HEALTH & MEDICINE

A New 'Fresh Hell' for Surprise Medical Bills

Five years after the federal No Surprises Act, its arbitration system is driving up everyone's premiums.

BY DAVID A. HYMAN AND BENEDIC N. IPPOLITO

In 2018, a survey conducted by the health policy research group KFF reported that "surprise medical bills are what Americans fear most in paying for health care" (Rau 2018). They feared it more than their deductible for health insurance. More than prescription drug costs. More than their monthly health insurance premium.

What are surprise medical bills, and why were Americans so scared of them in 2018? Surprise medical bills were what happened when an insured patient was unexpectedly treated by an out-of-network provider, and the provider refused to accept what the patient's insurer was willing to pay. Providers would then pursue patients for the unpaid difference (i.e., "balance billing").

The "surprise" in "surprise medical bills" was because insured patients were not expecting to be on the hook for something they thought was covered by their insurance. Until the mid-2000s, balance billing disputes typically involved relatively modest sums. However, providers in several hospital-based specialties (e.g., emergency medicine, anesthesiology, radiology and pathology) discovered that the sky was the limit when sending balance bills. Group practices and individual physicians (and private equity firms that were buying up those practices) discovered that being out of network and engaging in balance billing was more financially lucrative than being in network and getting paid a negotiated (i.e., smaller) amount. Ground and air ambulances got in on the action as well.

NO SURPRISES ACT

In relatively short order, about one in five Americans received a surprise medical bill, sometimes amounting to tens of thousands of dollars. After the problem attracted considerable media attention, multiple states enacted legislation. The states adopted a variety of approaches, ranging from direct price-setting, to forcing insurers to pay up regardless of the amount of the bill, to creating a system for arbitrating these disputes. Because of federal law, those efforts only applied to a minority of privately insured patients.

In 2020, Congress passed the No Surprises Act (NSA) to address the problem more comprehensively. The NSA didn't directly set the prices that could be charged or keep surprise billing from happening in the first place. Instead, it removed patients from the equation and created a system of Independent Dispute Resolution (IDR) for providers and insurers that were deadlocked over how much should be paid for out-of-network care. The IDR was modeled on a New York law, which was itself based on what Major League Baseball uses to decide player salary disputes. In "baseball arbitration," both the player and the team present information supporting their preferred position, and an arbitrator picks one of the two numbers.

The NSA was limited to bills that were generated after a patient received "emergency care either at an out-of-network facility or from an out-of-network provider," "when an enrollee uses air ambulance emergency transport services" (but not ground ambulance services), or "when an enrollee receives nonemergency care at an in-network facility but is treated by an out-of-network health care provider without knowingly electing that provider or giving consent to be billed." Thus, the NSA covered most (but not all) of the situations in which surprise medical bills had been generated.

From the patient's perspective, the NSA eliminated the problem of surprise medical bills by capping their finan-

DAVID A. HYMAN is the Scott K. Ginsburg Professor of Health Law and Policy at Georgetown University Law Center. BENEDIC N. IPPOLITO is a senior fellow in Economic Policy Studies at the American Enterprise Institute, where he specializes in health economics.

DPA PICTURE ALLIANCE / ALAMY

cial exposure at whatever cost sharing they would have been responsible for if the care had been provided in network. That approach left providers and insurers to sort out how much of the balance should be paid, with the IDR system available if the parties were unable to agree.

For the disputes that end up in the IDR system, the NSA provides a laundry list of factors to be considered by the arbitrator, including:

- the median in-network rate
- any information submitted by the parties
- the training, education, experience, and quality of the provider
- the patient's acuity and complexity of services
- the market share for the provider or the insurer
- whether the provider had made good faith efforts to join the network
- any prior contracted rates involving the same parties

The NSA tasked the Department of Health and Human Services (HHS) with filling in the details. HHS issued several rounds of regulations. Initially, these regulations required that arbitrators start with the presumption that the median in-network rate (called the qualifying payment amount, or QPA) was appropriate unless other factors argued otherwise. Providers filed more than 30 lawsuits challenging almost every aspect of the implementation of the NSA by HHS, including the emphasis on the QPA.

Providers scored their most important legal victory when HHS was forced to back away from its heavy reliance on the QPA. Instead, the final regulations state that arbitrators should weigh all the factors in the NSA equally, even though most were not readily reducible to a dollar amount, and some were of questionable relevance to determining the market rate for the services in question.

A DISCOURAGING PICTURE

We are coming up on the fifth anniversary of the NSA going into effect. How is it working? Is the law accomplishing the intentions of its drafters? What (if any) unintended consequences have materialized? Are further reforms needed?

We are not disinterested parties. We met with members of Congress when the NSA was being drafted, and we provided technical assistance and advice. While the NSA was under consideration, we co-authored a piece in *Regulation* that raised serious questions about the utility of an IDR-based approach (Hyman & Ippolito 2019). Specifically, we noted that the IDR system did not "prevent surprise medical bills. Instead, arbitration is an ex-post dispute resolution system that represents a non-transparent version of [a] price-setting approach." In our conclusion, we also highlighted how peculiar the phenomenon of surprise medical bills actually is, and how odd it was to rely on IDR as a stop-gap solution to what was ultimately a problem of competition:

> Out-of-network balance bills are unique to health care. When you take your car to a body shop, the painter who repaints the door panel does not send you an inflated, separate bill and then balance-bill you when your insurance refuses to pay it in full. This is not because we have an elabo-

rate arbitration system to adjudicate door panel repair bills; it is because the market demands all-in pricing.

In health care, normal market forces have failed to prevent surprise medical bills. Although a well-designed IDR system can help resolve such disputes, design details matter greatly in how effective this approach will be in arriving at market prices.

On the positive side, the NSA has taken patients out of the middle of these disputes, at least as long as they have insurance. That is a significant success that should not be ignored. But a closer look at how the IDR system is working points to a discouraging overall picture.

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The IDR system was intended to deal with a small number of cases, on the order of 20,000 per year according to an estimate in the *Federal Register* from when the IDR process was launched. Instead, there has been an avalanche of cases (2.6 million separate filings in 2025). Private-equity-owned staffing firms and other intermediaries have realized they can extract very high payments from the IDR system—much more than the same insurer is paying for in-network treatment, let alone what Medicare is paying. There has also been significant aggregation on the filing side; the top three entities accounted for about 45 percent of recent filings.

Press accounts indicate that providers in multiple specialties are deliberately staying out of network and using the IDR system to extract inflated fees after the fact. With win rates in excess of 85 percent and inflated payments when they win (particularly for neurology, surgery, and radiology, according to a 2025 report by the Congressional Research Service), it isn't surprising that this strategy has become a viable business model for the same providers and specialties that were sending surprise bills prior to the passage of the NSA, plus multiple new entrants. Indeed, many of the disputes that have entered the IDR system involve elements of scheduled procedures, which were responsible for a tiny share of the surprise bills that pre-dated the NSA.

In one high-profile example featured in the *New York Times*, one physician's website advertised a $25,000 or less charge for breast reduction, but the same physician used the IDR system to extract $440,000 from an insurance company for the exact same procedure (Kliff & Sanger-Katz 2026). Another example in the same article featured a neurosurgery practice that persuaded an arbitrator to award it $333,000 for a diagnostic procedure to measure blood flow to the brain. If the care had been provided in-network, the insurer would have paid $2,660.

Another article highlighted how providers have used the IDR to extract dramatically higher payments for the out-of-network surgical assistant than what the in-network primary surgeon received for the same procedure (Sanger-Katz & Kliff 2026). In one recent case, "a surgical assistant in Dallas earned $50,456 through arbitration for a prostate removal operation. The surgeon, who accepted the patient's insurance, earned $1,843." Even if these examples are extreme outliers, they point to a set of larger problems with using IDR to resolve disputes over payment for out-of-network care.

High IDR awards don't just drive-up spending in the cases that are decided by an arbitrator. They also affect the amounts that insurers must pay to get doctors to agree to be in-network. Government regulations, which require insurers to have sufficient doctors in the network to meet the requirements of patient care (i.e., "network adequacy" requirements), turbocharge these incentives, resulting in higher health care premiums, higher co-payment and deductibles, and people dropping their health insurance entirely.

All told, the IDR system awarded nearly $15 billion in 2025, more than triple what was awarded in 2024 and roughly six times the amount that would have been paid had the providers been in-network. While unusually large payments are surely justifiable in some extraordinary cases, the fact that the IDR system is awarding amounts that vastly exceed negotiated in-network rates signals a systemic problem.

A BETTER APPROACH

Even in the bizarro world of health care finance, the IDR system stands out as a case study of good intentions resulting in bad consequences for everyone but those who are financially benefiting (i.e., the doctors, group practices, and private equity firms that receive elevated payments from the IDR system, as well as the arbitrators who are paid a fee for each case they decide, typically around $600).

Given all that, how should we fix the IDR system and the underlying problem of surprise medical bills? Unless Congress decides to revisit the problem of surprise medical bills, we are left with extremely limited options. As noted previously, HHS has already been sued repeatedly for deviating in the slightest from the statutory language of the NSA. Recent changes made by the Supreme Court to administrative law also constrain HHS's ability to make adjustments to the choices Congress made in the NSA, no matter how dysfunctional the results.

In fairness, the NSA requires HHS to recertify arbitrators

periodically. HHS has indicated it will consider performance and "faithful execution of [the NSA's] requirements," including "complet[ing] eligibility and payment determinations accurately" in doing so. But even if this provision allows the administration to decertify arbitrators with extreme rulings, the effects will likely be quite limited. Playing whack-a-mole against arbitrators who hand out outlier awards won't change the fundamental problems with the NSA and the IDR system.

If Congress is inclined to act, we continue to believe that contract law provides a better approach to solve most surprise bills. As we noted in our earlier *Regulation* article:

> A contract-based solution, which would require all providers at an in-network hospital to either contract with the same insurers as the hospital or secure payment from the hospital (who will bundle those costs as part of their in-network facility fee), will outperform IDR. A contract-based approach entirely eliminates the sending of surprise medical bills at in-network settings and puts the burden of negotiating market prices on those closest to the situation. A contract-based approach requires nothing from the vast majority of providers that do not engage in surprise billing, and it eliminates the need for policymakers to impute a market price or create and fund a dispute resolution system to do the same.

However, if Congress is unwilling to move to a contract-based approach, there are second-best options that retain the basic structure of the arbitration system but limit its downsides. The easiest solution is to eliminate outlier payments by introducing an upper limit on IDR payments. The upper limit could be based on a multiple of Medicare rates (e.g., 300–400 percent of Medicare reimbursement) or existing commercial rates (e.g., the 80th percentile of in-network rates in that area). The latter approach could be coupled with better data on the actual in-network rates that are being paid. The Trump administration has already taken steps to improve the transparency of data on in-network rates. This approach would provide sufficient flexibility in handling the bills for out-of-network treatment while preventing outlier awards.

More effort should also be directed at excluding ineligible and unbundled claims from the IDR system. As part of that initiative, Congress should introduce a sliding fee schedule for using arbitration that increases substantially with an entity's volume of claims. Doing so would retain modest costs for genuine, infrequent use of the system while making it less attractive to have a business model built around routine reliance on the IDR and on unbundling. These reforms should be paired with efforts to ensure prompt payments by insurers after decisions, thereby combating a source of considerable frustration for providers.

Arbitrators might also benefit from additional mandatory training in how to implement the NSA IDR system. For example, reporting and analysis suggest that assistant surgeons are frequently receiving payments that are comparable to (and sometimes far larger than) those of primary surgeons—outcomes that are simply not seen anywhere else in the health care system. These cases suggest that at least some arbitrators are "making it up as they go along" rather than trying to determine what the market rate should have been for the services in question.

We acknowledge that capping outlier awards amounts to rate-setting, but the IDR system is doing that already, just in a less-visible and thoroughly ad hoc way based on the preferences of individual arbitrators with poor incentives to arrive at the market-clearing price. We should be honest about what we are already doing and then take steps to reserve the IDR system for a very small number of intractable cases. The alternative is to continue to allow the IDR tail to wag the out-of-network payment dog.

With the NSA, Congress succeeded in protecting patients from surprise bills, but it created a new, opaque payment mechanism that has underperformed even our low expectations. The IDR system is already contributing to increasing commercial insurance premiums. These problems will only get worse over time. While policymakers have been reluctant to adopt more sensible contract-based approaches to resolving surprise bills, they can at least constrain the costs imposed by the IDR system.

Writer and satirist Dorothy Parker was famous for her cutting wit. When the phone or doorbell rang, she would invariably respond, "What fresh hell is this?" Congress's fix for the "hell" of surprise medical bills gave us the "fresh hell" of the IDR system. The longer Congress waits to fix the new problem it created, the more entrenched and expensive this fresh hell will become. *R*

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