

What is the The No Surprises Act

The No Surprises Act (NSA), enacted in 2020, is a bipartisan health care law aimed at shielding patients with private insurance from high, unexpected medical bills from certain categories of care:

- out-of-network (OON) emergency care providers,
- OON providers providing non-emergency care at an in-network facility, and
- air ambulance service providers.*



Before the NSA, a patient with health insurance could receive care, be discharged, and later receive a bill in the mail for out of network services. Under the NSA, patients receive care as usual and pay their typical coinsurance or copayment, while the plan and provider are responsible for resolving the total cost of the care provided. The NSA establishes a process for plans and providers to negotiate a rate for services already furnished to the patient and establishes an arbitration process for situations where the plan and provider cannot agree without intervention.

** Ground ambulances are not covered by the No Surprises Act and patients are still subject to "surprise billing" for these services.*

Example Scenario: Maria has health insurance through her employer. One morning, she woke up with intense abdominal pain and went to the nearest emergency department that was listed as in-network in her health plan's app. At the emergency department, she was told she needed an emergency appendectomy for acute appendicitis. Maria consented to the surgery and underwent the procedure, which was completed without complications.



Before the No Surprises Act: While in recovery, a member of the hospital's finance team visited Maria to discuss her insurance coverage and how her bills would be handled. Maria provided her health insurance information, and the finance team member explained that the hospital would submit the claim to her insurer first and then bill her for her portion of the care. A week later, Maria received a letter from the hospital notifying her that the on-call surgeon who performed her appendectomy was OON and that she would be responsible for the full cost because her insurer would not cover it. Even though the rest of Maria's care at the in-network hospital was covered by insurance, Maria is left to navigate the denied portion of her claim.



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The No Surprises Act In Review:

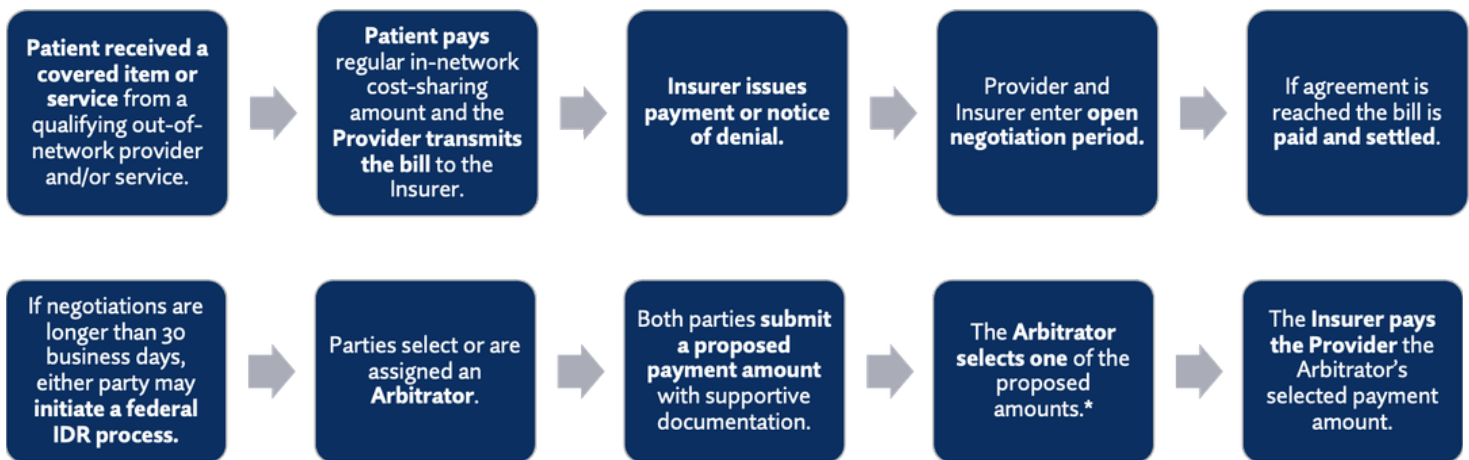
Tracking Trends and Public Sector Implications

The Federal Independent Dispute Resolution Process

The NSA established a process for plans and providers to settle the cost of certain medical services so that patients are not left with the bill. Federal legislators created a two-step process. First, it encourages plans and providers to negotiate independently, without involving the federal government. If they cannot agree, a fallback allows them to use a third-party entity certified by the federal government to arbitrate and settle the claim.

The federal independent dispute resolution (IDR) process is as follows:

Standard First benefit	Non-Members First set benefit
\$31.20	\$21.20
\$38.70	\$41.00
\$26.70	\$18.00
\$118.20	\$74.70
\$73.80	\$48.80
\$153.00	
\$25.20	
	\$101.10
	\$588.30
	\$677.00



**The IDR Entity must use baseball-style arbitration, in which they pick one offer over the other, with no option to identify a middle-ground amount. The plan must then pay the provider the IDR Entity's award amount. The IDR Entity's decision is final and binding, meaning the plan has no avenue to appeal a decision they disagree with.*



Under the No Surprises Act: While in recovery, Maria paid her typical copayment for an emergency department visit, appendectomy, and the related services she received during her stay. After her discharge, the hospital submitted her bill to her health insurance company for payment. The insurer noticed that the on-call surgeon who performed Maria's appendectomy was OON. As a result, the federal IDR process requires the plan and provider to negotiate the cost of these services without involving Maria or holding her responsible for the cost.

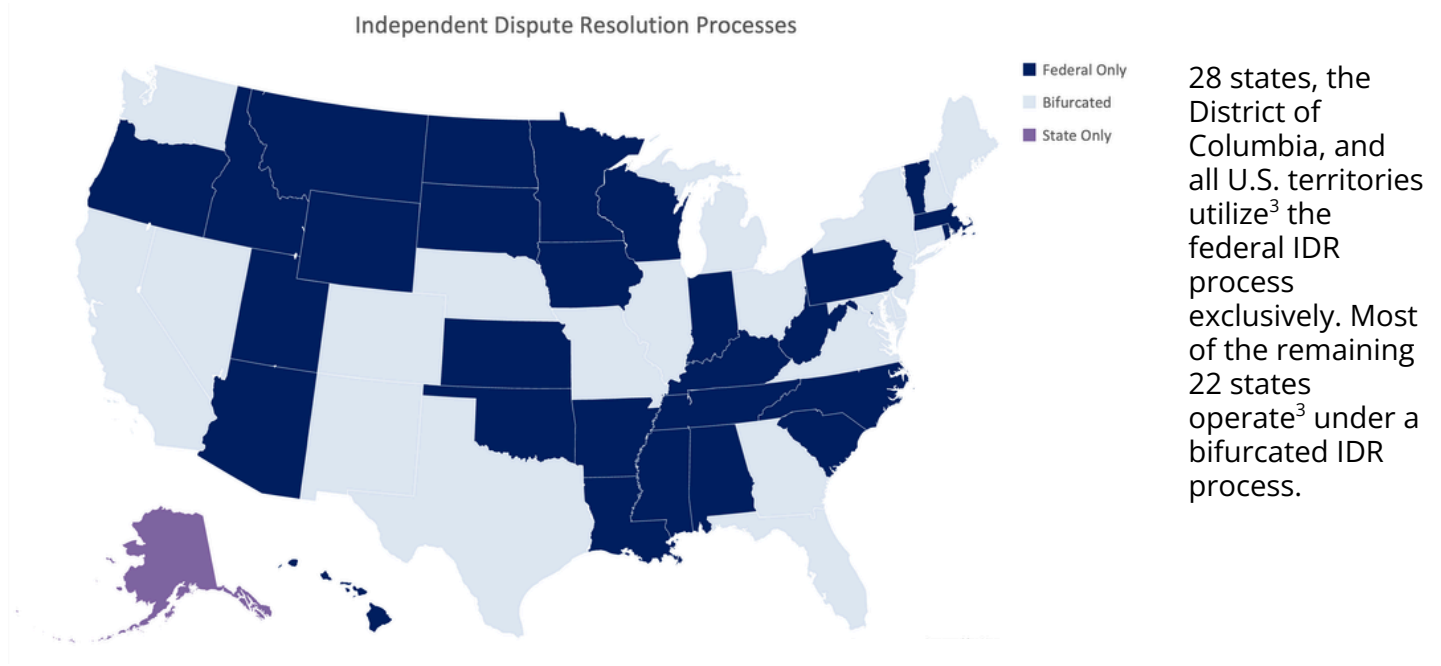
The Mosaic of Federal and State Surprise Billing Legislation and IDR Processes

While the federal IDR process applies across the country, many states have their own laws regulating surprise billing as well. This creates a mosaic of federal and state IDR processes¹ that plans and providers must use to resolve payment disputes. This **fragmented landscape complicates surprise billing dispute resolution**, requiring plans and providers to navigate both federal and state regulations. Different items and services furnished during the same episode of care may fall under different rules, so resolving all line items on a single patient's charge sheet can require both the federal and state IDR processes.

Generally, **plans that are self-funded are subject² to the federal IDR process** via the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). In these instances, dispute information is transmitted by plans and providers to the Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) and subsequently sent to EBSA.

Plans that are partially- or fully- insured may be subject to state or federal surprise billing legislation and dispute resolution processes, depending on state-specific legislation. Typically, **partially- and fully-insured plans are subject² to their state's surprise billing IDR process.**

Plans operating in states with an **All-Payer Model Agreement** (Maryland and Vermont) are not subject to the NSA or federal IDR arbitration process.



¹ <https://www.cms.gov/files/document/caa-federal-idr-applicability-chart.pdf>

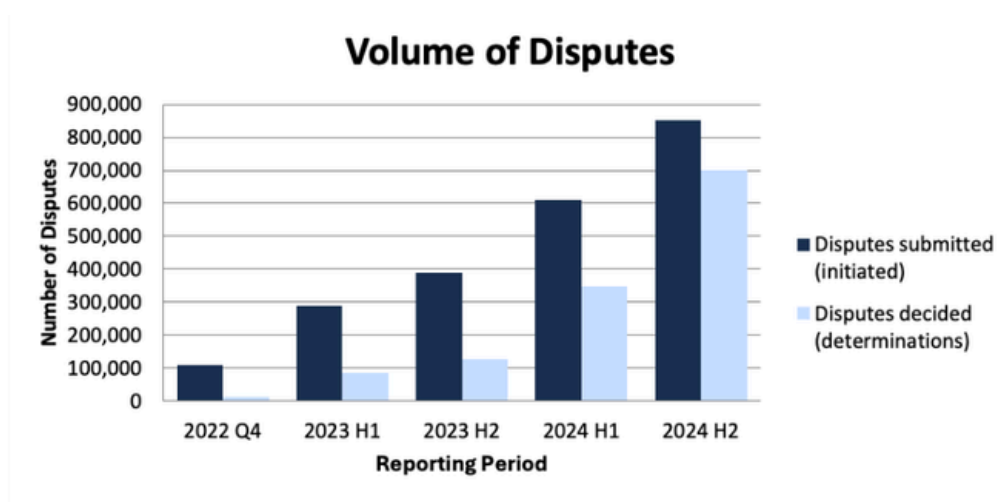
² https://asra.com/docs/default-source/practice-management/applicability-federal-idr-bifurcated-states.pdf?sfvrsn=9e059e65_2

³ <https://www.cms.gov/files/document/caa-federal-idr-applicability-chart.pdf>

First Four Years of the Federal IDR Process

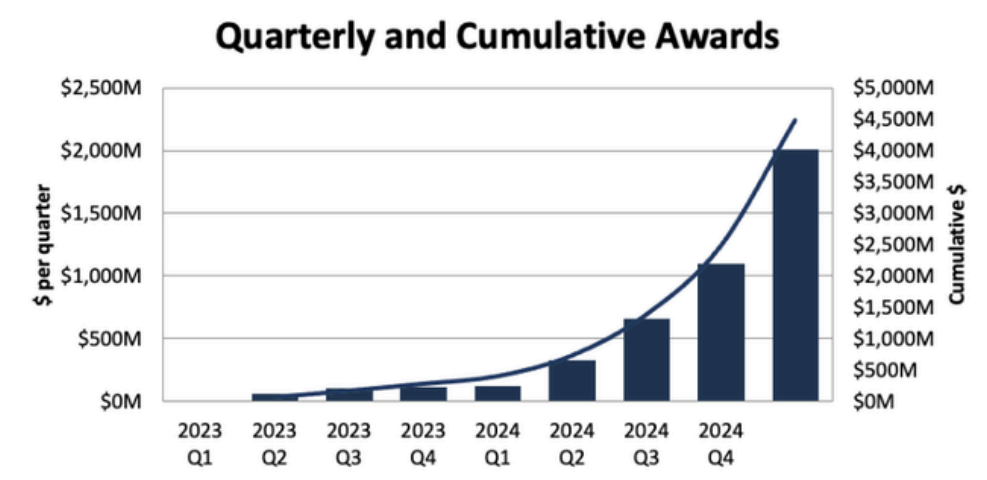
Congress **intended the federal IDR process to be a backstop** for plans and providers who could not settle payment disputes, anticipating that 17,000 disputes would be submitted annually. Utilization of the process has far exceeded those estimates and continues to grow rapidly.

In 2025, nearly 2.6 million new disputes were submitted⁴ to the federal IDR portal, significantly outpacing Congressional estimates.



In 2025, providers won⁵ almost **9 of every 10 arbitrated cases**. This compels insurers to pay providers the arbitrated amount, which often far exceeds typical market rates or in-network prices.

From 2022 to 2025, the federal IDR process **generated⁴ \$22.4 billion in total costs** to the health care system, almost half of which on award dollars.



⁴ <https://www.healthaffairs.org/content/forefront/spending-idr-process-pushes-no-surprises-act-costs-more-than-22-4-billion-over-just>

⁵ <https://www.healthaffairs.org/content/forefront/no-surprises-act-idr-process-early-look-2025-data>

Unintended Consequences for Public Sector Purchasers

Public sector health care purchasers are a distinct group of employers that provide health care benefits to public employees, retirees, and their dependents across the country. These employees, including teachers, firefighters, public safety officers, and other public servants, rely on their state, municipality, university system, or other public employer to offer affordable health care benefits. Public sector purchasers experience the cost burdens of rising federal IDR arbitration awards differently depending on the state in which they operate.

While much research addresses the national federal IDR burden, the Public Sector HealthCare Roundtable surveyed its public sector purchasers to understand how the federal IDR process affects them. The survey found that 86% of respondents were aware of the federal IDR process before taking the survey, while only half actively track IDR disputes; the remainder are not notified of or do not track disputes because of the nature of their contracts with plan administrators. Two-thirds of respondents reported that the federal IDR process is causing a moderate or significant financial impact, with five plans each reporting burdens of more than \$100 million.

For public sector purchasers, these high award amounts have measurably increased spending, reflected in rising premiums. Unlike other employer-sponsored insurance, public sector purchasers cover premium costs through state and local general revenue and direct member contributions. Due to constrained budgets, these costs are passed on to active and retired public servants through larger health care monthly costs. An investigation by the New York Times found⁶ that the United Service Workers health plan raised premiums by an additional 1.75 percentage points for 20,000 trades workers in the New York area to offset the costs of IDR arbitration awards and fees.

⁶ <https://www.nytimes.com/2026/04/22/us/politics/doctors-insurers-arbitration.html>

About The Institute



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The National Institute for Public Employee Health Care Policy (the Institute) was established in July of 2023. It is a non-profit (501)(c)(3), nonpartisan, national policy institute focused on public policy areas impacting health care plans available to public sector employees, retirees, and their beneficiaries. The Institute conducts research, develops authored papers and issue briefs, and hosts events to raise awareness and educate the Washington, D.C. policy community.

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