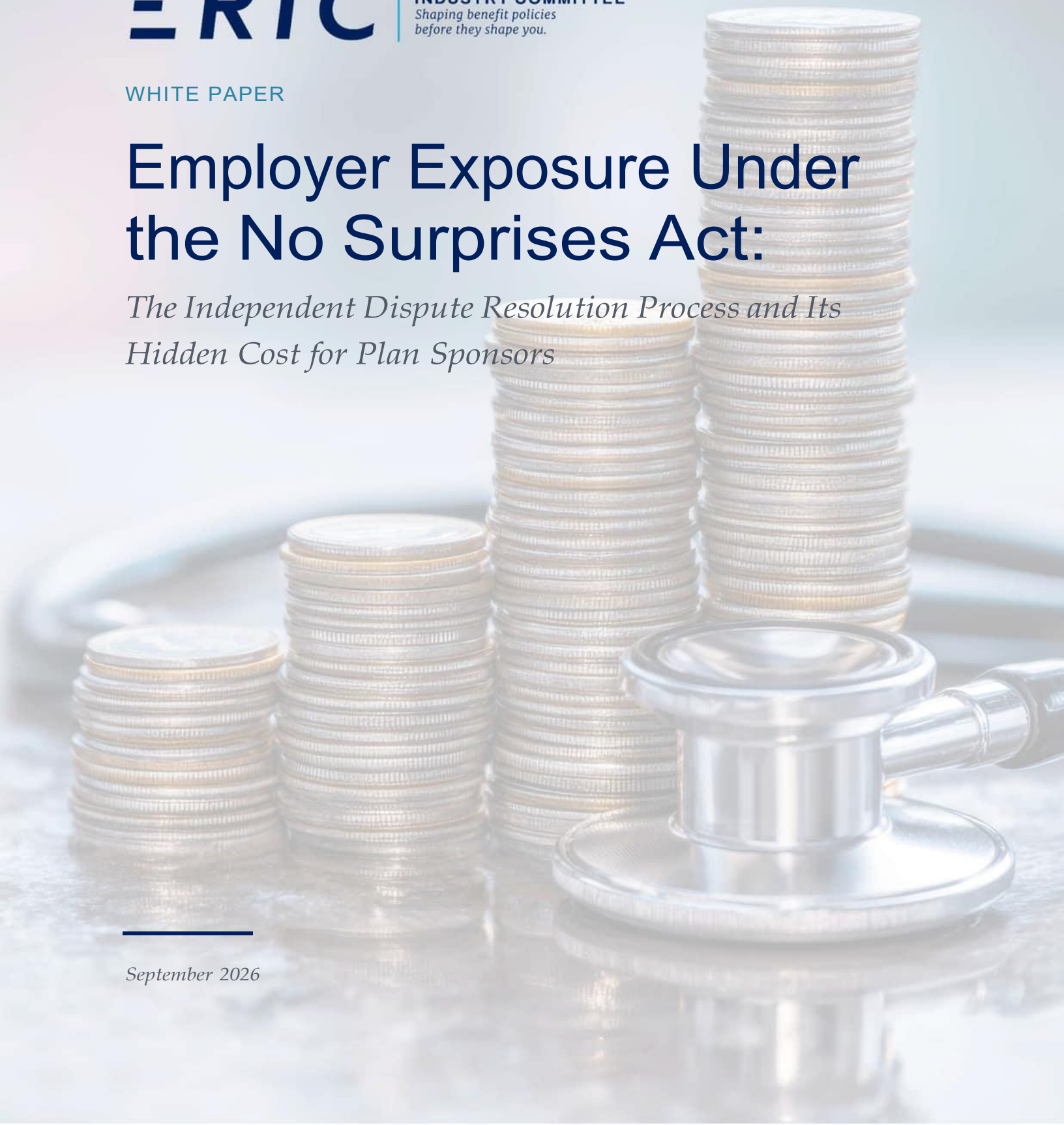
WHITE PAPER

Employer Exposure Under the No Surprises Act:

The Independent Dispute Resolution Process and Its Hidden Cost for Plan Sponsors



September 2026

Contents

I. Introduction 3
a. The Promise and the Reality 3
b. The Employer Stake 4
c. Scope of Impact 5
II. Background 6
a. Patient Protections and the Arbitration Backstop 6
b. How Self-Funded Plans Fit In 7
c. Regulatory Unraveling: Litigation and Its Effects 8
III. From Projection to Reality: What the Data Show 8
a. Dispute Volume 8
b. Arbitration Outcomes 9
c. The Premium Projection Miss 11
IV. Employer Costs and Relevance 12
a. The Zero-Sum Reality 12
b. Quantifying the Burden 13
c. Effect on Premiums and Coverage Affordability 15
d. The Absence of an Appeals Mechanism 19
V. Policy Recommendations 20
a. Restore the QPA's Intended Role 20
b. Establish a Limited Appeals Mechanism 20
c. Address Volume Abuse 21
d. Enact Transparency Reform 21
VI. Conclusion 22
Bibliography 23

Fast Facts

IDR by the Numbers

The employer cost of NSA arbitration

THE PROGRAM, BY THE NUMBERS

$22.4B	88%	~90%
TOTAL IDR SYSTEM COSTS, 2022–2025	PROVIDER/FACILITY WIN RATE, H1 2025	OF IDR COSTS ABSORBED BY SELF-FUNDED EMPLOYERS

FROM SELF-FUNDED EMPLOYER INTERVIEWS

$12M — One interviewed self-funded sponsor's projected 2026 IDR cost, up from $3.5 million in 2025, against roughly 2,000 disputes a year and an 80 percent provider win rate.

1–3% — Share of annual health care trend a second interviewed sponsor attributes specifically to IDR awards, a driver on par with recent GLP-1 drug spend.

5–6% — Share of total 2026 health care spend a third interviewed sponsor projects IDR payouts alone will consume, with awards already running more than four and a half times the original billed value of the underlying claims.

POLICY SHIFTS TO KNOW

QPA De-Anchored

Litigation stripped the qualifying payment amount of its presumptive weight in arbitration, removing the benchmark meant to keep awards near contracted rates. This shift, which is the opposite of what Congress intended, is at the center of escalating award amounts and subsequent costs.

Filing Fee Cut 87%

In 2026, the per-dispute administrative fee fell from $115 to $15, reducing the cost of filing disputes at scale, which may further accelerate a filing rate that was already high and rising. Between 2022 and 2025, 3.4 million disputes were filed, far exceeding the 17,000 per year that federal officials had projected.

CBO Calls for New Research

In June 2026, the Congressional Budget Office (CBO) issued a rare public acknowledgment that its original cost projections for the law have not held. The call for new research comes at a time when costs are growing and premiums are expected to rise as a result of the law, opposite of CBO's original projection of a 1% premium decrease.

I. Introduction

a. The Promise and the Reality

The No Surprises Act (NSA), enacted through the Consolidated Appropriations Act of 2021 and effective January 1, 2022, established federal patient protections against unexpected out-of-network billing, leaving patients responsible only for in-network cost sharing.[1] To resolve the residual payment dispute between plan and provider, the law established a federal independent dispute resolution (IDR) process. In a form of baseball-style arbitration, each party submits a single, final offer and a certified IDR entity selects one of those offers outright. No subsequent negotiation or appeals are allowed. The statute directs the IDR entity to consider the qualifying payment amount (QPA), the median rate the plan already pays in-network providers for the same service, and other specified factors that might account for the care requiring higher-than-average payments.[2]

Nearly four years into implementation, the core patient-protection aspects of the NSA are working. The U.S. Government Accountability Office (GAO) analyzed commercial claims for more than 110 million patients from 2019 through 2023 and reported that the share of claims billed in-network increased after 2022 for three of the four specialties historically associated with surprise billing (emergency medicine, radiology, anesthesiology, and air ambulance).[3] Patient spending moved in the same direction. A quasi-experimental study published in *The BMJ* estimates that adults with direct-purchase private coverage who gained protections saw an 18 percent relative reduction in out-of-pocket costs, roughly $567 per adult per year. That is larger than the reductions estimated for Medicaid expansion or for the Inflation Reduction Act's Medicare Part D redesign.[4]

However, the cost containment outcomes that the Congressional Budget Office (CBO) projected as a result of the law have not come to fruition. In fact, there is strong evidence that the opposite has occurred. While CBO projected that the NSA would reduce private health insurance premiums by 1 percent from 2021 through 2030,[5] self-funded employers are experiencing significant upward payment pressure due to both the volume of IDR awards and the award amounts themselves. Between 2022 and

[1] *Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, div. BB, tit. I, 134 Stat. 1182 (2020).*

[2] *Consolidated Appropriations Act, 2021, div. BB, tit. I, sec. 103.*

[3] *U.S. Government Accountability Office, Private Health Insurance: Provider Participation and Payments for Selected Services Before and After the No Surprises Act, GAO-26-107169 (Washington, DC, February 19, 2026), https://www.gao.gov/products/gao-26-107169.*

[4] *Michael Liu, Kushal T. Kadakia, Stephen A. Mein, and Rishi K. Wadhera, "Patient Healthcare Spending After the No Surprises Act: Quasi-Experimental Difference-in-Differences Study," BMJ 390 (2025): e084803, https://doi.org/10.1136/bmj-2025-084803.*

[5] *Congressional Budget Office, CBO's Approach to Estimating the Budgetary Effects of the No Surprises Act of 2021, March 7, 2024, https://www.cbo.gov/publication/59878.*

mid-2025, 3.4 million IDR disputes were filed, a figure that rose to 4.8 million by the end of 2025, far exceeding CBO's original estimate of approximately 22,000 cases annually, and providers won 88 percent of disputes in the first half of 2025, the highest rate recorded to date.[6] Payment determinations have consistently exceeded standard benchmarks. Brookings Institution researchers found that median IDR awards in the second half of 2023 averaged 4.0 times Medicare's rate for emergency services and 6.6 times Medicare's rate for imaging services. A separate evaluation by the U.S. Department of Health and Human Services (HHS) found that median IDR payment determinations ranged from 172 percent to 349 percent of the median out-of-network payment rate.[7] Litigation contributed directly to this shift: in *Texas Medical Association v. U.S. Department of Health and Human Services*, the United States Court of Appeals for the Fifth Circuit affirmed vacatur of the regulatory provisions requiring arbitrators to weigh the QPA before other statutory factors, removing the mechanism CBO's cost estimate had depended on.[8] Employers are already feeling this directly; one large self-funded sponsor interviewed for this report saw its IDR-related payments climb from $3.5 million in all of 2025 to more than $6 million in just the first half of 2026, a trajectory on pace to quadruple their payouts year-over-year.

In June 2026, CBO issued a formal call for new research on the NSA's impacts, an implicit acknowledgment that the assumptions underlying its original cost projections have not held and that the program's operational reality has diverged substantially from legislative intent.[9] A system designed to limit surprise billing for patients has, through the litigation-driven erosion of the QPA's role as the primary arbitration anchor, shifted payment obligations upward, redistributing costs onto self-funded employer plans, which, ultimately, may once again fall back on the workers and families those plans cover.[10]

b. The Employer Stake

Employer-sponsored insurance (ESI) covers approximately 154 million nonelderly Americans, and 67 percent of covered workers are enrolled in self-funded plans, in which the employer pays claims from its own funds rather than purchasing insurance.

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[6] *Jack Hoadley, Kennah Watts, Katie Keith, and Ellie DeGarmo, "The No Surprises Act IDR Process: An Early Look at 2025 Data," Health Affairs Forefront, March 20, 2026, https://www.healthaffairs.org/content/forefront/no-surprises-act-idr-process-early-look-2025-data.*

[7] *Matthew Fiedler and Loren Adler, "Outcomes under the No Surprises Act Arbitration Process: A Brief Update" (Washington, DC: Brookings Institution, July 31, 2024), https://www.brookings.edu/articles/outcomes-under-the-no-surprises-act-arbitration-process-a-brief-update/; U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Evaluation of the Impact of the No Surprises Act on Health Care Market Outcomes: Initial Post-Implementation Trends, Third Annual Report to Congress (Washington, DC: HHS, February 9, 2026), https://aspe.hhs.gov/reports/no-surprises-act-report-three.*

[8] *Texas Medical Association v. U.S. Department of Health and Human Services, 110 F.4th 762 (5th Cir. 2024).*

[9] *Tamara Hayford, Daria Pelech, and Jessica Hale, "A Call for New Research on the No Surprises Act," Congressional Budget Office, June 15, 2026, https://www.cbo.gov/publication/62491.*

[10] *Federal Independent Dispute Resolution Operations, 91 Fed. Reg. at 33901.*

Among firms with 200 or more workers, that share is 80 percent.[11] In a self-funded plan governed by the Employee Retirement Income Security Act (ERISA), the employer is the direct payer of every IDR award. Often, a third-party administrator (TPA) or an administrative-services-only (ASO) carrier represents the plan in the dispute, selects the offer submitted on the plan's behalf, and receives the determination, but the employer funds the outcome. This is no trivial matter. As IDR payouts reach upwards of $15 billion dollars throughout the life of the program,[12] the direct cost to employers is quickly becoming untenable. There is no insurer absorbing an adverse award and no risk transfer beyond whatever stop-loss attachment point applies, so employers bearing these costs themselves have been forced to confront a rising cost that they have almost no control over. The consequences of this are already visible in public disclosures, including those from the City of San Antonio, which is projecting a health fund shortfall of $40 million in 2026, with plan leaders attributing much of this to a single out-of-network emergency room operator's use of the IDR process.[13]

That structure has a fiduciary dimension. Plan sponsors and their delegates are obligated under ERISA to act prudently and in the interest of participants and beneficiaries when administering plan assets, which includes managing the cost of benefits.[14] A dispute process that generates awards well above the QPA, and that offers no route to contest them on the merits, constrains the sponsor's ability to discharge that obligation, because the sponsor controls neither the outcome nor, in many cases, the offer made in its name.

c. Scope of Impact

The employer-side consequences of the IDR process have received comparatively little attention in the public debate, which has largely been framed as a contest between providers and insurers. Yet the party funding most of the disputed payments sits outside that frame. The IDR process is imposing substantial, growing, and unpredictable costs on self-funded plans, and it offers plan sponsors no meaningful mechanism for appeal or cost control. That exposure is already material. Interviews conducted for this report with self-funded employers found that IDR awards alone add between 1 and 6 percent to overall health care trend. These percentages translate into tens, sometimes hundreds, of millions of dollars annually for plan sponsors who are

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[11] *KFF, 2025 Employer Health Benefits Survey (San Francisco: KFF, October 2025), https://www.kff.org/health-costs/2025-employer-health-benefits-survey/.*

[12] *Jack Hoadley and Kennah Watts, "Spending on IDR Process Pushes No Surprises Act Costs to More Than $22.4 Billion over Just Four Years," Health Affairs Forefront, August 26, 2026, https://doi.org/10.1377/forefront.20260821.888041.*

[13] *Megan Rodriguez, "San Antonio Is $40 Million Over Its Employee Healthcare Budget. What Went Wrong?" San Antonio Express-News, August 12, 2026, https://www.expressnews.com/politics/article/san-antonio-budget-prestige-er-healthcare-costs-22383604.php.*

[14] *Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1104(a)(1)(A)-(B).*

already facing rising health care costs. Public and union-sector plans corroborate this pattern in premium terms; New York's Empire Plan attributed a nearly 10 percent premium increase largely to IDR-driven claims growth,[15] and a union health plan covering 20,000 trades workers in New York raised premiums by an additional 1.75 percentage points specifically to offset arbitration awards and fees.[16]

This is not an argument against the NSA's patient protections, which the evidence suggests are working. It is an argument that arbitration, as currently implemented under the law, is not delivering what Congress and CBO expected, and that the resulting cost shift is better understood as a growing coverage affordability problem than as merely a dispute between providers and payers.

> *"…Arbitration, as currently implemented under the law,* ***is not delivering what Congress and CBO expected****, and that* ***the resulting cost shift is better understood as a growing coverage affordability problem****…"*

II. Background

a. Patient Protections and the Arbitration Backstop

The NSA prohibits out-of-network providers and facilities from balance billing patients for emergency services, for non-emergency services delivered at in-network facilities without valid advance notice and consent, and for air ambulance services. In each case the patient only owes the equivalent of in-network cost sharing, and the remaining balance is resolved between the patient's plan and the provider.[17]

When a plan and an out-of-network provider cannot agree on payment during a thirty-day open negotiation period, either party may initiate IDR. The process uses final-offer, or so-called baseball style, arbitration, in which each party submits a single payment offer and a certified IDR entity selects one offer in its entirety without splitting the difference.[18] The design rationale is that final-offer arbitration pushes both parties

[15] *New York State Division of the Budget, "FY 2027 New York State Executive Budget: Public Protection and General Government, Article VII Legislation, Memorandum in Support," January 20, 2026, 26, https://www.budget.ny.gov/pubs/archive/fy27/ex/artvii/ppgg-memo.pdf.*

[16] *Sarah Kliff and Margot Sanger-Katz, "A $440,000 Breast Reduction: How Doctors Cashed In on a Consumer Protection Law," New York Times, April 22, 2026, https://www.nytimes.com/2026/04/22/us/politics/doctors-insurers-arbitration.html.*

[17] *Consolidated Appropriations Act, 2021, div. BB, tit. I, secs. 102, 105; 45 C.F.R. §§ 149.110-.140, 149.410-.440.*

[18] *Consolidated Appropriations Act, 2021, div. BB, tit. I, sec. 103; 45 C.F.R. § 149.510(b)-(c).*

toward realistic offers near the market rate, because an extreme offer is unlikely to be selected.

The regulations directed certified IDR entities to select the offer closest to the QPA unless credible information submitted by the parties demonstrated that the QPA was materially different from the appropriate out-of-network rate.[19] CBO's savings projection assumed this anchoring would hold, so that IDR would function as a narrow backstop rather than a routine channel for setting prices.[20] However, this presumptive weight of the QPA has since been invalidated in court rulings, and award amounts have significantly deviated from this standard, averaging multiple times higher than the QPA. In 2025, Emergency Department provider awards averaged 315 percent of the QPA, while Neurology and Neuromuscular procedures averaged 2,450 percent.[21]

b. How Self-Funded Plans Fit In

The distinction between self-funded and fully insured arrangements determines who bears IDR risk. In a fully insured arrangement, the carrier pays the award out of premium revenue, spreads it across every employer in its book, and reprices at renewal, so any individual employer bears the cost in diluted form and only after a delay. In a self-funded plan, the arrangement covering 67 percent of workers with employer-sponsored insurance, the employer retains the claims risk.[22] The TPA administers the dispute, but every dollar of the award is paid from plan assets funded by the employer and, through contributions, by employees.

The consequence is that IDR exposure lands as a current-period plan expense, with no renewal cycle to spread the cost across and no pool of other employers to share it with. The sponsor also cannot budget for it in advance, because the volume, timing, and size of determinations depend on which providers choose to file and on how arbitrators weigh factors outside the sponsor's control. For a plan sponsor obligated to manage plan costs prudently, that is the operative problem.

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[19] *Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55980 (Oct. 7, 2021).*

[20] *Congressional Budget Office, Estimate for Divisions O Through FF, H.R. 133, Consolidated Appropriations Act, 2021 (Washington, DC, January 2021), https://www.cbo.gov/publication/56962.*

[21] *Hoadley and Watts, "Spending on IDR Process."*

[22] *KFF, 2025 Employer Health Benefits Survey.*

c. Regulatory Unraveling: Litigation and Its Effects

Provider groups challenged the regulatory provisions that gave the QPA presumptive weight in arbitration. Federal courts, principally in the *Texas Medical Association* line of cases, sided with providers in a series of decisions between 2022 and 2024 and vacated those provisions.[23] Arbitrators are now required to consider the QPA alongside the other statutory factors, including patient acuity, provider training and experience, prior contracted rates, and market share, without a hierarchy among them.

Provider win rates in arbitration have consistently been high and have generally been on the rise since the program's inception, from 81 percent in 2023 to 85 percent in 2024 and 88 percent in the first half of 2025, before easing to approximately 85 percent in the second half of 2025.[24] The timing is consistent with the de-weighting of the QPA, though the available data do not support a causal claim. The association is a reasonable basis for concern, however. Removing the anchor removes the penalty for an aggressive offer, and in a single-offer format the party willing to submit the higher number captures the difference whenever the arbitrator finds the non-QPA factors persuasive.

Regulators have since revisited the process, at least in part. The Departments of Health and Human Services, Labor, and the Treasury finalized the Federal Independent Dispute Resolution Operations rule on May 28, 2026, updating select technical rules; however, the rule does not restore the QPA's presumptive weight, cap dispute volume, or create an appeals pathway, all central concerns for self-funded plan sponsors.

III. From Projection to Reality: What the Data Show

a. Dispute Volume

CBO and the implementing Departments anticipated approximately 17,000 non-air-ambulance disputes per year (reaching 22,000 when including air ambulance claims).[25] Filings in the first half of 2024 alone reached upwards of 600,000 for all covered services.[26] Filings in the first half of 2025 reached approximately 1.2 million, roughly double the year-earlier figure, and filings in the second half of 2025 reached nearly 1.4

[23] *Texas Medical Association v. U.S. Department of Health and Human Services, 110 F.4th 762 (5th Cir. 2024); Federal Independent Dispute Resolution Operations, 91 Fed. Reg. at 33901.*

[24] *Hoadley et al., "An Early Look at 2025 Data"; Centers for Medicare and Medicaid Services, Supplemental Background on the Federal IDR PUF, July 1 – December 31, 2025 (July 2026), https://www.cms.gov/priorities/innovation/data-and-reports/2026/federal-idr-supplemental-background-2025-q3-2025-q4.*

[25] *CBO, Estimate for Divisions O Through FF; Jack Hoadley and Kennah Watts, "The Substantial Costs of the No Surprises Act Arbitration Process," Health Affairs Forefront, August 25, 2025, https://www.healthaffairs.org/content/forefront/substantial-costs-no-surprises-act-arbitration-process.*

[26] *Centers for Medicare and Medicaid Services, Supplemental Background on the Federal IDR PUF, January 1 – June 30, 2024 (March 18, 2025), https://www.cms.gov/files/document/supplemental-background-federal-idr-puf-january-1-june-30-2024-march-18-2025.pdf.*

million, bringing cumulative filings to approximately 4.8 million through December 2025.[27]

Who is filing IDR claims is also consequential. Providers, facilities, and their representatives initiated 90 percent of the 1,265,737 disputes filed from the beginning of 2023 through mid-2024, while insurers accounted for fewer than 1 percent. Among the top ten initiating parties, every one is affiliated with private equity. Those groups submitted approximately 72 percent of the total dispute volume.[28] The top three, TeamHealth, SCP Health, and Radiology Partners, accounted for 53 percent of all disputes nationwide across that period and approximately 44 percent of those initiated in the first half of 2024.[29] Concentration has persisted as volume has grown. Four entities, HaloMD, TeamHealth, Radiology Partners, and SCP Health, accounted for 56 percent of first-half 2025 filings, and the top ten initiating parties accounted for approximately 69 percent of filings in the first half of 2025 and approximately 66 percent in the second half.[30]

This concentration is what distinguishes the volume problem from ordinary payment friction. A process built for the residual case in which two parties genuinely cannot agree is instead being used at industrial scale by a small number of firms for which arbitration is a routine revenue operation.

Employer and consumer organizations have responded collectively. In February 2026, more than sixty employer, labor, and consumer groups asked the Departments to clarify arbitrator guidance, improve transparency, and establish accountability for certified IDR entities.[31] In May 2026, a coalition of forty-eight organizations, including The ERISA Industry Committee (ERIC), urged federal investigation of entities alleged to be exploiting the IDR system.[32]

b. Arbitration Outcomes

The rising provider and facility win rate described elsewhere in this paper has moved steadily upward since the program's first full reporting period, tracking the growth in dispute volume and the litigation-driven erosion of the QPA's presumptive weight.

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[27] *Hoadley et al., "An Early Look at 2025 Data"; CMS, Supplemental Background, July 1 – December 31, 2025.*

[28] *Peterson-KFF Health System Tracker, "The Performance of the Federal Independent Dispute Resolution Process Through Mid-2024," https://www.healthsystemtracker.org/brief/the-performance-of-the-federal-independent-dispute-resolution-process-through-mid-2024/.*

[29] *Peterson-KFF Health System Tracker, "Performance of the Federal IDR Process"; CMS, Supplemental Background, January 1 – June 30, 2024.*

[30] *Hoadley et al., "An Early Look at 2025 Data"; CMS, Supplemental Background, July 1 – December 31, 2025.*

[31] *The ERISA Industry Committee et al., letter to the Departments of the Treasury, Labor, and Health and Human Services, February 24, 2026, https://www.eric.org/wp-content/uploads/2026/02/IDR-Sign-On-Letter-for-Distribution-Nonbranded-1.pdf.*

[32] *Plan Sponsor Council of America, "Industry Groups Urge Probe into No Surprises Act Arbitration System," May 2026, https://www.psca.org/news/psca-news/2026/5/industry-groups-urge-probe-into-no-surprises-act-arbitration-system/.*

Table 1 reports the provider and facility win rate as published in each of the semiannual Federal IDR Supplemental Background reports issued by the Centers for Medicare and Medicaid Services (CMS).[33]

Table 1. Provider and Facility Win Rate in the Federal IDR Process, by Reporting Period

Reporting Period	Provider/Facility Win Rate
H1 2023 (Jan.–Jun.)	77%
H2 2023 (Jul.–Dec.)	82%
H1 2024 (Jan.–Jun.)	84%
H2 2024 (Jul.–Dec.)	85%
H1 2025 (Jan.–Jun.)	88%
H2 2025 (Jul.–Dec.)	85%

Source: CMS Federal IDR Supplemental Background reports for each period.

The increase in the provider win rate is concentrated in default decisions rather than fully contested ones. Providers were awarded 75 percent of default decisions in the first half of 2024, compared with 59 percent in the second half of 2023, while the win rate on fully contested disputes, those in which both parties participated, held comparatively steady at approximately 86 percent over the same period.[34] The increase in the overall win rate therefore reflects, in part, a change in how often determinations are contested rather than a uniform shift in outcomes on the merits.

Interviews with self-funded plans conducted for this report illustrate how unpredictable the process has become for sponsors who are managing it directly, or in partnership with their TPAs. One sponsor instructed its representatives to submit initial offers at the QPA plus a fixed ten percent negotiating margin, reasoning that it could calibrate that margin over time. However, two years in, the sponsor found the offer amount was immaterial, as the arbitration outcomes had almost no relationship to the price it offered, describing the decisions as "functionally random." Another sponsor that tracks win-loss percentages by IDR entity found wide dispersion across

[33] *Centers for Medicare and Medicaid Services, Supplemental Background on the Federal IDR PUF, January 1 – June 30, 2023 (February 15, 2024), https://www.cms.gov/files/document/federal-idr-supplemental-background-2023-q1-2023-q2.pdf; CMS, Supplemental Background, January 1 – June 30, 2024 (also reporting the comparison win rate for July–December 2023); Centers for Medicare and Medicaid Services, Supplemental Background on the Federal IDR PUF, July 1 – December 31, 2024 (May 28, 2025), https://www.cms.gov/files/document/federal-idr-supplemental-background-2024-q3-2024-q4.pdf; Centers for Medicare and Medicaid Services, Supplemental Background on the Federal IDR PUF, January 1 – June 30, 2025 (January 21, 2026), https://www.cms.gov/files/document/federal-idr-supplemental-background-2025-q1-2025-q2.pdf; CMS, Supplemental Background, July 1 – December 31, 2025.*

[34] *CMS, Supplemental Background, January 1 – June 30, 2024.*

the companies, with some ruling in favor of providers at percentages in the high nineties. Many of these plan sponsors have been approached by third-party firms offering to represent them in arbitration in exchange for a share of savings. However, at least one concluded that the arrangement would not be worthwhile even at an improved win rate, because the fees would consume most or all of the savings such representation might generate.

> *"Two years in, the sponsor found the offer amount was immaterial, as the arbitration outcomes had almost no relationship to the price it offered, describing the decisions as functionally random."*
>
> SELF-FUNDED PLAN SPONSOR INTERVIEWED FOR THIS REPORT

c. The Premium Projection Miss

Georgetown researchers originally estimated that the IDR process generated at least $5 billion in total costs from 2022 through 2024. Roughly $2.24 billion of that was in the form of additional payments from plans to providers above what would otherwise have been paid. Approximately $884 million was administrative and IDR entity fees, and approximately $1.9 billion was the parties' internal costs of participating.[35] That estimate has since proven conservative. The same researchers' updated analysis, incorporating a full additional year of data, puts total IDR system costs at $22.4 billion from 2022 through 2025, including $15.6 billion in payment amounts above the QPA.[36] Costs are compounding rather than leveling off as the program matures: in 2025 alone, total IDR costs reached $16.6 billion, nearly three and a half times the 2024 total, as dispute volume rose 77 percent and total award amounts rose 267 percent year-over-year. This rapid expansion of claims is only expected to continue. The administrative fee cut from $115 to $15 per party per dispute removes most of what remained as the price of entry.[37] The entity fee, however, was left untouched, which compounds the problem. Entity fees account for roughly three-quarters of fee costs, and every dispute carries one, so lowering the barrier to filing without lowering the cost of adjudicating means each new filing arrives with several hundred dollars of arbitration expense attached.[38] Put simply, volume is a major cost driver, and the rule has made volume cheaper to generate.

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[35] *Hoadley and Watts, "Substantial Costs."*

[36] *Hoadley and Watts, "Spending on IDR Process."*

[37] *Centers for Medicare and Medicaid Services, "Federal Independent Dispute Resolution Operations Final Rule," fact sheet, May 28, 2026, https://www.cms.gov/newsroom/fact-sheets/federal-independent-dispute-resolution-operations-final-rule.*

[38] *Hoadley and Watts, "Substantial Costs."*

While these large figures might easily be dismissed as abstract 'system costs,' they directly impact plan budgets and patient affordability. However, employers are directly paying much of the $15.6 billion in award payouts, which has created a direct and rapidly compounding liability on plan budgets, one that sponsors did not build into their models and that may ultimately reach workers through higher premiums, higher cost sharing, and slower wage growth. How this reaches premiums is the question CBO is now revisiting. The agency originally projected that the law would reduce commercial premiums by roughly 1 percent and federal deficits by $17 billion through 2030.[39] In a June 15, 2026, call for new research, it flagged a mechanism running the other way. If providers can systematically secure large awards through arbitration, they gain leverage to remain out-of-network or to demand higher in-network rates, which would raise prices and premiums and, through subsidy and tax-preference channels, federal deficits.[40] The Peterson-KFF Health System Tracker and HHS's Office of the Assistant Secretary for Planning and Evaluation (ASPE) reach a compatible conclusion that the law is likely not reducing prices and spending.[41] For self-funded employers, however, this is not just speculation; it is a reality they are living today.

Source: Hoadley and Watts, Health Affairs Forefront, Aug. 26, 2026; CMS Federal IDR Supplemental Background reports.

IV. Employer Costs and Relevance

a. The Zero-Sum Reality

Debate over NSA implementation has largely centered on the relationship between providers and insurers. Self-funded employers, which ultimately finance their plans, are largely absent from that framing, and this omission is critical because self-funded plan mechanics operate under entirely different risk models. The carrier serves as an administrator rather than a risk bearer, so every arbitration award is paid from plan assets with no insurer standing between the employer and an unfavorable outcome.

[39] *CBO, Estimate for Divisions O Through FF.*

[40] *Hayford, Pelech, and Hale, "A Call for New Research."*

[41] *Peterson-KFF Health System Tracker, "Performance of the Federal IDR Process"; ASPE, Third Annual Report.*

The employer is also not the one arguing the case, since the offer that determines the award is typically submitted by a third-party administrator on the plan's behalf. The party carrying the financial consequence is rarely the party at the table, and this is not a marginal population. Self-funded plans cover 67 percent of workers with employer-sponsored coverage,[42] and Elevance Health has estimated that self-funded employers absorb nearly 90 percent of IDR-related costs, including some facing more than $10 million in unanticipated exposure within a single year.[43] Against that background, the patient savings under the NSA look less like a reduction in cost than a change in who bears it.

~90%	$10M+
OF IDR-RELATED COSTS ABSORBED BY SELF-FUNDED EMPLOYERS	IN UNANTICIPATED EXPOSURE FOR SOME SPONSORS IN A SINGLE YEAR

Source: Elevance Health, "Curbing Misuse of the No Surprises Act," December 2025.

The absence of a premium effect is consistent with that. If IDR were returning awards near the QPA, plan costs would be roughly unchanged, and the patient savings would represent a genuine reduction in system spending. Awards are instead running well above the QPA, plan costs are rising, and the offset appears on the plan sponsor's ledger. ERIC's president and CEO made the point directly, arguing that inflated arbitration awards translate into higher premiums, deductibles, and cost sharing for workers and their families in later plan years.[44]

b. Quantifying the Burden

National figures describe an aggregate pattern; individual plan sponsors experience it as a specific, and rapidly escalating, line item in their budgets. Interviews with large self-funded employer benefits teams, conducted in the summer of 2026, paint a more complete picture of how IDR awards are becoming both an operational and financial burden. Consistent with the terms under which they were conducted, the interviews are presented here without company names or other identifying detail, and the details below should be read as illustrative case data rather than as a representative sample.

Reported cost impact clustered in a comparable range once normalized, despite very different levels of visibility and very different plan structures across sponsors.

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[42] *KFF, 2025 Employer Health Benefits Survey.*

[43] *Elevance Health, "Curbing Misuse of the No Surprises Act," December 2025, https://www.elevancehealth.com/our-approach-to-health/consumer-centered-health-system/curbing-misuse-of-the-no-surprises-act.*

[44] *James Gelfand and Patricia Kelmar, "Congress Must Fix the No Surprises Act Before It Bankrupts Patients and Employers," STAT, March 20, 2026, https://www.statnews.com/2026/03/20/no-surprises-act-independent-dispute-resolution-process/.*

One sponsor tracked its own IDR-related payments rising from approximately $3.5 million in 2025 to more than $6 million in the first half of 2026 alone, on pace to exceed $12 million for the year. At roughly 2,000 disputes annually and an 80 percent provider win rate, that amounts to almost $4,000 in excess costs per IDR claim, contributing an estimated 1 percent increase to overall trend, a driver on par with other significant recent cost pressures, such as increased drug spend related to GLP-1s. Other interviewed sponsors report comparable effects. One estimated a 1 to 3 percent impact on annual trend specifically attributable to IDR awards. Another, which tracks every determination in-house, reported that awarded amounts through the first half of 2026 already ran more than four and a half times the original billed value of the underlying claims, with volume still accelerating. On that trajectory, the sponsor estimates that full-year IDR payouts alone will equal 5 to 6 percent of total health care spend. While these aggregate percentages may seem small, they represent tens of millions of dollars in spend and, critically, they all run in the opposite direction of CBO's original projection of a 1 percent premium reduction.

CASE STUDY — INTERVIEWED EMPLOYER A

$12M PROJECTED 2026 IDR COST	This large self-funded employer's IDR costs climbed from $3.5 million in 2025 to a projected $12 million in 2026, driven almost entirely by a single emergency room operator. Settlement timelines have stretched from about one month to roughly three, and the sponsor has turned down repeated pitches from contingency-fee vendors offering to handle its disputes, concluding the fees would likely exceed any recovery.

CASE STUDY — INTERVIEWED EMPLOYER B

1–3% OF ANNUAL HEALTH TREND	A second interviewed self-funded sponsor attributes 1 to 3 percent of its annual health care trend specifically to IDR awards.

CASE STUDY — INTERVIEWED EMPLOYER C

5–6% OF TOTAL 2026 HEALTH SPEND	A third interviewed sponsor, which tracks every IDR determination in-house, reports that awarded amounts through the first half of 2026 already ran more than four and a half times the original billed value of the underlying claims. On that trajectory, the sponsor projects that IDR payouts alone will consume 5 to 6 percent of its total health care spend for the year.

Source: Confidential interviews conducted for this report; figures are not attributable to a specific company.

The interviews also surfaced a shared structural complaint: many plan sponsors cannot reliably determine what IDR is costing them, which providers are driving the exposure, or whether the parties negotiating on their behalf are optimally engaging in the process. High default rates, in which one party does not submit the necessary evidence to contest a dispute and the dispute is decided automatically in favor of the party that did comply, compound the problem. Twenty-two percent of IDR determinations in the first half of 2025 were resolved this way, a share that has held roughly steady for several years rather than improving as the process has matured.[45] Public data do not break defaults out by which party fails to respond, but one interviewed sponsor suspected its own carrier defaults more often than the initiating provider, reasoning that a provider group that files a dispute arrives prepared to litigate it, while the responding carrier, often managing a far higher volume of disputes across its entire book of clients, may not always have documentation ready in time to mount a challenge. This dynamic is not merely speculative. Another sponsor that took IDR management in-house, rather than continuing to rely on its TPA, reported that its own win rate meaningfully improved once it began to represent itself in these disputes. That a change in process alone, with no change in the underlying statutory factors, could move outcomes is itself an important indicator that procedural attrition, not the merits of the case, is helping drive lopsided win rates in favor of providers.

Taken together, these interviews suggest that IDR has moved from a marginal dispute-resolution mechanism to a cost driver of the same order of magnitude as other line items plan sponsors already track and budget for, yet one that sponsors can neither isolate with precision nor manage directly. A cost large enough to move plan trend but too opaque to audit is a significant cost concern, one that directly affects long-term sustainability and affordability.

c. Effect on Premiums and Coverage Affordability

Employer-sponsored insurance covers roughly 154 million nonelderly Americans, and average family premiums reached $26,993 in 2025, a 6 percent increase over the prior year.[46] Rising IDR costs eventually reach these workers because an employer facing an unbudgeted increase in out-of-network claims has three realistic responses. It can absorb the cost, holding contributions flat while constraining the budget available for wages and other benefits. It can shift the cost through higher payroll contributions, higher deductibles, or both. Or it can narrow the network.

[45] *Hoadley et al., "An Early Look at 2025 Data."*

[46] *KFF, 2025 Employer Health Benefits Survey.*

The third response is the one most directly in tension with the NSA's access objectives, and pressure from the provider side reinforces it. If arbitration reliably pays more than contracted rates, high-volume specialty groups have less reason to join networks in the first place. Employer cost pressure and provider incentives push in the same direction, and the population exposed to out-of-network care in covered settings grows. Patients remain protected from balance bills, but more claims flow through arbitration, feeding the cost back into plan experience the following year. These are not hypothetical concerns; public disclosures already tie IDR awards directly to premium increases. The interviews summarized above are necessarily general, consistent with the confidentiality under which they were conducted. Public reporting, however, corroborates the same dynamic in specific, verifiable terms, illustrating how the mechanics described anonymously above play out in practice across the employer landscape.

The City of San Antonio, Texas's self-funded health plan, which covers more than 28,000 employees and their dependents, was $20 million over its $250 million health care budget when plan leaders disclosed the overrun to employees in a May 2026 memo. By August of the same year, the gap had doubled to $40 million. Leaders attributed most of the increase to a single provider, Prestige Emergency Room, a freestanding out-of-network provider whose four locations, out of fifty freestanding and hospital-based emergency rooms citywide, accounted for more than 53 percent of the plan's emergency claims costs in 2025. The average cost per claim from Prestige more than doubled from 2025 to 2026, from $886 to $1,846, a period in which federal arbitrators sided with Prestige in 99.6 percent of the disputes it filed against the city's plan. In response to this extraordinary financial liability, the plan is expected to pay off the $40 million overrun through higher insurance premiums. Public reporting on this matter mentions that health providers were abusing IDR as a business strategy, evidenced by their waiving all patient cost sharing and out-of-pocket costs, instead relying entirely on the IDR process for payment.[47]

$40M

CITY OF SAN ANTONIO HEALTH-PLAN BUDGET OVERRUN, AUG. 2026

99.6%

WIN RATE FOR THE SINGLE PROVIDER DRIVING IT

In New York, the State Division of the Budget reported that the Department of Civil Service identified more than $200 million in additional Empire Plan claim payments

Source: "San Antonio Is $40 Million Over Its Employee Healthcare Budget," San Antonio Express-News, August 12, 2026

[47] *Rodriguez, "San Antonio Is $40 Million Over Its Employee Healthcare Budget.*

attributable to IDR award payments, which it identified as the primary contributor to a nearly 10 percent increase in the plan's 2026 premium rates.[48] The costs were so deleterious to the state's budget, that the New York legislature passed a law, as part of their annual budget process, to overhaul surprise billing rules in the state and prevent it from being further abused specifically against the state employee plan or the state's Medicaid program.[49] Similarly, the United Service Workers health plan reported raising premiums by an additional 1.75 percentage points specifically to offset arbitration awards and fees.[50]

Source: New York State Division of the Budget, Jan. 2026; Kliff and Sanger-Katz, New York Times, Apr. 2026.

Union-negotiated health funds report comparable exposure through their own public advocacy. 32BJ Health Fund, a Taft-Hartley trust covering building-service workers, disclosed in July 2026 that it had been ordered to pay IDR determinations of approximately $37 million on claims originally expected to cost only $8 million. Further, they had paid out over $700,000 in entity fees over the same period. [51] 1199SEIU Funds, representing health care workers, reported being involved in 4,919 IDR disputes since the process became operational in 2022, with awards to providers totaling $52 million above regular out-of-network rates. The fund also flagged a pattern in which some providers represent themselves as in-network specifically to route claims into IDR rather than furnish the advance notice the NSA otherwise requires of out-of-network providers to share with patients.[52]

Source: AFL-CIO Legislative Alert, Aug. 2026.

[48] *New York State Division of the Budget, "FY 2027 New York State Executive Budget," 26.*

[49] *Allison Bell, "New York posts health plan billing dispute resolution regulations," BenefitsPRO, August 13, 2026, https://www.benefitspro.com/2026/08/13/new-york-posts-health-plan-billing-dispute-resolution-regulations/.*

[50] *Kliff and Sanger-Katz, "A $440,000 Breast Reduction."*

[51] *AFL-CIO, Legislative Alert: Letter from Jody Calemine, Director, Government Affairs, to the Honorable Jason Smith, Chairman, and the Honorable Richard Neal, Ranking Member, U.S. House Committee on Ways and Means, Re: Opposition to the No Surprises Act Enforcement Act (H.R. 4710), August 26, 2026.*

[52] *AFL-CIO, Legislative Alert, August 26, 2026.*

Table 2. Reported Dollar Figures Tied to IDR Awards by Self-Funded Employers, State Plans, and Unions

Featured Example	Reported IDR-Related Dollar Figure	Basis / Period	Source
City of San Antonio	$40 million cumulative budget overrun (as of Aug. 2026)	Largely attributed to one out-of-network ER group	San Antonio Express-News, Aug. 2026
NY Empire Plan	More than $200 million in added claim payments	Cited as primary driver of a 10% 2026 premium increase	NY State Div. of the Budget, Jan. 2026
32BJ Health Fund	$37 million in IDR determinations vs. $8 million originally paid; $700,000+ in duplicate admin/entity fees	As of July 2026	AFL-CIO Legislative Alert, Aug. 2026
1199SEIU Funds	$52 million in awards above out-of-network rates ($27 million non-emergency/non-ancillary)	Across 4,919 disputes since 2022	AFL-CIO Legislative Alert, Aug. 2026
Interviewed Employer A	$3.5M (2025) → >$6M (H1 2026); on pace to exceed $12M for the year (~$4,000 excess cost/claim)	>2,000 disputes/yr, 80% provider win rate	Confidential interview for this report
Interviewed Employer B	1–3% of annual health care trend attributed to IDR	Attributed specifically to IDR awards	Confidential interview for this report
Interviewed Employer C	Awards 4.5× original billed claim value; full-year payouts projected at 5–6% of total health spend	H1 2026 run rate	Confidential interview for this report

Note: figures for interviewed employers are drawn from confidential interviews conducted for this report and are not attributable to a specific company; all other figures are drawn from the public sources cited in the body text and notes above.

d. The Absence of an Appeals Mechanism

An employer absorbing these costs might be expected to have some recourse against the determinations producing them, but under the NSA, it has none. IDR awards cannot be challenged on the merits. The NSA makes determinations binding and limits judicial review to the narrow grounds in section 10(a) of the Federal Arbitration Act (FAA), reaching fraud, corruption, and procedural defects, none of which include the size of an award.[53]

Most of the litigation to date has tested the opposite question, asking whether providers may sue to collect awards that went unpaid, and federal courts are split on whether the FAA supplies a mechanism to confirm them. The Fifth Circuit held on June 12, 2025, in *Guardian Flight* that the NSA confers no private right of action to confirm an IDR award in court, and the Supreme Court declined review on January 12, 2026, leaving that holding in place.[54] The Eleventh Circuit reached a comparable result in November 2025,[55] and district courts in New York, Florida, Arizona, the Northern District of Texas, and Pennsylvania have ruled the same way.[56] Two have gone the other direction, the District of Connecticut in May 2025 finding an implied private right of action and the District of Maryland in March 2026 finding a narrow one. In New Jersey, where providers have filed hundreds of enforcement suits, at least three decisions have found no private right of action, and the chief judge has stayed the remaining cases.[57]

None of that helps a plan sponsor. Those rulings constrain a provider's ability to collect an unpaid award; they do not create a route for a plan or its sponsor to challenge an award it believes is factually inconsistent with the statutory criteria. The award remains binding. Ultimately, the combination of large awards, escalating volume, and no employer-side appeal produces a one-sided cost structure with no safety valve for plan sponsors.

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[53] *42 U.S.C. § 300gg-111(c)(5)(E); 9 U.S.C. § 10(a).*

[54] *Guardian Flight, L.L.C. v. Health Care Service Corp., No. 24-10561 (5th Cir. June 12, 2025), reh'g denied (July 10, 2025), cert. denied, No. 25-441 (U.S. Jan. 12, 2026), https://www.supremecourt.gov/docket/docketfiles/html/public/25-441.html.*

[55] *REACH Air Medical Services, L.L.C. v. Kaiser Foundation Health Plan, Inc., No. 24-10135 (11th Cir. Nov. 19, 2025); Husch Blackwell LLP, "No Surprises, New Challenges: Supreme Court Limits Provider Enforcement Under NSA," January 2026, https://www.huschblackwell.com/newsandinsights/no-surprises-new-challenges-supreme-court-limits-provider-enforcement-under-nsa.*

[56] *Proskauer Rose LLP, "Government Issues Final Rule in NSA, Streamlining IDR Process and Lowering Dispute Costs," June 2026, https://www.healthcarelawbrief.com/2026/06/no-surprises-here-government-issues-final-rule-in-nsa-streamlining-idr-process-and-lowering-dispute-costs/; Crowell & Moring LLP, "Not So Surprising: The Fifth Circuit Finds No Private Right of Action in the No Surprises Act," July 18, 2025, https://www.cmhealthlaw.com/2025/07/not-so-surprising-the-fifth-circuit-finds-no-private-right-of-action-in-the-no-surprises-act/.*

[57] *O'Neill Institute for National and Global Health Law, "First Two Court Decisions in Insurer Lawsuits Under the No Surprises Act," April 2026, https://oneill.law.georgetown.edu/california-court-issues-first-decision-in-insurer-lawsuits-under-the-no-surprises-act/.*

V. Policy Recommendations

a. Restore the QPA's Intended Role

Congress should clarify the statutory text to restore the QPA as the primary factor in IDR determinations, with a presumption in favor of QPA-anchored outcomes rebuttable only by clear and convincing evidence. Final-offer arbitration without a price anchor rewards the more aggressive offer, because the arbitrator has no ordered criterion against which to test it. With an anchor, IDR performs the function Congress designed, serving as a backstop for genuine valuation disputes rather than a routine rate-setting channel.

Any such amendment should also address the provider critique of QPA construction. If the QPA is to serve as the benchmark, its calculation must be verifiable and must reflect genuine contracted rates. Requiring disclosure of QPA methodology inputs at a level sufficient for independent audit would strengthen the benchmark and reduce one of the stated drivers of dispute initiation.

b. Establish a Limited Appeals Mechanism

Congress should create a limited administrative appeal process, available to either party that would be confined to three narrow grounds: procedural error in the conduct of the arbitration, jurisdictional defect (for example, a dispute that did not meet the cooling-off or batching requirements central to IDR eligibility), and an award that is factually inconsistent with the statutory criteria the certified entity was required to apply. The appeal would be reviewed by an assigned administrative body within the Departments of Health and Human Services, Labor, and the Treasury, consistent with their joint authority over the IDR process, rather than a federal court, and would be time-limited (for example, thirty days from the date of the award) to avoid reopening settled cases long after payment had been made or received.

The design objective is a safety valve for outlier determinations, not de novo review of every award, and the eligibility threshold should be set high enough that the appeal channel does not reproduce the volume problem it is meant to address.

c. Address Volume Abuse

That requirement will only work if the entities applying it are held to it. The Departments should act on the May 2026 coalition's request for federal investigation of entities alleged to be filing ineligible disputes at scale.[58] Tiered fees or filing thresholds for high-volume initiating parties are also worth evaluating. The current structure charges the same amount to a hospital filing twice a year and to an entity filing hundreds of thousands of times. A per-party fee schedule that rises with annual filing volume would preserve access for the occasional filer while pricing high-volume arbitration closer to the administrative burden it imposes.

The reduction in the administrative fee from $115 to $15 lowers the cost of a marginal filing by approximately 87 percent and should be paired with a volume review trigger.[59] CMS should commit in advance to a corrective action plan if filings exceed a defined threshold in the twelve months following the change, using the 1.2 million disputes filed in the first half of 2025 as the pre-change baseline.[60] Committing to the threshold before the data arrive avoids relitigating what counts as an unacceptable increase after the fact.

d. Enact Transparency Reform

CMS should also publish IDR outcome data disaggregated by plan funding type. Self-funded sponsors cannot currently determine their aggregate exposure from public data, which leaves them responsible for a cost they have no way to size. This is a reporting gap rather than a collection problem, since the funding type is already known to the plans and their administrators, and adding the field to the existing public use files would let fiduciaries and researchers measure incidence directly rather than by attribution, as this paper has been required to do.

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[58] *ERISA Industry Committee et al., February 24, 2026 letter; Plan Sponsor Council of America, "Industry Groups Urge Probe."*

[59] *CMS, "Federal Independent Dispute Resolution Operations Final Rule" fact sheet; Healthcare Financial Management Association, "IDR Dispute Mediation Likely to Be More Disruptive as a Result of New Rule," June 22, 2026, https://www.hfma.org/revenue-cycle/idr-dispute-mediation-likely-to-be-more-disruptive-as-a-result-of-new-rule/.*

[60] *Hoadley et al., "An Early Look at 2025 Data."*

VI. Conclusion

The NSA protects patients from surprise bills, and that outcome is worth preserving. The arbitration process attached to it is another matter. Litigation removed the QPA as the anchor, arbitration became reliably profitable for the parties that use it most, an entire private equity-driven industry arose to engage in mass IDR filings, and volume has since exceeded the CBO projection by multiple orders of magnitude. This is not what Congress intended. Awards run at multiples of the benchmark the system was designed around, and self-funded employers fund them directly, generally without participating in the proceeding and with no mechanism to contest the result. This is not sustainable.

"Litigation removed the QPA as the anchor, arbitration became reliably profitable for the parties that use it most, an entire private equity-driven industry arose to engage in mass IDR filings, and volume has since exceeded the CBO projection by multiple orders of magnitude. ***This is not what Congress intended****."*

Costs absorbed through IDR awards eventually reach workers through higher contributions, higher cost sharing, or narrower networks, which makes this a coverage affordability problem rather than a provider-payer dispute. The remedy does not require reopening the patient protections. It requires making the process sustainable for the employers who pay for coverage, so the law can continue to deliver on its core affordability promise for patients.

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About ERIC

ERIC is a national advocacy organization that exclusively represents large employers that provide health, retirement, paid leave, and other benefits to their nationwide workforces.

You are likely to engage with an ERIC member company when you drive a car or fill it with gas, use a cell phone or computer, watch TV, dine out or at home, enjoy a beverage, fly on an airplane, visit a bank or hotel, benefit from our national defense, receive or send a package, go shopping, or use cosmetics.

With member companies that are leaders in every sector of the economy, ERIC advocates on the federal, state, and local levels for policies that promote flexibility and uniformity in the administration of their employee benefit plans.

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This report was prepared on behalf of ERIC by Charm Economics

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