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Reforming the No Surprises Act's IDR Process:

Policy Options to Improve Incentives and Outcomes

Key Takeaways

The No Surprises Act (NSA) has protected patients from surprise bills, but its Independent Dispute Resolution (IDR) process has produced negative unintended consequences:

- **Dispute volume is far higher than expected and increasing dramatically.** IDR disputes in 2025 were **115 times** the government's initial projections.
- **Providers win the vast majority of cases, and their win rate is increasing.** In 2025, providers prevailed over insurers in approximately **85 percent** of disputed line items.
- **Arbitration awards are much higher than expected and growing.** The median award in 2025 was nearly **4 times** the qualifying payment amount (QPA) and **5.5 times** the Medicare rate for the same service. Awards at the 90th percentile reached nearly **18 times** the QPA in 2025.

These outcomes create incentives to use arbitration rather than negotiate network contracts — with Americans absorbing the costs through higher premiums and lower wages.

Recommendations

Congress should pursue a two-track framework that distinguishes between situations where patients have meaningful choices and situations where they do not:

Elective Services: Eliminate the federal IDR process. Instead, require up-front pricing with meaningful advance notice and affirmative patient consent.

- Expected charges must be disclosed through an Advanced Explanation of Benefits (AEOB) — a requirement not yet implemented.

Emergency Services: Either eliminate the IDR process, or retain it only for emergency services and implement the following fixes:

- Change the definition of the QPA to the most up-to-date median in-network rates, not merely adjusting the 2019 median in-network rates for inflation.
- Place a reasonable limit on awards through a system that approximates pre-NSA out-of-network payments, which could take the form of an upper limit on payments set at a given percentile of a plan's in-network rates for a specific service.
- Stronger enforcement of prompt pay requirements. Create monetary penalties for insurers who fail to pay out awards within the required 30 days of a settled dispute.
- Require transparency of arbitrators' decisions, audit arbitration firms for outlier outcomes and accuracy of eligibility determinations, implement consequences for negligence, improve arbitrator training, strengthen conflict of interest rules, assign disputes through a randomized allocation process, and restore the $115 administrative filing fee.

This framework would improve incentives and lead to more appropriate payments while preserving important patient protections.

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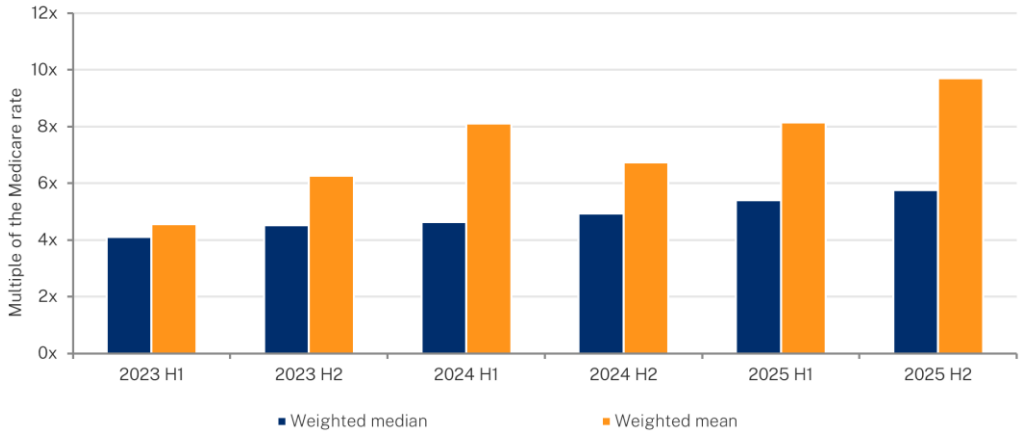
IDR Awards Are Far Above Medicare Rates and Grew Significantly from 2023 to 2025

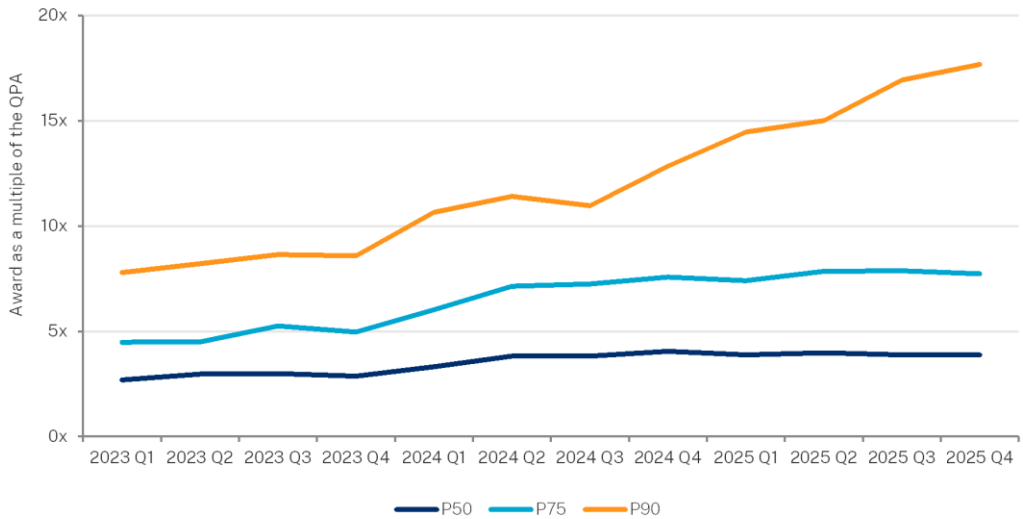
Median awards rose from about 4 to 6 times Medicare rates, and mean awards from over 4 to nearly 10 times



Note: Line-item level; emergency and non-emergency disputes (air ambulance excluded). Line items are counted by determination date, not initiation date. Each line-item award is divided by the Medicare rate for the same service and area (methodology adapted from Matthew Fiedler and Loren Adler, "A First Look at Outcomes Under the No Surprises Act Arbitration Process," Brookings Institution, March 2024). The median and mean are weighted by each line item's Medicare rate so that services with low Medicare rates, for which even small IDR awards create large multiples, do not skew the results to make overall multiples appear larger. The Medicare rate is the physician fee schedule amount for the professional service, so hospital facility bills do not belong in the comparison. Because the IDR public use files do not identify facility bills, which are typically the largest payments, the largest payments in each quarter are excluded in a share equal to the estimated facility share (about 1 to 3 percent in 2023, rising to about 10–13 percent in 2025). Bundled payment arrangements, whose single award covers several services, are excluded where the IDR public use files identify them (from the third quarter of 2023); in the first two quarters of 2023 they remain, and the facility share for those quarters is estimated on the same basis. Items without a valid location (about 19 percent of included line items) use the code's average Medicare rate. Services without a physician fee schedule rate, including anesthesia, which Medicare prices by a separate method, are excluded, as are services whose Medicare rate depends on whether they were performed on one or both sides of the body, which the IDR public use files do not report.
Source: Paragon Health Institute analysis of CMS Federal IDR Public Use Files and Medicare physician fee schedule files, 2023 Q1 – 2025 Q4.

The Top 10 Percent of IDR Awards Have Significantly Escalated Over Time

Median IDR awards have increased across the distribution, with 90th percentile awards reaching 17.7x the QPA



Note: Line-item level; emergency and non-emergency disputes (air ambulance excluded). Line items are counted by determination date, not initiation date. Awards are the prevailing offer, expressed as a multiple of the QPA; selected percentiles (P50, P75, P90) by quarter; unreported offers excluded; zero-dollar offers and awards are retained; ratios above 100 times the QPA are excluded. The QPA is generally the insurer's median in-network rate for the relevant item or service in the relevant market as of January 31, 2019, adjusted for inflation.
Source: Paragon Health Institute analysis of CMS Federal IDR Public Use Files, 2023 Q1 – 2025 Q4.

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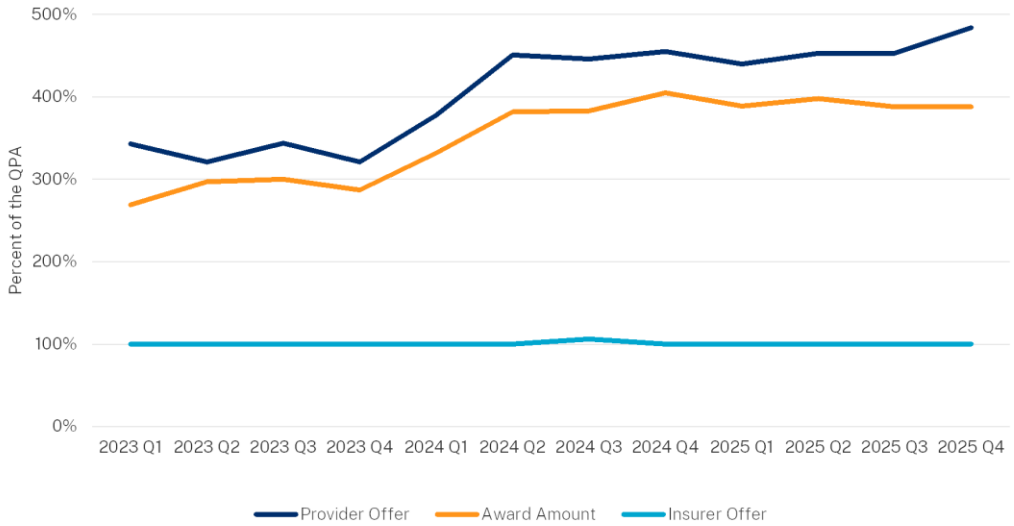
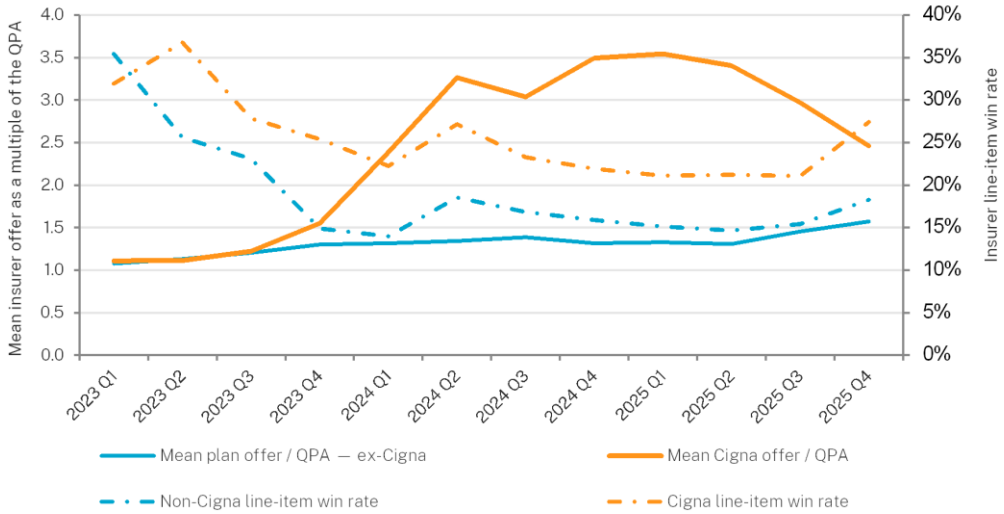
Median Provider Offers and Award Amounts Are Rising, While the Median Insurer Offer Has Stayed at the QPA



Note: Line-item level; emergency and non-emergency disputes (air ambulance excluded). Line items are counted by determination date, not initiation date. Median offer ratios by quarter, as a percent of the QPA; unreported offers excluded; zero-dollar offers and awards are retained; ratios above 100 times the QPA are excluded. The QPA is generally the insurer's median in-network rate for the relevant item or service in the relevant market as of January 31, 2019, adjusted for inflation.
Source: Paragon Health Institute analysis of CMS Federal IDR Public Use Files, 2023 Q1 – 2025 Q4.

Cigna Raised Offers Higher Than Other Insurers but Still Lost the Majority of Its Disputed Line Items



Note: Line-item level; emergency and non-emergency disputes (air ambulance excluded). Line items are counted by determination date, not initiation date. All four series are based on line items with a reported insurer offer of 0 to 100 times the QPA; line items with no reported offer, and offers above 100 times the QPA, are excluded. Offers (left axis, solid lines) are the mean insurer offer expressed as a multiple of the QPA. Win rates (right axis, dashed lines) are the share of those same line items decided in the insurer's favor, including disputes decided by default. Each bundled payment arrangement is counted as one line item; a bundle covers multiple services but receives a single payment determination (45 CFR 149.510(c)(4)(ii)). Its component line items (about 4 percent of line items, 2023–2025) are not counted separately. Cigna-family plans are grouped across all plan-name variants, including repricers filing on Cigna's behalf. The QPA is generally the insurer's median in-network rate for the relevant item or service in the relevant market as of January 31, 2019, adjusted for inflation.
Source: Paragon Health Institute analysis of CMS Federal IDR Public Use Files, 2023 Q1 – 2025 Q4.

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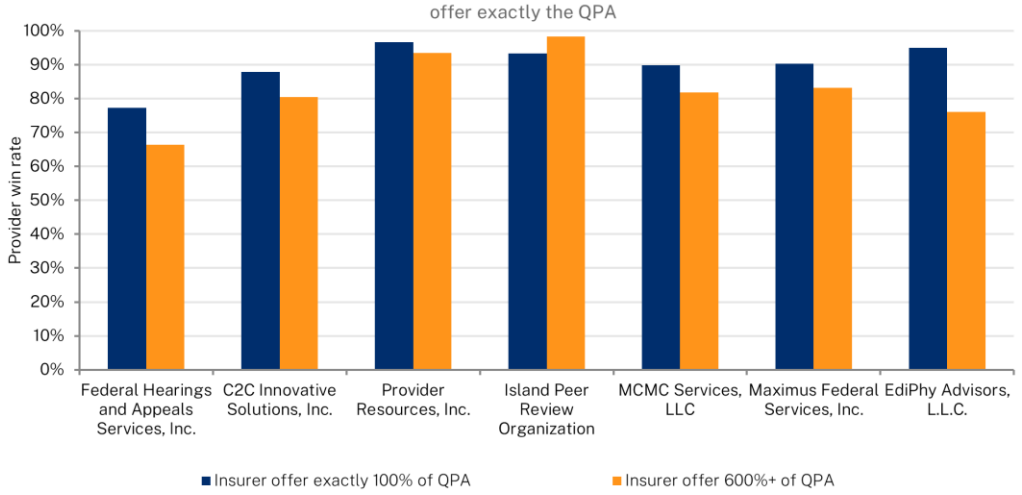
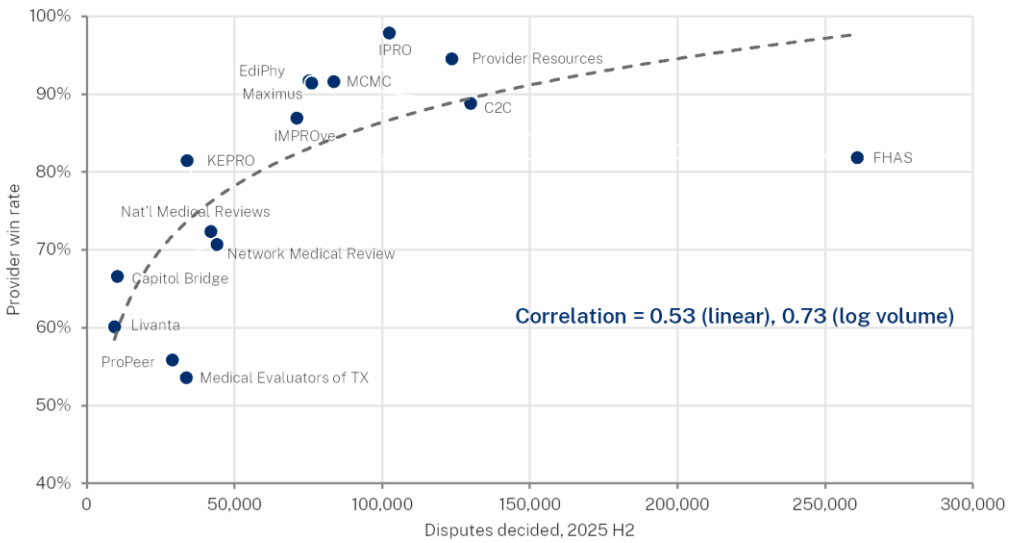
Arbitrators Side with Providers the Majority of the Time, Regardless of Insurer Offers

When insurer offers 600% or more of the QPA, provider win rates decrease only slightly compared to when insurers offer exactly the QPA



Note: Line-item level; emergency and non-emergency disputes (air ambulance excluded), including line items in disputes decided by default. Line items are counted by determination date, not initiation date. Each line item falls in exactly one band based on its own insurer offer; a win means the arbitrator selected the provider's offer for that line item. Each bundled payment arrangement is counted as one line item; a bundle covers multiple services but receives a single payment determination (45 CFR 149.510(c)(4)(ii)). Its component line items (about 4 percent of line items, 2023–2025) are not counted separately. The seven highest-volume of the 15 certified IDR entities (arbitration firms) are shown; together they decided about 76 percent of disputes, and 79 percent of line items. The QPA is generally the insurer's median in-network rate for the relevant item or service in the relevant market as of January 31, 2019, adjusted for inflation.
Source: Paragon Health Institute analysis of CMS Federal IDR Public Use Files, 2025 Q3–Q4.

Arbitration Firms with Higher Dispute Volume Have Higher Provider Win Rates



Note: Dispute level; emergency and non-emergency disputes (air ambulance excluded), including disputes decided by default. Disputes are counted by determination date, not initiation date. Volume is the number of disputes each of the 15 certified IDR entities (arbitration firms) decided in 2025 H2. Dashed line: least-squares fit of win rate on log volume.
Source: Paragon Health Institute analysis of CMS Federal IDR Public Use Files, 2025 Q3–Q4.

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Win Rates Are Uniformly High Across Provider Types, but Median Awards Vary Widely

Among the 21 highest-volume provider types, merit win rates cluster around 84 percent, while median awards range from 2.3 to 28 times the QPA

Provider type	Line Items	Provider Win Rate	Provider Merit Win Rate	Median Prevailing Award (xQPA)
Neurological Surgery	22,072	85.0%	85.0%	28.10
Physician Assistant	83,297	87.9%	86.8%	25.99
Specialist/Technologist, Other	26,411	82.6%	83.6%	23.25
Orthopaedic Surgery	32,904	86.3%	85.9%	22.56
Obstetrics & Gynecology	15,437	89.4%	89.9%	22.02
Plastic Surgery	28,346	88.5%	88.2%	19.01
Psychiatry & Neurology	200,380	86.3%	84.1%	16.67
Surgery	57,323	84.6%	85.9%	16.14
Electrodiagnostic Medicine	49,347	82.7%	82.9%	15.42
Nurse Anesthetist, Certified Registered	79,305	80.2%	81.9%	13.46
Specialist	18,687	79.9%	78.7%	13.04
Internal Medicine	56,750	82.8%	82.0%	7.29
Clinic/Center	1,132,100	81.4%	75.8%	5.95
Radiology	1,414,568	92.8%	92.7%	5.59
Special Hospital	73,413	72.5%	72.8%	4.73
General Acute Care Hospital	798,801	82.9%	80.0%	4.26
Anesthesiology	394,954	83.3%	82.6%	3.85
Emergency Medicine	2,261,724	85.0%	85.9%	3.50
Pediatrics	42,136	79.0%	82.4%	3.29
Hospitalist	57,887	88.3%	88.4%	3.18
Family Medicine	72,524	89.8%	89.9%	2.30

Note: Line-item level; emergency and non-emergency disputes (air ambulance excluded). Line items are counted by determination date, not initiation date. Provider types are the NUCC provider-taxonomy classifications, assigned by each NPI's primary taxonomy record in the NPPES registry (May 2026 file); the categories include some facility types (e.g., hospitals and clinics). Line items whose NPI was not reported, or whose NPI could not be matched in the NPPES registry, are excluded. Each bundled payment arrangement is counted as one line item; a bundle covers multiple services but receives a single payment determination (45 CFR 149.510(c)(4)(ii)). Its component line items (about 4 percent of line items, 2023–2025) are not counted separately. Win rate is the share of line items decided in the provider's favor; merit win rates exclude disputes decided by default. Awards are the prevailing offer, expressed as a multiple of the QPA; the median award is computed over provider-won line items, with ratios above 100 times the QPA excluded. High-volume = provider types with more than 10,000 disputed line items; all 21 provider types meeting that threshold are shown, ranked from highest to lowest median award. The QPA is generally the insurer's median in-network rate for the relevant item or service in the relevant market as of January 31, 2019, adjusted for inflation.

Source: Paragon Health Institute analysis of CMS Federal IDR Public Use Files, 2023 Q1 – 2025 Q4.