Rate Expectations:
Evaluating the Validity of the QPAs Reported Under the No Surprises Act

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I. Executive Summary

The No Surprises Act (NSA) was passed to protect patients from medical bills related to unexpected out-of-network (OON) healthcare services. Under the NSA, providers and insurers are expected to negotiate fair reimbursement for OON services directly. The patient cannot be deemed responsible for any out-of-pocket cost beyond what the patient's health plan requires for in-network (IN) services. Providers and insurers that cannot agree on a reimbursement rate for an OON service resolve disputes through a binding arbitration process termed Independent Dispute Resolution (IDR).

For claims that do get to IDR, the NSA specifies several criteria for the neutral, third-party arbiters to consider when determining a reasonable rate of reimbursement for the service, one of which is the Qualifying Payment Amount (QPA). The QPA was intended to represent the median in-network rate of a service in a particular region. In addition to its role in IDR, the QPA is also used as the basis for determining individual patient cost sharing for items and services protected by the NSA.

Because of its statutory definition as the "median in-network rate", the QPA is often used rhetorically to represent what the median cost of care would be should services protected by the NSA be in network. However, the QPA has been subject to scrutiny since the calculation methodology was first announced in 2021.[2] For several years, the Texas Medical Association (TMA) has been engaged in litigation with the Departments tasked with administering the NSA (the Department of Health and Human Services and its Centers for Medicare and Medicaid Services (CMS), the Department of Labor, and the Department of the Treasury). Regarding the QPA, the basis of the litigation is two-fold: the weight of the QPA when determining the market rate of reimbursement for a service, and the validity of the QPA calculation methodology in representing the median in-network rate. While some aspects of the litigation have been settled (e.g., the

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[2] U.S. Departments of Health and Human Services, Labor, the Treasury, and the Office of Personnel Management. "Requirements Related to Surprise Billing; Part I. Interim Final Rules with Request for Comments." 86 Fed. Reg. 36872. July 13, 2021. https://www.govinfo.gov/content/pkg/FR-2021-07-13/pdf/2021-14379.pdf

QPA must be only one of several factors considered when determining what a reasonable reimbursement amount is), others remain ongoing.[3]

Despite the Departments' statutory obligations for auditing the reported QPA, CMS has cited the ongoing litigation as reason for ongoing enforcement discretion. Because of that, there has been little transparency or oversight of the QPAs being reported. In 2025, CMS reported to the House of Representatives a summary of audits completed, indicating that CMS had initiated 25 QPA audits. However, to date, CMS has released a report on only one.[4] The audit that was released found examples of Aetna, the insurer being audited, miscalculating the QPA.

In this analysis, we seek to assess the validity of the reported QPAs as a benchmark for typical (median) IN care rates. The study uses QPAs, as reported in the IDR dispute data published by CMS, along with insurer-published contracted rate data, to compare the reported QPA to actual median IN contracted rates. The analysis shows that, across insurers, services, and locations included in the study, median IN contracted rates were above the QPA reported in the Public Use Files (PUFs) in 60.6% of the dispute cases in the study. Among these disputes, on average, median IN rates were 290.5% higher than reported QPAs.

The QPA is often used as a point of reference for measuring how the NSA impacts the cost of care for protected services. However, these analyses assume that the QPAs being reported in publicly available data are an accurate representation of the median in-network rate. This study demonstrates that notion to be frequently untrue. Policymakers should consider these findings as they consider reforms to the NSA and its IDR process. Because of enforcement discretion and limited oversight of the calculation methodology used by insurers to date, there has been little incentive for insurers to use accurate QPAs. In fact, recent analysis suggests that insurers may be incentivized to report inaccurate and below market QPAs, not only because of the rhetorical value it creates, but because it enables increased profit opportunity through shared savings arrangements.[5] But, accuracy in the QPAs being reported is imperative to understanding how the NSA achieves its intended goals of reducing the total cost of care and incentivizing fair networking arrangements. By ensuring the QPAs being reported are accurate, the Departments and Congress can compel insurers to better align initial payments to OON providers with actual median IN contracted rates. The result would be reduced need for IDR, reduced administrative spending, and a lower overall total cost of care.

II. Background and Introduction

The No Surprises Act (NSA) is a federal law that was enacted in December 2020 and went into effect on January 1, 2022. The NSA protects patients from unexpected medical bills, specifically for hospital-based and air ambulance services provided by out-of-network (OON) providers at in-network (IN) facilities or for emergency care. For the services covered under the NSA, patients are not expected to pay more than the IN cost-sharing amount defined by their health plan. The remainder of reimbursement must be negotiated between the provider and the insurer. When providers and OON insurers cannot agree on a rate of payment

[3] ReedSmith. "Fifth Circuit grants en banc rehearing for TMA III, will consider vacating QPA calculation rules." June 4, 2025. https://www.reedsmith.com/en/perspectives/2025/06/fifth-circuit-grants-banc-rehearing-tma-iii-vacating-qpa-calculation-rules

[4] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. "Report to Congress: 2024 Qualifying Payment Amount Audits." August 2025. https://www.govinfo.gov/content/pkg/CMR-HE22-00196613/pdf/CMR-HE22-00196613.pdf

[5] Heller, Richard, et al. "Hidden Incentives Drive IDR Volume and Cost: The Role of Commercial Insurer "Shared Savings" Programs. October 31, 2025.

for an NSA-eligible service, there is an arbitration process termed Independent Dispute Resolution (IDR).[6] Under IDR, an independent arbitrator is either jointly selected by both parties or, if one cannot be agreed to, is assigned by the government, to review offers from both parties and choose the offer that best represents the value of that service.

For help determine a patient's IN cost-sharing amount, and to be used one criterion in arbitration, the NSA established the Qualifying Payment Amount (QPA). The QPA is intended to represent an insurer's median IN contracted rate for the same or similar service in the same or similar geography as of January 2019, adjusted for inflation. So, if a patient's health plan requires a 20% co-insurance payment for an IN emergency care visit, their out-of-pocket responsibility for an OON emergency care visit would be 20% of the QPA.

Arbitration is "baseball style", meaning the arbiter must select either the insurer offer or the provider offer, they cannot decide their own rate. QPA is one of several factors taken into consideration in an arbitration decision.[7] Pursuant to the NSA, arbiters (termed IDR entities, or "IDREs") are not exclusively bound to the QPA when making awards to prevailing providers. In fact, the statute obligates arbitrators to consider a number of other factors, including[8]:

1) The level of training, experience, and quality and outcomes measurements of the provider or facility.
2) The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided.
3) The acuity of the individual receiving such item or service or the complexity of furnishing such item or service.
4) The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service.
5) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and contracted rates between the provider or facility and the plan or issuer during the previous 4 plan years.

The only publicly available, consolidated claims data pertaining to the NSA is the CMS Public Use Files (PUFs)[9], which detail the disputes that have been decided in arbitration. According to a survey conducted by AHIP, this accounts for about 6% of the total volume of claims for services protected by the NSA.[10] For every claim subject to IDR, a QPA, calculated by the insurer, must be provided. Per CMS, insurers tend to benchmark their arbitration offers to the QPA.[11]

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[6] Centers for Medicare & Medicaid Services. "Initial Report on the Independent Dispute Resolution (IDR) Process April 15-September 30, 2022. https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf

[7] U.S. Departments of Health and Human Services, Labor, and the Treasury. "Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities. December 2023 Update to March 2023 Guidance." December 2023. https://www.cms.gov/files/document/federal-idr-guidance-idr-entities-march-2023.pdf

[8] United States Congress. "Public Law 116-260—December 27, 2020". https://www.congress.gov/116/statute/STATUTE-134/STATUTE-134-Pg1182.pdf

[9] Centers for Medicare & Medicaid Services. "Independent Dispute Resolution Reports (No Surprises Act)." Page last modified September 19, 2025. https://www.cms.gov/nosurprises/policies-and-resources/reports

[10] New AHIP/BCBSA Survey Finds Providers are Flooding IDR System with Ineligible Disputes. October 2025. https://ahiporg-production.s3.amazonaws.com/documents/202510_AHIP_IB_No_Surprises_Act_Survey51.pdf

[11] U.S. Departments of Health and Human Services, Labor, and the Treasury. "Supplemental Background on the Federal Independent Dispute Resolution (IDR) Public Use File (PUF), July 1–December 31, 2024 (as of May 28, 2025)." May 28, 2025. https://www.cms.gov/files/document/federal-idr-supplemental-background-2024-q3-2024-q4.pdf

However, speculation on the accuracy of the QPAs reported in the PUFs has been subject to scrutiny by providers. For several years, the Texas Medical Association (TMA) has been engaged in litigation with the Departments tasked with administering the NSA (the Department of Health and Human Services and its Centers for Medicare and Medicaid Services (CMS), the Department of Labor, and the Department of the Treasury). The basis of the litigation is two-fold: the weight of the QPA when determining the market rate of reimbursement for a service, and the validity of the QPA calculation methodology in representing the median in-network rate. While some aspects of the litigation have been settled (e.g., the QPA must be only one of several factors considered when determining what a reasonable reimbursement amount is), others remain ongoing.[12]

Despite the Departments' statutory obligations for auditing the reported QPA, CMS has cited the ongoing litigation as reason for ongoing enforcement discretion. Because of that, there has been little transparency or oversight of the QPAs being reported. In 2025, CMS reported to the House of Representatives a summary of audits completed, indicating that CMS had initiated 25 QPA audits. However, to date, CMS has released a report on only one.[13] The audit that was released found examples of Aetna, the insurer being audited, miscalculating the QPA.

In this analysis, we utilize PUF data and insurer-reported IN contracted rate data to evaluate the accuracy of the QPA as a reliable indicator of the actual median IN rate.

III. Methodology

a. Identifying the PUF sample

Almost 4 million payment disputes were resolved through IDR between mid-2022 through the end of 2024. To manage the feasibility of this analysis, we chose to analyze a single quarter of PUF data (Q4 2024).

PUF data published by CMS details insurer and provider offers for disputes that have been resolved through IDR. Each quarter, CMS provides detailed information about dispute cases with information on each dispute in two different Excel spreadsheets. The "QPA and Offers" spreadsheet includes a row for each disputed claim, and details the geographical region, represented by the metropolitan statistical area (MSA), the reported QPA in US dollars (USD), the provider/facility offer in USD, and the health plan/issuer offer in USD, but not the name of the health plan/issuer. Using the QPA and Offer data, we were able to manually calculate the offer amounts as a percentage of the QPA for each dispute line. The "OON Emergency and Non-Emergency" spreadsheet also includes a row for each disputed claim, detailing information about the provider and health plan and information about both party's offers, represented as a percentage of the QPA but not in USD. The "OON Emergency and Non-Emergency" spreadsheet also does not include information about the MSA.[14] In the Q4 2024 PUF file, there were 947,215 claim lines on each spreadsheet, suggesting a 1:1 match.

[12] ReedSmith. "Fifth Circuit grants en banc rehearing for TMA III, will consider vacating QPA calculation rules." June 4, 2025. https://www.reedsmith.com/en/perspectives/2025/06/fifth-circuit-grants-banc-rehearing-tma-iii-vacating-qpa-calculation-rules
[13] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. "Report to Congress: 2024 Qualifying Payment Amount Audits." August 2025. https://www.govinfo.gov/content/pkg/CMR-HE22-00196613/pdf/CMR-HE22-00196613.pdf
[14] CMS PUFs also include a spreadsheet for detailed dispute information on OON air ambulance services.

We used Current Procedural Terminology (CPT) codes, state, provider/facility offer as % of QPA, and health plan/issuer offer as % of QPA to match each dispute line with the name of the health plan/issuer in the OON Emergency and Non-Emergency spreadsheet with a dispute line in the QPA and Offers spreadsheet. We were able to confidently match 445,447 disputes out of the 947,215 (47.0%) total disputes in the Q4 2024 PUF workbook.

To further focus our analysis, we narrowed our research to only the most common insurers and service types disputed. This resulted in the inclusion of four insurer groups—Aetna, Blue Cross Blue Shield (BCBS), Cigna, and UnitedHealthcare (UHC)—which collectively represent 77% of disputes for the quarter; and eight medical service codes: computed tomographic angiography of the head (70496), computed tomographic angiography of the neck (70498), magnetic resonance imaging of the brain (70553), computed tomography of the abdomen and pelvis (74177), an emergency department visit for evaluation and management (99283), an emergency department visit of high complexity (99284), an emergency department visit with a high level of medical decision-making (99285), and critical care services in the first 30-74 minutes (99291).

Our analysis included no focus on specific geographies, rather all disputes that matched the criteria described previously were included, irrespective of geography. The final sample included 159,600 disputes and represented 192 MSAs.

b. Identifying the Relevant Insurer In-network Contracted Rates

The second set of data used in our analysis is insurer-reported contracted rates with IN service providers. These rates are published monthly in a machine-readable format by insurers in compliance with the 2021 Transparency in Coverage (TiC) Rule. PayerPrice, a commercial data service provider that aggregates the TiC data published by insurers, was used for TiC analysis.[15]

There are common challenges with TiC data, including the presence of unused rates (e.g., ghost rates[16]), multiple rates for the same service, repetitive rates for different services, and inconsistency in reporting structures. We used PayerPrice functionality to narrow the scope of our analysis to specific taxonomies and service types, as well as a discrete period of time (July and August 2024). This filtering minimized the risk of inclusion of ghost rates, month-to-month changes in reporting structure, and duplicate contracts for the same Tax Identification Number (TIN).[17]

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[15] PayerPrice, https://payerprice.com/

[16] Ghost rates are one of the components of the QPA methodology subject to litigation in the TMA lawsuit. Providers attest that the inclusion of ghost rates in the QPA calculation artificially deflates the QPA. An example of a ghost rate would be an insurer having a contracted rate with a primary care provider to provide emergency room services—not a service that a primary care provider would ever bill for. In some instances, these ghost rates will be as low as $0. Avalere. "PCP Contracting Practices and Qualified Payment Amount Calculation under the No Surprises Act." 2022-8-15-avalere-qpa-whitepaper_final.pdf

[17] While we acknowledge that there may be slight inaccuracies that result from these challenges, we are confident that these inaccuracies have been mitigated to prevent distortion to the extent that would influence ultimate findings. Centers for Medicare and Medicaid Services. "Qualifying Payment Amount Calculation Methodology." December 2021. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAAQualifying-Payment-Amount-Calculation-Methodology.pdf

The final data set included every reported contracted rate that an insurer had with a provider in July or August of 2024 for each service included in our analysis. The data was categorized by insurer group, service, and MSA.

c. Comparing IN Contracted Rates to Reported QPAs

Using the QPAs reported in the CMS PUF data and the IN contracted rates from PayerPrice, we compared the median contracted rate between an insurer and their IN service providers for a specific CPT code within an MSA to the reported QPA of the same insurer for the same CPT code within the same MSA, to understand how the reported QPA compares to actual contracted rates. [18]

We were able to match 140,997 of the 159,600 disputes extracted from the PUFs (88.3%) to an associated contracted rate from PayerPrice.

IV. Results

The findings show that the median IN contracted rate was greater than the QPA reported in IDR in 60.6% of disputes. In such disputes, the median IN contracted rate was, on average, 290.5% higher than the QPA. There was variability in frequency by insurer and CPT, ranging from 16.5% of UHC's disputes for 99283 to 100.0% of Aetna's disputes for 70496 and 70498 and UHC's disputes for 70496. (Table 1) There is meaningful difference in the average reimbursement across services and the scale by which the reported QPA undervalues the median IN contracted rate appears to correlate to that value. To use emergency department codes, since they are reimbursed on a sliding scale based on acuity, according to the PUFs, CPT 99283 (emergency room visit of high complexity) has an average reported QPA of $282, while 99291 (critical care services in the first 30-74 minutes) has an average reported QPA of $581. Almost uniformly across insurers, as emergency care services become more expenses, the share of dispute cases with median IN contracted rates greater than the QPA grows.

Table 1.
Share of Dispute Cases with the Median Contracted Rates Greater than the QPA by Insurer by CPT

	Aetna	BCBS	Cigna	United Healthcare (UHC)
CPT 70496	**100.0%**	**47.1%**	**99.3%**	**100.0%**
# of dispute cases	739	34	444	447
CPT 70498	**100.0%**	**55.0%**	**99.3%**	**99.8%**
# of dispute cases	692	40	445	499
CPT 70553	**89.7%**	**16.7%**	**99.7%**	**99.6%**

[18] According to the NSA guidance published by CMS, the QPA calculation should be an insurer's 2019 median contracted rate for a specific service within a particular MSA, adjusted for inflation. Ideally, the analysis would have included the 2019 contracted rates which were then adjusted for inflation. However, since the TiC was not mandated until 2022 and implementation has been slow, 2024 contracted rate data was used. Qualifying Payment Amount Calculation Methodology

# of dispute cases	863	6	294	449
CPT 74177	**92.6%**	**41.5%**	**93.6%**	**98.9%**
# of dispute cases	6,140	571	2,938	3,533
CPT 99283	**59.1%**	**56.4%**	**75.5%**	**16.5%**
# of dispute cases	2,124	6,294	2,016	6,292
CPT 99284	**63.8%**	**65.9%**	**77.9%**	**26.8%**
# of dispute cases	6,049	19,138	12,473	24,426
CPT 99285	**65.8%**	**72.4%**	**74.9%**	**31.8%**
# of dispute cases	5,566	12,394	11,369	9,753
CPT 99291	**76.0%**	**68.0%**	**87.9%**	**92.6%**
# of dispute cases	521	1,344	1,022	2,082

The data was further categorized by MSA to determine if the variability between contracted rates and QPAs was localized or national. In 86% of the MSAs studied, there were examples of disputes where the median IN contracted rate exceeded the reported QPA. Figure 2, below, plots all 192 MSAs and their average difference between the median IN contracted rate and the QPA. Coincidentally, 86% (166 MSAs) also had an average difference greater than 0%, meaning on average, the median IN contracted rate was greater than the QPA. Just 26 MSAs (14%) had an average difference less than 0%, meaning on average, the median IN contracted rate was less than the QPA. When the QPA is less than the IN contracted rate (right of the vertical line) the spread is substantial. When the IN is less than the QPA (left of the vertical line), the distribution is smaller. This tells us that the magnitude of the difference between the median IN contracted rates and the QPAs of those respective disputes was higher in MSAs where the median IN contracted rates exceeded the QPAs.

Figure 2. **The Median of IN Contracted Rates as a Percentage of the QPA by Unique MSA**

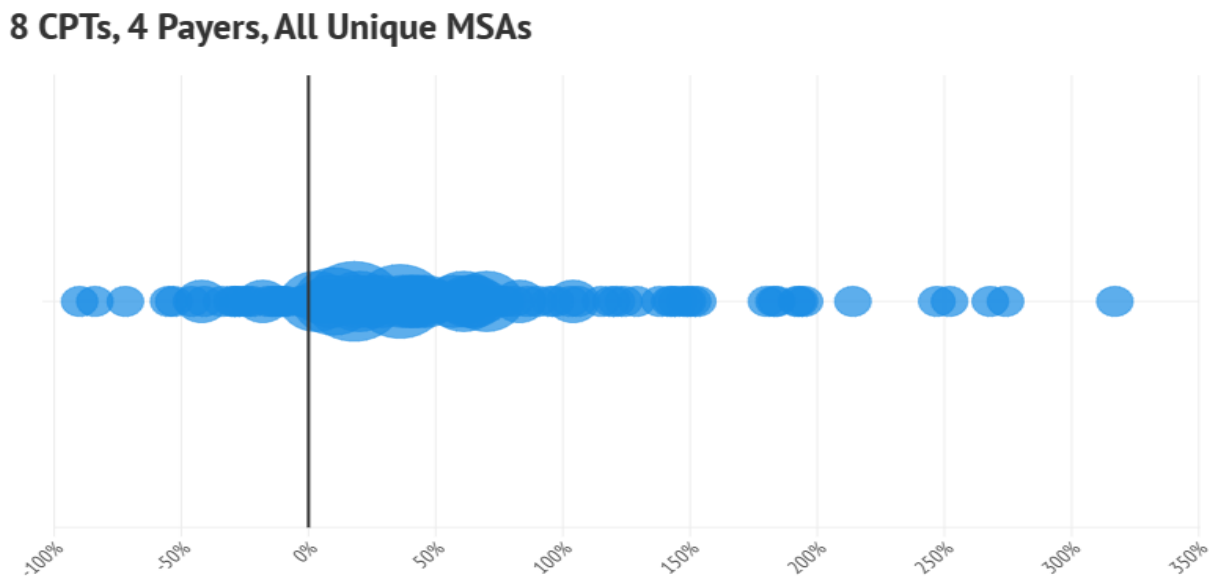

Figure 2: Each blue dot represents one of the 192 analyzed MSAs. The vertical line represents the point of equivalency between the reported QPA and the actual IN rate. The horizontal axis is the percentage of the IN rate relative to the QPA, with IN rates below the QPA to the left of the vertical line and represented as negative.

When examining the differences by individual insurers and CPTs, the data shows that (Table 2):

1. For Aetna, in three out of four radiology CPT codes, median IN contracted rates were higher than reported QPAs in all MSAs (and in over 90% of the MSAs for the 4th code).

2. Across BCBS plans, median IN contracted rates were higher than reported QPAs in the majority of MSAs in all four emergency department and critical care services (ED) CPT codes.

3. For Cigna, in three out of four radiology CPT codes, median IN contracted rates were higher than reported QPAs in all MSAs (and in almost 80% of the MSAs for the 4th code).

4. For UHC, median IN contracted rates were higher than reported QPAs in the majority of MSAs in all eight CPT codes.

Table 2.
Share of MSAs with Median Contracted Rates Greater than the QPA by Insurer by CPT

	Aetna	BCBS	Cigna	United Healthcare (UHC)
CPT 70496	**100.0%**	**33.3%**	**100.0%**	**100.0%**
# of MSAs	13	6	9	10
CPT 70498	**100.0%**	**28.6%**	**100.0%**	**100.0%**
# of MSAs	13	7	9	10
CPT 70553	**100.0%**	**50.0%**	**100.0%**	**100.0%**
# of MSAs	13	2	8	10
CPT 74177	**91.2%**	**42.9%**	**78.1%**	**82.4%**
# of MSAs	34	21	32	34
CPT 99283	**68.8%**	**83.3%**	**93.6%**	**50.5%**
# of MSAs	48	54	78	105
CPT 99284	**64.3%**	**82.1%**	**91.5%**	**69.3%**
# of MSAs	70	78	117	150
CPT 99285	**56.2%**	**77.0%**	**85.0%**	**67.9%**
# of MSAs	73	74	120	140
CPT 99291	**72.2%**	**76.5%**	**85.5%**	**95.2%**
# of MSAs	36	34	55	83

V. Conclusion and Policy Implications

This study demonstrates that across insurers, services, and geographies, the reported QPA is frequently below the actual in-network contracted rate. There are several possible explanations for these findings. First,

the QPA methodology itself might be flawed and may not accurately reflect the median of IN contracted rates in the present day. For example, it is possible that increases in contracted rates have outpaced inflation since 2019. In such cases, the QPA calculation methodology would not accurately reflect the current market rate. However, there is no data to indicate this has been the case and in fact survey data suggests that there has actually been *downward* pressure on rates since the NSA was passed.[19] Alternatively, as the ongoing litigation by Texas Medical Association notes, there is a belief that the inclusion of "ghost rates" in the QPA calculation may be artificially deflating the reported QPA. In this analysis, we removed ghost rates for our median IN contracted rate data by limiting our analysis only to those contracted rates for providers of our relevant taxonomies. This could help explain some of the difference in our findings and would reinforce the importance of the court's findings.

Alternatively, the QPA, which is calculated for reporting by the insurers, may be being calculated inaccurately. Limited oversight and ongoing enforcement discretion of the QPA due to pending litigation have created a "black box" in NSA data. Although statutorily required, to date there have been limited audits to assess the accuracy of reported QPAs. This finding is reinforced in analysis of the QPAs reported in the PUF data. For example, in the Q4 2024 PUF data, there are more than 1,000 instances of QPAs being reported as less than $1. General awareness of the market dynamics in healthcare would tell us that this was likely inaccurate. An example is a dispute for CPT code 99284 (an emergency department visit of high complexity) –the dispute has a reported QPA of $0.01. In this case, the PUFs also tell us that the provider won with a prevailing offer 120,000% of the QPA. But if you look further, you find that prevailing offer was $1,196. Far more reasonable than payment aligned with the reported QPA would be.

Importantly, as statute dictates and as the courts have reinforced, the QPA is not the end-all-be-all in reimbursement determinations under IDR. There are a number of reasons why prevailing offers should exceed the QPA. Guidance is explicit in what else must be considered when determining what an appropriate rate of reimbursement is, and CMS has included elements like the training and education of the personnel providing services, previous contracted rates between the payer and the provider, and good-faith efforts to resolve the dispute outside of IDR and through networking.[20] When initiating arbitration, insurers and providers may provide such information to the IDREs to justify their offer. These additional criteria help explain why even if the reported QPAs are rightsized based on the findings of this research, we will likely still see prevailing offers that exceed QPAs in some instances.

None the less, the finding that reported QPAs are frequently below the median of actual IN contacted rates has several implications.

First, it suggests that the insurer-determined QPAs are not a reliable benchmark for the median IN reimbursement rate. To that effect, IDREs, may wish to consider the validity of the QPA as they weigh the various factors when making an arbitration determination. Given that providers frequently win over 80% of IDR disputes, it may be that IDREs already are skeptical of QPAs and instead rely more on transparent, objective and quantifiable data, such as previous and current payment rates.

[19] Americans for Fair Health Care. "Surveys." 2025. https://www.americansforfairhealthcare.org/surveys
[20] United States Congress. "Public Law 116-260—December 27, 2020". https://www.congress.gov/116/statute/STATUTE-134/STATUTE-134-Pg1182.pdf

Second, with respect to employers, who have expressed concerns about the costs that the NSA have on employer and employee premiums,[21] miscalculations of the QPAs potentially create profit incentives for health insurance companies, which may harm the 63% of employer plans that are either partially or fully self-funded. Recent analysis suggests that insurers are incentivized to use below market QPAs, despite the costs of IDR, as it enables increased profit generation through so-called shared savings arrangements and complete passthrough of the cost of the process.[22]

Third, with respect to patients, the study presents a mixed picture. On the one hand, lower QPAs, even if they are inappropriately low, result in lower cost-sharing amounts for patients. On the other hand, if low QPAs drive IDR and plan payment of shared savings fees, the costs to the health plan may be felt by patients as higher premiums. In addition, the ability of insurers to use incorrectly calculated QPAs may financially undermine or even destabilize the medical practices that care for patients, resulting in reduced services and access to care concerns. This is contrary to congressional intent, who designed the NSA to protect patients from OON bills while also preserving sustainable provider reimbursement rates as a means to maintaining patients' access to care.[23]

Finally, the misrepresentation of the QPA identified in this analysis raises questions about previous assessments of the NSA's cost. For example, *Health Affairs Forefront* featured an analysis of the cost of the NSA's IDR process, using the QPA as a proxy for in-network rates and comparing that to the prevailing offer in IDR.[24] It appears inflationary when an IDR determination is presented that is 4x the QPA. However, if the actual median IN contracted rate is 290% of the reported QPA, which was shown in this study, then an IDR determination of around 300% (or 4x) the reported QPA is actually deference to the previously accepted median rate and not inflationary. Based on this analysis, if insurers increased their initial offers to better align with typical IDR determinations, or better yet contracted at reasonable rates, undoubtedly there would be far less submissions into IDR which would reduce administrative expense and could help reduce overall cost of care.

To address these concerns, and protect the integrity of the NSA, governmental enforcement and oversight are paramount. CMS should prioritize alignment of the QPA calculation methodology with statute and end enforcement discretion. Since QPAs are calculated by insurers without transparency or oversight, regular audits with public reporting are not just statutorily mandated, they are necessary to ensure system integrity. The Departments must honor their oversight responsibilities that Congress established in the law.

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[21] The ERISA Industry Committee. Letter to the NSA Tri-Departments. SMB-IDR-Employer-Draft-10-27-25-with-Signatures.pdf. October 27, 2025.

[22] Heller, Richard, et al. "Hidden Incentives Drive IDR Volume and Cost: The Role of Commercial Insurer "Shared Savings" Programs. October 31, 2025. https://www.healthaffairs.org/content/forefront/hidden-incentives-drive-idr-volume-and-cost-role-commercial-insurer-shared-savings

[23] American College of Emergency Physicians. "Letter to Secretaries Becerra, Yellen, and Walsh Regarding the No Surprises Act Interim Final Rule (Requirements Related to Surprise Billing; Part II)." November 5, 2021. https://www.acep.org/siteassets/new-pdfs/advocacy/2021.11.05-no-surprises-act-letter.pdf

[24] Hoadley, Jack, and Kennah Watts. "The Substantial Costs of the No Surprises Act Arbitration Process." August 25, 2025. https://www.healthaffairs.org/content/forefront/substantial-costs-no-surprises-act-arbitration-process