March 25, 2026

The Honorable Secretary Scott Bessent
Department of the Treasury
1500 Pennsylvania Avenue NW
Washington DC, 20220

The Honorable Secretary Lori Chavez-DeRemer
Department of Labor
200 Constitution Avenue NW
Washington, DC 20201

The Honorable Secretary Robert F. Kennedy, Jr.
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretaries, Bessent, Chavez-DeRemer, and Kennedy,

On behalf of the undersigned organizations, we are writing to you because of the critical role your agencies play in the successful implementation of the No Surprises Act (NSA), the landmark legislation that protects patients from unaffordable out-of-network bills. We are appreciative of your commitment to defending the patients who receive care protected by the NSA.

Together the specialty societies and trade organizations below represent over 100,000 physicians and clinicians working on the frontlines of our healthcare system to deliver NSA-protected care, and over 100 supporting organizations to those physicians. **On behalf of our memberships, we advocated for the strong patient protections that became law, and have since continued to be extremely supportive of maintaining the NSA patient protections**. We believe that with commonsense reforms and investment in enforcement, the NSA can continue to be the landmark healthcare affordability law that it was intended to be.

However, a pervasive lack of engagement and ongoing non-compliance by health insurers continues to threaten these basic patient protections, increases costs for all stakeholders, and undermines the viability of our healthcare infrastructure.

Here is where we believe the implementation of the NSA stands today.

1. The No Surprises Act is well designed, has good fundamentals, and is supporting its intended objectives.

The NSA's primary objective is to guarantee patients are protected from unexpected out-of-network bills while protecting their access to care. Its secondary objectives were to (1) incentivize in-network agreements between clinicians and insurers; and (2) create incentives that, over time, moderate health care costs.

The patient protections of the NSA were generally realized almost immediately following its implementation, with America's Health Insurance Plans (AHIP) reporting 10 million surprise medical

bills being stopped during the first 9 months of 2023.[1] A recent report from the Government Accountability Office (GAO) found that both of the law's secondary objectives are being achieved as well, with the proportion of *in-network* claims for key hospital-based medical specialties remaining high and even increasing since the NSA passed, and in-network inflation-adjusted costs *falling* over the same period. [2]

Overall, the GAO's findings are consistent with the experience of the many physicians, clinicians, and healthcare professionals represented by this letter. The NSA is an excellent vehicle for patient protection and, in addition, protects the overall healthcare system. Its mechanism for resolving payment disputes between clinicians and insurers, known as Independent Dispute Resolution (IDR), is critical to practice viability in an environment of record inflation and declining payment.

2. Data demonstrates that clinicians use the IDR process sparingly and appropriately.

Survey data provided by AHIP and the Blue Cross Blue Shield Association (BCBSA) found that during the first three quarters of 2023, about 10 million claims were eligible for the NSA's IDR process. However, an extremely small percentage (about 6.6%) of those eligible claims were submitted for resolution.[3] The same survey noted that claims eligible for IDR constituted about 0.7% of all commercial claims processed by health insurance providers. **This means that only about 0.046%, or roughly 1 in every 2,174 commercial claims went to arbitration.**
The IDR process was designed to be used sparingly and only when the initiating party can demonstrate payment was not aligned with the value of the service provided. The insurance industry's surveys, paired with CMS data, confirm current use aligns with original design:

- The vast majority of eligible claims (over 93%) are resolved *without* the IDR process
- Clinicians were the prevailing party in dispute resolution roughly 75% of the time – clearly demonstrating that the disputed payment offer from insurers was out of alignment with the value of the service.[4]

3. Overall professional payment continues to decline under the NSA and the IDR process. Inaccurately low Qualified Payment Amounts (QPAs) and misrepresentations of dispute volume give the incorrect perception that medical spend is increasing.

Reimbursement rates for those 93% of out-of-network claims resolved without IDR have *declined* since the NSA passed. Last year, the RAND Corporation published research examining the sustainability of emergency medicine, including a novel review of over 50 million emergency medicine claims. Researchers found that from 2018 to 2022, **out-of-network reimbursement for emergency department services declined an incredible 47.7%.** This data tells us that the vast majority of out-of-network emergency claims are being processed and paid (1) outside of IDR and (2) at nearly 50% less than they were being reimbursed 8 years ago. Despite these realities, IDR

[1] https://www.ahip.org/news/press-releases/new-survey-shows-no-surprises-act-continues-to-protect-millions-of-americans-from-surprise-medical-bills
[2] https://www.gao.gov/products/gao-26-107169
[3] https://ahiporg-production.s3.amazonaws.com/documents/202401-AHIP_SurpriseBilling-v02.pdf
[4] https://www.cms.gov/nosurprises/policies-and-resources/reports

utilization is not common—and consistent with the GAO report referenced above—overall costs are lower, not higher.

An overreliance on unaudited QPAs as a proxy for in-network rates has fueled a misconception that the average IDR determination is much higher than historical in-and-out-of-network rates. However, research from ndp Analytics shows this is not true. In a report released earlier this year, ndp Analytics compared the Q4 2024 QPAs reported in CMS' Public Use Files (PUFs) to median in-network rates disclosed under the Transparency in Coverage (TiC) data. This research found that 60% of QPAs were *below* the actual corresponding median in-network rates. On average, **the median in-network rate in the TiC data, which reflects the actual contracts in effect for a given insurer, was nearly 300% higher than the reported QPA.**[5] Allowing policy decisions to be informed by inaccurate and misleading QPAs all but guarantees unintended consequences for patients and clinicians.

4. IDR is administratively expensive and clinicians welcome the chance to avoid it altogether if possible. However, insurers leave little alternative.

IDR is intended to serve as a backstop for clinicians to ensure that they are able to pursue—and receive—a sustainable rate of payment while simultaneously leaving the patient out of payment disputes. Decreasing payment rates for out-of-network clinical services force clinicians to seek the remedies afforded to them under the NSA. In an effort to encourage cooperation and reduce administrative costs, Congress created the Open Negotiation period—a 30-day window prior to the initiation of arbitration where the health insurer and the clinician are required to attempt to resolve payment disputes without using the IDR process. **But according to survey data from Americans for Fair Health Care (AFHC), only 1% of disputes are resolved in Open Negotiation**—not because clinicians refuse to take an offer but because **insurers only respond to Open Negotiation offers 50% of the time and even when they respond, they usually don't provide a counter-offer.**[6]

This lack of engagement in payment disputes forces clinicians to pursue IDR when they feel they have been undercompensated but cannot resolve it another way—not because they want to, **but because with declining initial offers and lack of good faith (or even any) engagement in negotiations, insurers leave no alternative.**

5. **So-called "shared savings" arrangements create a perverse financial incentive for insurers acting as third-party administrators (TPAs) to steer care out-of-network, driving IDR usage. In the end, insurers profit at the expense of employer-sponsored health plans and providers.**

As reported by the *New York Times* and detailed in *Health Affairs*, insurers functioning as TPAs identified a way to generate additional revenue by managing out-of-network claims. Rather than

[6] https://www.americansforfairhealthcare.org/_files/ugd/11639b_3948738a47e7439c910c4490a8c47778.pdf

prioritizing robust networks, this structure can incentivize narrower networks and greater use of out-of-network care. Under these arrangements, insurers charge "shared savings" fees to the employer-sponsored health plan, purportedly based on the difference between billed charges and the amount ultimately paid. In practice, these fees can exceed the cost of the underlying medical service itself, with the employer sponsor of the health plan paying more overall than it would have for in-network care.

The financial impact is further compounded when disputes proceed to IDR. In those cases, administrative fees, arbitration costs, and any incremental payment amounts are typically borne by the employer-sponsored health plan. The result is a system in which the employer's total costs increase, potentially dramatically, with a significant portion of the additional spending flowing to insurers. In effect, "shared savings" arrangements shift incentives away from cost-effective network management and toward revenue generation through out-of-network billing and dispute processes, ultimately driving up costs for employer-sponsored health plans without improving patient care.

6. Determining eligibility is one of the greatest challenges that providers face in the IDR process. Lack of transparency by the insurers directly leads to eligibility challenges and increases administrative costs.

Shortly after the NSA passed, physician specialty societies and supporting trade organizations expressed concern to the Centers for Medicare and Medicaid Services (CMS) about the challenges providers would face determining claim eligibility under the NSA.[7] As predicted, the bifurcated nature of balance billing laws (there are both state and federal laws that have to be considered) and the lack of information available to providers when determining plan type, has led to significant cost and uncertainty.[8]

We have worked diligently with our members to educate them on dispute eligibility and identify new best practices for obtaining necessary eligibility information. While our efforts have proven to be effective (CMS reports ineligible dispute initiation is down from 69% to 17%),[9] ineligible IDR referrals remain primarily a result of insurers failing to disclose the type of plan within which the patient is enrolled.

The IDR process presents multiple opportunities for insurers to disclose this information:

A. On the patient's health insurance card;
B. In a functional database kept up-to-date and fully accessible to clinicians;
C. In a Remark Code (RARC) on the explanation of benefits sent to the clinician; and
D. At the time of open negotiation.

[7] https://www.asahq.org/advocacy-and-asapac/fda-and-washington-alerts/washington-alerts/2025/10/asa-urges-swift-release-of-final-idr-operations-rule-to-stabilize-no-surprises-act-implementation
[8] https://edpma.org/wp-content/uploads/2021/02/ACEP-EDPMA-RARC-Code-Request.pdf
[9] https://www.cms.gov/files/document/federal-idr-supplemental-background-2025-q1-2025-q2.pdf

If the plan disclosed this information at any point, the problem of ineligible disputes would be avoided. We are strong advocates for policy changes that would incentivize the transparency of this information and ease the administrative burden researching eligibility puts on the provider and the IDREs.

There are many improvements to the NSA that our organizations and others in the clinician community would support, including many of those asked for by the health insurance community. We have engaged with members of Congress and the Administration to make these same asks of them.

1. **Improving transparency in claim eligibility for state vs. federal dispute resolution.** As early as 2021 and as recently as February, affected medical specialty organizations and other stakeholder have urged the Departments to assist in defining eligibility for claims that go to IDR.[10][11] Because this is information that **only the insurers have access to**, clinicians consistently struggle with knowing whether or not a claim is eligible for the Federal or a state IDR process. We are hopeful that the IDR Operations Rule, set to be finalized in the first half of 2026, will make changes that improve the efficiency of determining eligibility.

2. **Passage of the No Surprises Act Enforcement Act.** This bicameral, bipartisan bill would create financial penalties for health insurers that deny NSA-protected care or illegally attempt to increase the patient's cost share based on an IDR determination; these are the same penalties that clinicians are already subject to. The bill would also penalize disputing parties that fail to pay timely after an IDR determination. EDPMA survey data from 2024 showed that for approximately 300,000 IDR awards, the health plans failed to make timely payment nearly 60% of the time. This bill is opposed by insurers, despite its focus on protecting patients.

3. **Improved transparency, oversight, and enforcement of the basic fundamentals of the NSA.** Clinicians have long supported further evaluation of the NSA, its underlying processes, and the behavior of stakeholders engaged in the process. We support further investment into the IDR portal to streamline the uniform application of guidance across all stakeholders; assessing fee structures to ensure all stakeholders are incentivized to participate in the process as it was intended; providing access to the IDR offers and supporting documentation for both the prevailing and non-prevailing parties; and welcome the opportunity to support other ideas that the health insurers or the Administration have to make the process more efficient.

We are committed to ensuring the NSA is implemented in a way that protects patients from unaffordable out-of-pocket costs while preserving the integrity, sustainability, and availability of clinical practices. If you have questions or would like additional information, we encourage you to contact

[10] https://www.reginfo.gov/public/do/viewEO12866Meeting?viewRule=false&rin=0938-AV15&meetingId=1319273&acronym=0938-HHS/CMS

[11] https://edpma.org/wp-content/uploads/2021/02/ACEP-EDPMA-RARC-Code-Request.pdf

us at matt@edpma.org or (202) 204-8400. We welcome the opportunity to meet with you on behalf of the physicians and clinicians we represent.

Respectfully,

American College of Emergency Physicians (ACEP)
American College of Radiology (ACR)
American Society of Anesthesiologists (ASA)
Emergency Department Practice Management Association (EDPMA)
Healthcare Business Management Association (HBMA)
Medical Group Management Association (MGMA)
Radiology Business Management Association (RBMA)