

Why better enforcement of the No Surprises Act is needed now



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President

No one should be afraid to get medical care because of the threat of a surprise bill. That's why, when the No Surprises Act (NSA) took effect in 2022, it was a welcome development for patients and physicians alike.

This landmark law aims to protect patients from unexpected, often devastating out-of-network bills they might receive after receiving care in an emergency, or at an in-network hospital where not every physician or provider was on their insurance plan. The NSA not only protects patients but also promotes fair contracting incentives for physicians and insurers through an independent-dispute resolution (IDR) process.

But fast forward to today, and it's clear that some health plans are undermining both the letter and the spirit of the NSA. Unless federal agencies step in with robust enforcement and transparency, the careful balance Congress created will unravel, putting patient access at risk and threatening the viability of independent physician practices. That is precisely the message (PDF) the AMA and 111 specialty societies and state medical associations are now sharing with federal officials.

I was honored to provide testimony on behalf of the AMA (PDF) at the first congressional hearing on NSA legislation seven years ago, when insurance-industry representatives also shared their views. After hearing our views and deliberating at length, Congress passed a sound law on surprise billing. To have insurers fail to follow its provisions is a source of immense frustration.

How insurers undermine the No Surprises Act

Disturbingly, some insurers are reprocessing claims after a physician prevails in IDR, increasing the patient's cost-sharing amount leaving patients holding the bag. A 2024 study of emergency physicians (PDF) found that half had seen payers increase the cost-sharing amount after an IDR win. That must stop.

Timely payment following an IDR decision in the physician's favor is another issue. Despite statutory requirements for insurers to pay within 30 days after an IDR decision, surveys reveal (PDF)



widespread delays, partial payment, or no payment whatsoever. In 2024, nearly half of payments weren't remitted in time, and a substantial percentage were either incomplete or never delivered.

Additionally, some insurers are exploiting technical guidance (PDF) intended for rare circumstances to broadly revisit previously settled payment determinations, using this as yet another reason to withhold payments to physicians—despite the guidance expressly stating that the 30-calendar-day requirement continues to apply “regardless of whether a request to reopen a closed dispute has been filed.”

Physicians, health professionals and health care organizations, meanwhile, spend countless hours and resources fighting over payment that should be final and timely. For independent physicians like me, completing the work required to successfully submit an IDR claim is a significant challenge in itself; to have an insurer ignore the law afterward is particularly exasperating.

Threat to independent physician practices

Many smaller physician practices cannot afford these payment delays or the repeat IDR fees. As a result, they disproportionately face barriers to participating in the IDR process (PDF) and are instead forced to accept the rates payers offer, even when they are well below market value or what is sustainable to run a practice. These actions can erode physicians' ability to practice independently as well as patients' access to care. Practices can't stay open when reimbursement is unreliable—and patients can't get care when their doctors are forced to shut their doors.

If these insurer tactics are allowed to continue, the results could be felt well beyond individual claims disputes. Many independent physician practices may not survive the continuous low reimbursement rates and administrative barriers to pursuing relief through the IDR process.

That means less competition, reduced choice for patients, and even higher premiums as market power further consolidates among large payers. Failing to enforce the NSA also means surprise bills and unpredictable costs may return, undermining public faith in both the law and the health system.

Realizing the goals of the No Surprises Act

The AMA is invested in the successful implementation of the NSA's balanced framework and is committed to working with regulators and other stakeholders to address issues that may impede that success.

For example, health plans have expressed concern with the prevalence of ineligible claims entering the dispute process. It is often difficult for physician practices to determine if a claim is regulated under the NSA or a state statute, if it meets all the NSA's eligibility requirements, etc. While plans hold the



relevant eligibility information and have opportunities to challenge eligibility from the start, we support regulatory proposals to use remittance codes to clarify eligibility from claim inception and reduce ineligible claims in the system.

Similarly, as the volume of IDR claims is concerning to some, we are dismayed by data showing low participation rates by health plans in the entire negotiations and dispute process. For example, in the last quarter of 2024, 26% of disputes were resolved through a default decision and about 90 percent of default decisions were in favor of the physician or provider, showing low insurer engagement.

To increase engagement in the process and reduce reliance on IDR decisions, we have supported proposals to formalize the dispute system, including open negotiations, and increase participation by the health plans.

Why enforcement matters

Increased enforcement and transparency are the linchpins of meaningful NSA implementation. As outlined by the AMA and our partners in the Federation of Medicine, meaningful regulatory enforcement is needed to ensure that the NSA continues to protect patients from surprise bills and preserve the sustainability of independent physician practices.

The NSA is intended to safeguard patients and create a fair payment system for physicians. Insurers are subverting these protections by shifting costs, reopening closed cases and refusing payments. Regulators must now ensure that central tenets of the NSA including patient protections, fair and prompt payment, and good-faith negotiations are not optional, but standard procedure.

The NSA was put in place after a thorough assessment of surprise billing problems by Congress. But without strong federal enforcement, its effectiveness hangs in the balance. Now is the time for the departments of Health and Human Services, Labor and the Treasury to use their authority to realize the promise of the NSA for everyone who depends on America's health care system.

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

ndp | analytics¹

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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

¹ Nam D. Pham is Managing Partner at ndp | analytics. Marc Dupont provided research assistance. Americans for Fair Health Care provided financial support to conduct this study. The opinions and views expressed in this report are solely those of the author.

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, including⁸:

- 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

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 rates¹⁶), 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

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-gpa-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 expensive, 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**

8 CPTs, 4 Payers, All Unique MSAs

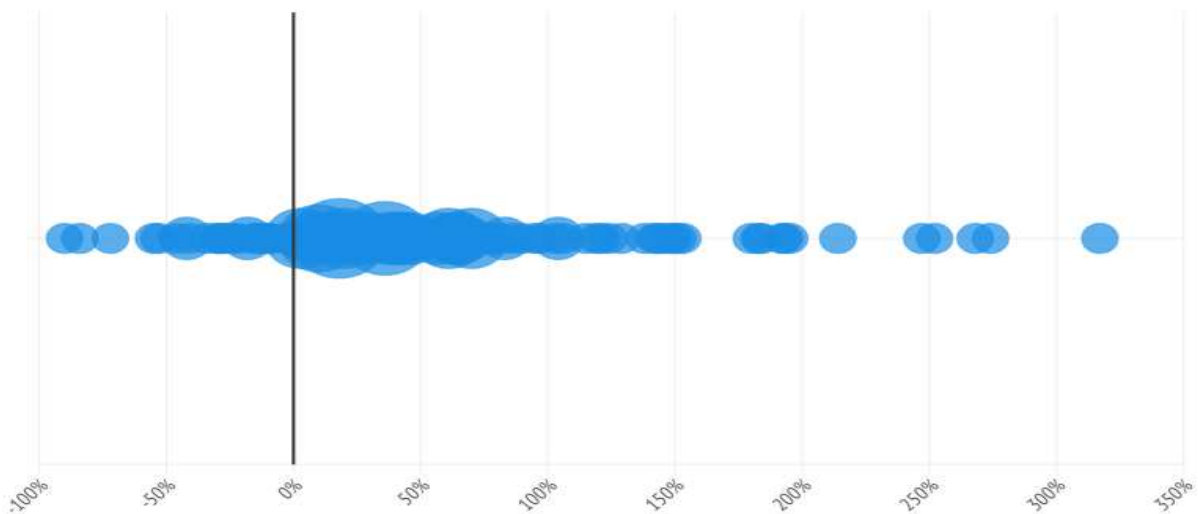


Figure 2: Each blue dot represents one of the 192 analyzed MSAs. The vertical line represents the point of equivalency between the reported QPA and the actual IN rate. The horizontal axis is the percentage of the IN rate relative to the QPA, with IN rates below the QPA to the left of the vertical line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

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>



Insurers Are Squeezing Doctors and Their Patients

By Wendell Potter
September 26, 2025

AP Photo/Don Petersen, File

As health insurers have consolidated and tightened their grip on the U.S. health care system – and in particular on physician practices – doctors increasingly have to spend their days battling red tape, fighting with insurers, and watching their reimbursements shrink while their operating expenses increase every year. Doctors who are determined to resist being bought by an insurer or large hospital system are finding it harder and harder to do so without outside investment.

I frequently speak at physician conferences and I repeatedly hear doctors' concern that private sources of capital are being blamed for the dysfunction in the health care system, deflecting attention away from the harm being done to their patients by the business structure and practices of health insurance conglomerates.

UnitedHealth, Cigna, CVS/Aetna, and Elevance have quietly built vertically integrated empires. They don't just sell insurance. They own pharmacy benefit managers (PBMs), physician practices, urgent care chains, and data clearinghouses. UnitedHealth's Optum unit controls one of the largest networks of doctors in the country. CVS Health has combined its insurance arm – Aetna – with retail pharmacies, PBMs, and growing numbers of clinics.

This is consolidation on a massive scale—far beyond what any physician group could achieve on its own. It is consolidation that directly reduces competition, drives up premiums, and limits patient choice.

Take what came to be called “surprise billing.” The real surprise for many patients isn't that a doctor billed too much.

Rather, their insurance company dropped that doctor from its provider network or narrowed its network so severely that patients had no meaningful choice. Insurers then used the passage of the No Surprises Act as leverage to slash reimbursements further. Doctors are being strong-armed into take-it-or-leave-it contracts that make it impossible to keep their doors open.

Insurers turned a reform meant to protect patients into a tool to expand their own market power.

These dynamics are also fueling a crisis in the health care workforce. Physicians are burning out, retiring early, or discouraging the next generation from entering medicine. The reason isn't "outside investment," but crushing administrative burdens imposed by insurers, including endless prior authorizations, repeated denials, and opaque appeals processes.

Doctors are being forced to work longer hours for less pay, more time spent on paperwork and less time spent with patients. It's no wonder the U.S. faces growing shortages across specialties. Insurer-driven bureaucracy is draining the lifeblood from the profession.

When insurers delay or deny care, patients suffer. Examples abound: a cancer diagnosis that's missed because a scan wasn't approved, a child who can't see a specialist because the network is too "narrow," a parent who's forced to switch doctors mid-treatment because the insurer suddenly dropped the practice.

Such anecdotes are the inevitable outcome of a system in which insurers make money by saying "no." Every denial, every delay, every hoop they make a doctor jump through saves them money and shifts the cost onto families.

Critics of private capital in health care often fail to acknowledge that independent physician practices that have access to the financial resources they need to stay in business and independent are often the ones best positioned to provide high-quality, patient-centered care.

What matters most is whether physicians retain the autonomy to make decisions in the best interest of their patients. Private capital, when structured with physician leadership, can preserve that autonomy and serve as a counterweight to hospital monopolies and insurance takeovers.

Meanwhile, the largest insurance companies have been reporting record profits. They have perfected the art of blaming everyone else—doctors, hospitals, even patients—for high costs. But it is their business model built on consolidation and denial of care that is driving the crisis.

It's time to stop pretending that doctors and patients are the biggest problem. The obstacle to affordability and access are the business practices and structure of big insurance conglomerates. If the U.S. wants to preserve physician independence, protect patient choice, and make health care more affordable, it needs to rein in insurer abuses.

That means enforcing antitrust laws against vertical monopolies, holding insurers accountable when they flout the No Surprises Act to line their pockets, and streamlining prior authorization so doctors can spend more time with patients and less time on hold with insurance clerks.

Doctors should be free to focus on healing, not haggling. Patients should trust that their care decisions are made by physicians, not accountants in the insurance industry's executive suites.

Until the U.S. faces the truth about who is controlling the health care system, it will continue to chase the wrong villains and the crisis for both doctors and patients will only deepen.

Wendell Potter is president of Center for Health and Democracy.

Texas Tried to Enforce Basic Network Standards — The Industry Ran to Court to Stop It

A 2023 law gave regulators new authority to curb widespread network failures after more than 90% of plans fell short.



WENDELL POTTER

MAR 30, 2026



54



10



13

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Readers of HEALTH CARE un-covered know we focus a lot on the barriers health insurance companies have erected that make it harder for their enrollees to get the care they need, including unnecessary and excessive prior authorization requirements, unaffordable out-of-pocket costs and inadequate provider networks.

That third barrier has gotten less attention than the other two, but networks without a sufficient number of clinicians within a reasonable distance of a health plan's enrollees

can be lethal, as ProPublica's Max Blau reported so poignantly in a [story](#) that was dramatized on a New York stage last year.

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A number of states – including Texas – have considered or passed legislation to require insurers to meet network adequacy standards. Three years ago, Texas lawmakers passed a bill with unanimous support that gave the state's department of insurance more authority to bring insurers into compliance.

The Texas Department of Insurance (TDI) testified in 2023, prior to the passage of the bill, that more than 90% of insurers' health plan networks in the state did not meet the statutorily mandated network adequacy standards. You wouldn't think those standards should have been so hard for a health plan to meet. Plans in Texas that serve urban areas couldn't make patients travel more than 30 miles for primary or general hospital care or more than 75 miles to see a specialist or receive specialty hospital care. Rural patients had a 60-mile limit for primary and general hospital care.

Nevertheless, health plans were constantly filing waiver requests with the TDI claiming that for various reasons they couldn't meet those requirements, and the TDI routinely approved the waivers – until the 2023 law went into effect. Among other things, the law limited the number of times a health plan could be issued a waiver, and it required the TDI to ensure that health plans comply with the state's network adequacy standards before allowing them to enroll people in their plans.

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As a result, the TDI began denying some of the waiver requests from the state's insurers – and that has upset the insurance industry so much that the Texas

Association of Health Plans (TAHP) filed a lawsuit to stop TDI from doing what the 2023 law requires.

TAHP claims that some Texas counties don't have enough specialists and hospitals to meet the requirements. But in many cases, insurers are taking actions to "narrow" their networks to meet their investors' profit expectations. UnitedHealthcare's executives told its shareholders during a recent earnings call that it would be doing exactly that (in addition to reducing benefits) – and other insurers have also begun implementing policies to cull their provider networks.

At the end of January, a state court in Austin granted TAHP temporary injunctive relief, saying that it agreed that some insurers could be "unable to continue providing access to their PPO plans." It enjoined the TDI from enforcing its rules "to preserve the status quo pending a final adjudication of TAHP's claims for declaratory and permanent relief."

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Inside Big Insurance's \$1.7 Trillion Year | EP 2

In second episode of the **HEALTH CARE un-covered Show**, we walk you through the most recent earnings reports of seven of the largest for-profit health insurance corporations in the country.

The court said the TDI cannot deny any waiver applications on the basis of a PPO plan's failure to demonstrate "multiple good faith attempts" to comply with state law. The court order also said TDI had agreed to initiate new rulemaking regarding the implementation of the law. A trial on the merits of the litigation is set for October 19, 2026.

I reached out to the Texas Medical Association, which worked with TAHD on the network adequacy legislation, for a reaction to the litigation and got this from TMA President Jayish "Jay" Shah, MD:

The Texas Medical Association has always advocated for robust network adequacy requirements, as they are imperative to promoting patient access to care and providing consumers value for their premium dollars. In that vein, (the Texas network adequacy law) was an important step forward for patients in our state. Notably, it was an agreed-to bill by both the TMA and the Texas Association of Health Plans that set forth a reasonable standard in generally requiring insurers offering PPOs and EPOs to make multiple good faith attempts to satisfy a network adequacy standard in order to be granted repeated [more than two consecutive] waivers from that standard. TMA will stay engaged in the rulemaking on the law as it is revisited. If consumers are paying for these plans, there must be accountability on the side of the health plans to ensure adequate networks in Texas.

The court's decision to grant temporary relief to insurers may preserve the "status quo" — but that status quo is one in which more than nine out of ten health plans in Texas were already failing to meet the state's network adequacy standards. For patients in rural communities especially, that isn't a status quo worth preserving. It's a crisis hiding in plain sight.

What's happening in Texas is a preview of what happens when insurers are held to account for promises they've made to their enrollees — and respond not by building

adequate networks, but by running to court to avoid compliance. The 2023 law passed with unanimous support precisely because lawmakers understood that waiver after waiver was becoming a permanent workaround, not a temporary accommodation.

Network adequacy rules exist for a reason: because when a patient can't reach a specialist within a reasonable distance, the consequences aren't administrative — they're medical. They can be fatal.

The question Texas courts will ultimately have to answer isn't whether insurers find network adequacy standards inconvenient. It's whether health plans that accept Texans' premiums — and in many cases, taxpayer dollars through Medicaid and ACA subsidies — have an obligation to actually provide the care they're paid to deliver.

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Joanne Wright Mar 30



Is it a feature or a bug when access to care (specialized care in particular!) is concentrated in urban areas and elders often live in remote areas.

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Jonathon Glennie Mar 30



Your statement below sums this up very succinctly. Patients are taking a back seat; again....

“The court’s decision to grant temporary relief to insurers may preserve the “status quo” — but that status quo is one in which more than nine out of ten health plans in Texas were already failing to meet the state’s network adequacy standards. For patients in rural communities especially, that isn’t a status quo worth preserving. It’s a crisis hiding in plain sight.”

The above sounds familiar. Through money at it, instead of complying. Network adequacy is a foundational component. Waiving does not serve the system or Patients.

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8 more comments...

How Insurers Are Using the Courts to Rewrite the No Surprises Act

A wave of coordinated lawsuits is transforming the No Surprises Act's arbitration system into a battlefield where insurers seek to intimidate physicians, rewrite the law and consolidate control.



WENDELL POTTER

MAR 11, 2026

♡ 60

💬 19

🔄 17

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As I have written, Congress passed the No Surprises Act (NSA) to safeguard patients from unforeseen medical expenses and establish a neutral, independent dispute resolution (IDR) process for payment conflicts between insurers and out-of-network providers. That design was meant to replace brinkmanship with an independent referee. What Congress designed as a neutral arbitration system is now being challenged by Big Insurance through coordinated litigation designed to narrow, intimidate, and ultimately reshape the law.

Major insurance conglomerates — including UnitedHealthcare entities, Elevance/Anthem affiliates and Blue Cross Blue Shield plans — have launched a coordinated series of federal lawsuits against providers, hospitals, and revenue-cycle vendors who have used IDR at scale. Employing nearly identical language, legal arguments, and allegations, these lawsuits are not isolated ordinary litigation. It is lawfare.

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Narratively, these suits recast lawful engagement in the NSA's IDR process as "abuse," but functionally they are designed to intimidate physicians from seeking NSA protection. A Pennsylvania suit from UnitedHealthcare against NorthStar Anesthesia presents the most urgent and perilous threat to independent physicians. If Unitedhealthcare prevails, insurers will be able to obtain judgments of fraud against physicians who incorrectly file NSA disputes. The effects of this will be catastrophic for independent physician practices, who cannot afford to litigate against billion dollar behemoths that have armies of lawyers on staff and retainer.

If successful in these efforts, the insurers will further weaken physician practices and make them ripe for acquisitions, continuing the dangerous path of vertically integrated insurance corporations – and the further decimation of independent physician practices.

The "Flooding" Myth

The lawsuits all start in a similar fashion. Each one claims that the defendant "abused" federal legislation "designed to protect patients from unexpected medical bills" and asserts that "the IDR process has not functioned as intended." This wording appears verbatim in cases filed months apart, across different jurisdictions, against completely different defendants. Insurers adopt the same basic allegation: providers or billing

companies “flooded,” “overwhelmed,” or “unleashed an “avalanche” of IDR disputes that insurers assert were ineligible.

5. Defendants also initiate an avalanche of disputes against Anthem simultaneously to overwhelm the IDR process and push their ineligible disputes to a payment determination. Their practices include submitting over 950 separate IDR proceedings against Anthem on the same day, nearly all of which were ineligible for the federal IDR process. Overall, nearly 60 percent of disputes from Defendants that reached a payment determination were ineligible for the IDR process. And Defendants’ payment offers on these knowingly ineligible disputes are more than 535 percent of Anthem’s qualifying payment amount (“QPA”), which generally represents the median contract rate for the service.

7. When the NSA was enacted, Zotec saw an opportunity to game the new system. Zotec’s strategy was simple: overwhelm the IDR Process with ineligible items and services, often in ways calculated to increase administrative review time and cost, and profit from the resulting improper awards.

Those characterizations are based on [bad data](#). Before the NSA went into effect, the Departments of Health and Human Services, Labor, and Treasury projected that the independent dispute resolution (IDR) process would see roughly 17,000 disputes annually. In reality, the system received nearly hundreds of thousands of disputes in its first year. That mismatch didn’t happen by accident. The departments based their projections on New York’s experience with a state arbitration system, scaling the state’s dispute numbers nationally. But New York’s law relied on an independent benchmark called FAIR Health that sharply reduced disputes. This is a structural feature the federal law does not have.

A more realistic comparison was available at the time: Texas. Unlike New York, Texas operated an arbitration system without an external benchmark making it a better comparison for the federal No Surprises Act. In its first year, the Texas system received nearly 49,000 arbitration requests for a population of just under six million people. That experience should have been a clear signal that arbitration volume would be far higher than federal projections suggested. Insurers have used this modeling error to their rhetorical advantage in their litigation.

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The image shows a video player interface with a blue background. At the top left is a circular logo with 'HEALTH CARE un-covered' and the number '1'. The main title is 'The Wall Street Chameleon: Big Insurance at an Inflection Point | EP'. On the right, there is a 'Copy link' button with a chain icon. The video content shows two men sitting in chairs facing each other. The man on the left is Wendell Potter, Editor-in-Chief of HEALTH CARE un-covered and a former health insurance executive. The man on the right is Joey Retino, Managing Editor of HEALTH CARE un-covered. A play button is centered over the video frame. The HEALTH CARE un-covered logo is also visible in the bottom right corner of the video frame.

The Wall Street Chameleon: Big Insurance at an Inflection Point | EP 1

*In Episode 1 of the **HEALTH CARE un-covered Show**, we examine what may be an inflection point in the health insurance reform debate. Plus, we're joined by pollster Madeline Conway of Impact Research.*

The volume of claims is treated as proof of misconduct, despite the fact that the statute imposes no limit on IDR submissions and explicitly allows for repeated use when payment disputes continue. Further, insurers base this claim on estimates of IDR submissions that were deeply flawed, forecasting nationwide utilization on the experience of one state.

The message is unmistakable: providers are not accused of breaking the NSA, but rather of utilizing it too effectively. For instance, insurers claim that providers submitted “thousands” of IDR disputes, including nearly “200 overlapping proceedings for the same services” across both the federal and state IDR systems, and batched an average of 66 separate items or services into a single IDR filing: Insurers describe these statistics as “overwhelming,” despite the fact that each dispute is linked to a corresponding payment denial or gross underpayment.

Recasting Physician Disputes as “Fraud”

Each lawsuit hones in on physician NSA disputes and castigates them as some kind of “fraud” or “abuse.” The HaloMD lawsuits are a prime example of the insurer taking an NSA dispute, challenging the disputes eligibility for arbitration and then recasting it as “fraud.” What these lawsuits notably fail to recognize is that the outcomes of IDR are determined by independent arbitrators, called certified IDR entities (IDREs), not by the providers themselves.

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According to CMS’s public-use files, 82% of 2024 disputes and 80% of 2025 disputes were found eligible for arbitration. This is orders of magnitude greater than what the government had estimated. What these numbers tell us is that the problem with the volume of disputes is not a conspiracy by doctors to abuse this system, but systemic underpayment by insurers, as we have reported.

In the lawsuits, insurers concede that it was the arbitrators, not the providers, who rendered the final awards in these disputes. Insurers also consistently and publicly voice their concerns that NSA awards surpass the Qualifying Payment Amount (QPA),

often describing results that are 'multiples' of the median in-network rates or even exceeding billed charges. Insurers assert that IDR awards are excessive, "citing CMS data showing that they are on average slightly over 300% of the QPA" of the QPA.

However, a recent [analysis](#) shows that the reported QPAs consistently underestimate the actual median in-network rates, with an average discrepancy of 290% in cases where such discrepancies are present. A pervasive problem reported by providers and evident in the public-use files shows thousands of initial offers for payment that amount to less than a dollar. In one documented case involving high-acuity emergency care, the insurer calculated the QPA at \$0.01. The arbitrator ultimately awarded \$1,196. The gap was not evidence of an inflated charge; it was evidence that the benchmark itself was flawed.

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This underestimation is attributed to calculations controlled by insurers, insufficient oversight, and the omission of market factors that Congress mandated arbitrators to consider.

Simply disagreeing with an IDRE's assessment does not equate to fraud. Rather than modifying payment practices, enhancing negotiations, or pursuing legislative clarity, insurers have opted for litigation as a tool to crush providers while claiming unfavorable arbitration results as evidence that the system is being "manipulated." They are both arsonists and firefighters.

The Litigation Boa Constrictor

Across jurisdictions, insurers clearly claim that defendants engaged in "coordinated enterprises," "strategic partnerships," or "associations-in-fact," alleging RICO violations founded on the concurrent use of IDR, common billing vendors, and simultaneous filings, even though there is no statutory restriction against coordinated IDR usage or shared administrative frameworks.

The recurring themes in these filings are hard to overlook. In the last 12 months, there have been 11 lawsuits targeting use of the *No Surprises Act*, four alleging RICO violations and five seeking treble damages.

So far, this coordinated lawfare effort includes the following suits:

- Blue Cross Blue Shield of Texas v. HaloMD et al. (E.D. Tex., Aug. 2025)
- Blue Cross Blue Shield of Texas v. Zotec Partners, LLC (E.D. Tex., Dec. 2025)
- Anthem Health Plans of Virginia v. AGS Health / SCP Health et al. (W.D. Va., Nov. 2025)
- Community Insurance Co. (Anthem Ohio) v. HaloMD et al. (S.D. Ohio, June 2025)
- Blue Cross Blue Shield Healthcare Plan of Georgia v. HaloMD et al. (N.D. Ga., May 2025)
- Anthem Blue Cross (CA) v. HaloMD et al. (C.D. Cal., July 2025)
- Anthem Blue Cross (CA) v. Prime Healthcare entities (C.D. Cal., Jan. 2026)
- UnitedHealthcare of Pennsylvania, Inc. v. NorthStar Anesthesia of Pennsylvania, LLC (E.D. Pa., Dec. 2025)
- UnitedHealthcare Insurance Co. v. Maui Emergency Care Physicians, LLC (D. Haw., Jan. 2026)
- United Healthcare Services, Inc. v. Concord Company of Tennessee, PLLC (W.D. Ky., Jan. 2026)
- UnitedHealthcare Ins. Co. v. Radiology Partners, LLC (D. Ariz, Aug. 2025)

These prosecutions follow a distinct pattern of allegations: strategic batching, simultaneous filings, excessive offers, false statements, and an alleged conspiracy to take advantage of IDR. Even when the factual circumstances vary, the narrative remains the same. This consistency indicates not an independent discovery of wrongdoing, but a calculated strategy.

The targets of these lawsuits represent the full spectrum of organizations utilizing the NSA. From revenue cycle management (HaloMD) to large physician staffing organization (SCP) to small physician practice management group (Concord Company), insurers are constricting the entire provider community hoping to alter the NSA through legal outcomes.

Litigation as Press Release

The litigation involving Prime Healthcare highlights this strategy particularly well. In this case, insurers openly admit that hospitals are utilizing IDR instead of balance billing patients, precisely what Congress intended, yet they still label this behavior as abusive because it led to payments that were higher than what insurers were prepared to offer. Lawful reliance on IDR is recast in this complaint as “extractive,” “indiscriminate,” or “profitable abuse,” as if the issue lies not with insurer underpayment but with the presence of an independent referee who has the authority to disagree with them.

The impact on the real world is far from just a theory. These lawsuits aim for treble damages, annulment of arbitration awards, and injunctions intended to completely deny providers future access to IDR. The message from insurers is clear: engage in the IDR process established by Congress, and you will face consequences. Providers who utilize IDR are not seen as legitimate participants in a federal program; instead, they are viewed as targets, labeled as racketeers, pulled into costly litigation, and compelled to defend their right to contest underpayment. These lawsuits serve as a deterrent and act as a warning to discourage providers from engaging in IDR by making the costs of participation excessively burdensome.

Breaking the NSA Balance

No lawsuit will have more far reaching consequences for physicians than *UnitedHealthcare v NorthStar Anesthesia* (the insurer has filed five similar lawsuits). While this suit follows the usual script of allegations it aims for something more pernicious than unflattering headlines: declaratory judgment of fraud for ineligible disputes. The eligibility of an NSA dispute rests solely with CMS and the independent arbitrator – they are administrative. Physicians have [repeatedly shown](#) that insurers withhold critical information needed to determine a claim’s eligibility, the result being that occasionally physicians will dispute a claim that is ineligible for arbitration. According to CMS, with more than 80% of claims sent to arbitration being determined as eligible, these mistakes are the exception, not the rule.

However, if *UnitedHealthcare* is granted the relief it seeks, insurers will be able to challenge dispute eligibility in court, outside of arbitration, and receive direct judgments of “fraud” against physicians who have filed ineligible claims. A declaratory judgment of fraud would not simply reverse a payment. It would create precedent

allowing insurers to relitigate administrative eligibility decisions in federal court and seek damages for disputes that arbitrators have already accepted into the federal process. This elevates an administrative error into reputational and legal risk that no physician practice could withstand.

The NSA's public policy goal of removing patients from billing disputes, was buttressed by leveling the playing field between physician practices and insurance behemoths. The sweeping effects of this case will fundamentally alter the scales in favor of insurers and not just chill, but shut out doctors from obtaining fair reimbursement.

Shifting the balance of power

This situation should alarm policymakers as well as doctors and their patients. It embodies the risk of extended, multi-faceted litigation initiated by trillion-dollar insurance conglomerates targeting individual physicians, small practices, and safety-net hospitals that do not possess equivalent resources.

This pressure does not safeguard patients. Instead, it discourages providers from contesting underpayment, shifts the balance of power firmly back to insurers, and dissuades the use of the very system intended to resolve disputes and protect patients. In the meantime, insurers leverage extensive financial resources to maintain coordinated litigation efforts while depicting providers, especially those offering emergency care, as wrongdoers for employing the only legal remedy available.

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Ultimately, these legal actions are not aimed at preventing misconduct. Instead, they focus on altering market structure. By transforming the routine application of IDR into a significant litigation risk, insurers are indicating that independent providers who challenge payment terms will face penalties instead of negotiations.

The foreseeable outcome is the consolidation of providers: small practices, emergency physician groups, and safety-net hospitals will be compelled to sell, affiliate, or close rather than endure the costs and uncertainties associated with defending against repeated federal lawsuits. As we've reported, Optum now [employs](#)

more than 90,000 clinicians. Simultaneously, this approach accelerates the vertical integration of insurers, directing care toward entities that are either owned or aligned with insurers, which are shielded from payment disputes and arbitration. Within this context, the courts do not serve as a venue for resolving conflicts; they function as a mechanism for enforcing market discipline. This undermines the fundamental objective of the No Surprises Act to balance bargaining power and, in turn, reinforces insurer dominance over pricing, networks, and access to care.

A law meant to protect patients and equalize bargaining power is being weaponized by insurers to suppress those who question insurer payment practices and, in doing so, to silence the underdog.

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Bill Ejzak Mar 11



Another reason to hate health insurance companies and wish for Medicare for all.

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2 replies



Jack Mar 11



Sorry, there has been abuse of the NSA. In fact, should the current structure continue, should providers prevail in the litigation you identify above, it is participants who will see their costs substantially increase.

You forget that point of purchase cost sharing, deductibles, copayments, coinsurance, excluded charges, are only one part of the cost equation for individuals. The indirect cost to covered individuals are the premiums for coverage:

- Those paid directly, as the cost of coverage increases, the amount employees and individuals are charged has consistently increased through cost sharing, and through cost shifting, and more importantly,
- For those who have employer-sponsored coverage, every dollar the employer spends on providing health coverage is, clearly and intentionally, equal to the reduction in wages that would otherwise be paid to workers.

NSA was simply a way for Congress to buy votes, without spending any money, using a structure that did nothing to reduce actual health care spending. Simply, the NSA shifts costs, hiding and reallocating a portion of the ever increasing cost of medical services.

Yes, you see your out of pocket spend capped, and that looks very attractive to that individual. Yes, you do see your contributions increase as the cost of coverage increases. However, none of the increase can be directly attributed to the stupidity of the NSA. And, no, you never see the impact on your wages from the cost shifting that is part of the NSA structure, when employers increase their contributions as the cost of coverage increases.

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The Economic Exploitation of Independent Physicians by Insurers

Stranded in the market – independent physicians are surrounded by insurer sharks.



SETH GLICKMAN

FEB 18, 2026

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12

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Imagine you're a full-time ride-share driver. You just bought a new car, insured it for commercial use, and rearranged your life around peak demand hours. A few months in, the ride-hailing platform slashes your per-ride pay by 50% percent. You're technically "free" to quit, but, practically, you're trapped. Your car payment, insurance, and your rent don't vanish because the company single-handedly changed the rules to squeeze more profit from your work.

Independent physicians, especially those in primary care, live a strikingly similar reality. They invest years in education and training before taking on the substantial

costs of running a practice: rent, staff salaries, electronic health records, and equipment. They also hold the responsibility of caring for thousands of patients who depend on access and continuity of care. Then commercial health insurers present contract “offers” at 50% percent of already inadequate Medicare rates, treating the exchange as a “negotiation.” On paper, doctors can walk away. In practice, they can’t. The fixed costs, patient commitments, and limited commercial payer alternatives mean they must accept unsustainable rates or risk dismantling the practices their communities rely on.

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At first glance, this might seem implausible. We are accustomed to hearing about [health systems that command 200-300% of Medicare rates from commercial payers](#) just to “stay afloat.” Yet the story is very different for independent physicians. When I worked as a strategic advisor to an innovative company delivering holistic preventive care to women, we encountered a large, for-profit insurer in a major U.S. state offering just 40% of Medicare (with a straight face, mind you!). The final offer (which we ultimately declined) wasn’t much higher. For context, this translates to roughly \$40 for a typical 30-minute office visit (CPT 99213 – moderate complexity). It equates to a payment to the physician of approximately \$40 while the average practice costs about [\\$300 per hour](#) to operate. Forty dollars might cover a coffee and bagel run for the staff but certainly not the cost of care delivery.

Across the country, these low commercial reimbursement rates for independent primary care physicians are widespread. Here are examples of median practice-level commercial payments for CPT 99213, as a percentage of Medicare, in several states:

- **New York:** 56.0%
- **California:** 67.8%
- **Florida:** 72%

- **North Carolina:** 80.8%
- **Alabama:** 84.9%
- **Tennessee:** 88.5%

These translate to reimbursement per visit that isn't even close to breaking even.

Is it any surprise that fewer trainees choose primary care and that many established physicians are retiring early or leaving medicine altogether? If these trends continue, we are facing a [projected physician shortfall of 80,000–90,000](#) by the late 2030s.

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While many factors contribute to this crisis, the systematic devaluation and economic exploitation of independent physicians by insurers is a major - and addressable - driver.

Policy Actions to Restore Fairness

Here are two structural remedies that policy makers at the state and federal levels should consider.

1. Establish a minimum payment floor for independent physicians

[The AMA has explored this concept but determined it was](#) not compatible with its existing positions. But given the current market failure, in which insurers and large hospital systems hold monopoly power and generate record corporate profits while income for independent physicians stagnate, this solution warrants renewed consideration. Commercial payers should be required to reimburse physicians at fair, transparent levels based on established benchmarks like Medicare rates, with geographic cost adjustments.

2. Modernize network adequacy standard for primary care

Insurers can underpay independent physicians precisely because outdated standards allow them to claim "adequate networks" and therefore have minimal incentive to add new ones. Traditional time and distance standards are decades old and ignore the real-world shortage of available primary care access. Many

physicians have closed their practices to new patients (or severely limit them), are retiring, or have excessively long wait times to get an appointment. Across the U.S., the average new-patient wait times now exceed **31 days** and are rising. Network adequacy should account for actual appointment availability and active patient panels. Regulators could also require insurers to admit any qualified independent clinician into their networks at fair rates. I am not suggesting that primary care physicians are worse off than ride-share drivers. But when the people who we entrust with our health and well-being face similar exploitation (and are subjected to the same churn, instability, and one-sided terms), it signals a deeper market failure. The gig-ification of medicine should alarm us all.

3. **Accelerate the transition to advanced payment models**

Provide physician practices with more predictable funding and real financial upside for improving outcomes. In these models, practices are rewarded for keeping patients healthier and reducing avoidable hospitalizations, not just for delivering more visits and procedures. By contrast, many payers are simply cutting baseline fee-for-service rates, then offering physicians the chance to earn some of that money back through bonuses and calling it "value-based care." That approach is unsustainable and effectively becomes a race to the bottom for primary care reimbursement (and a profit-making machine for insurers).

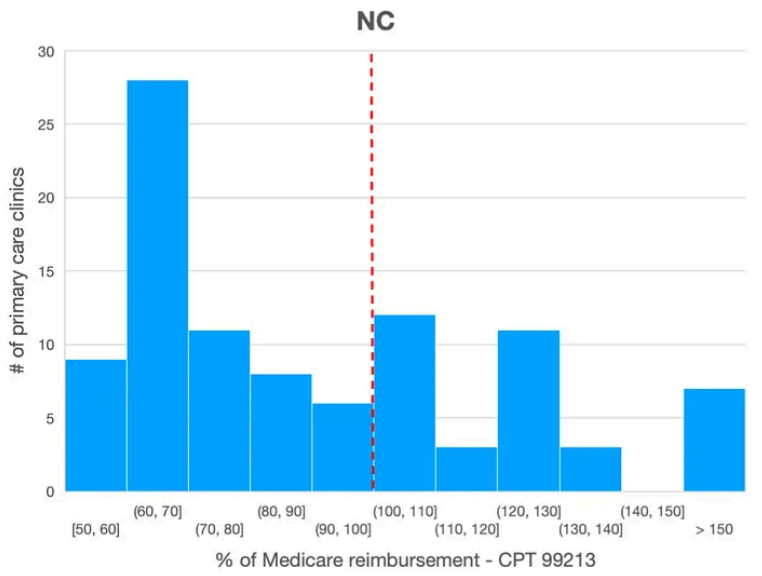
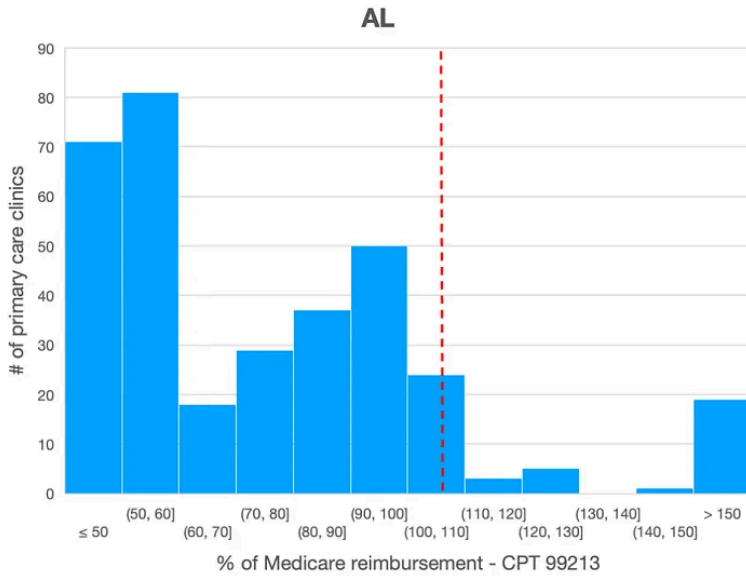
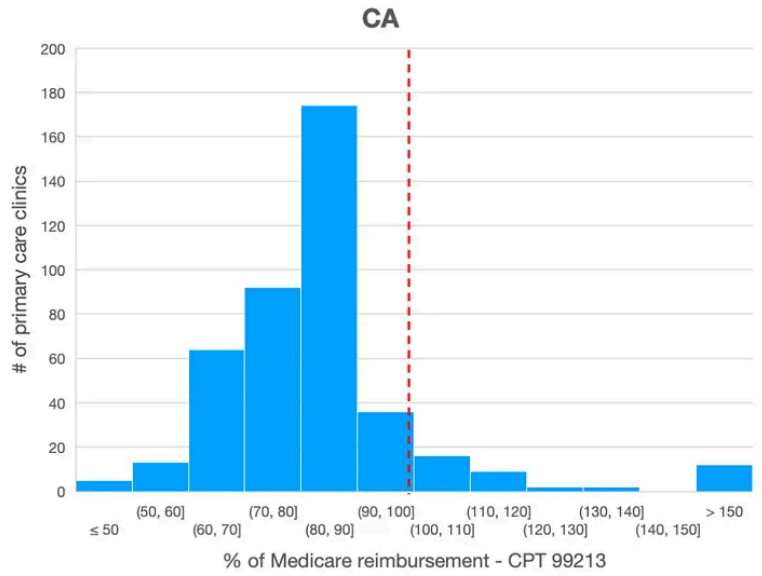
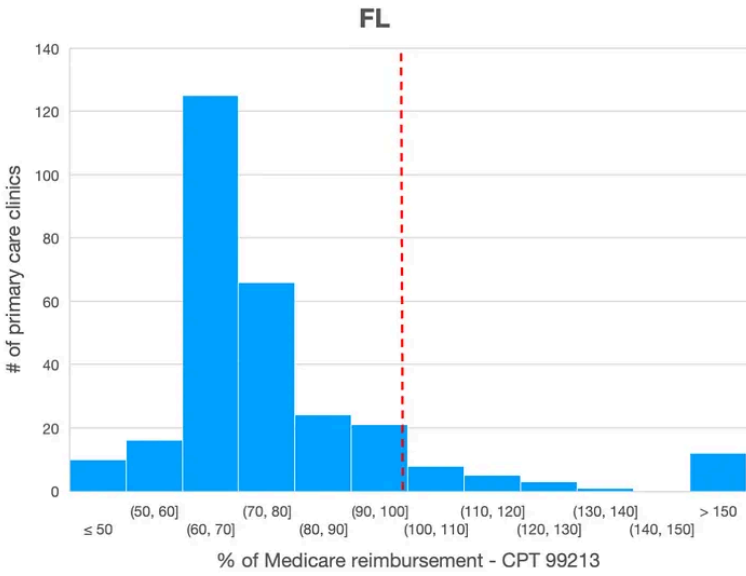
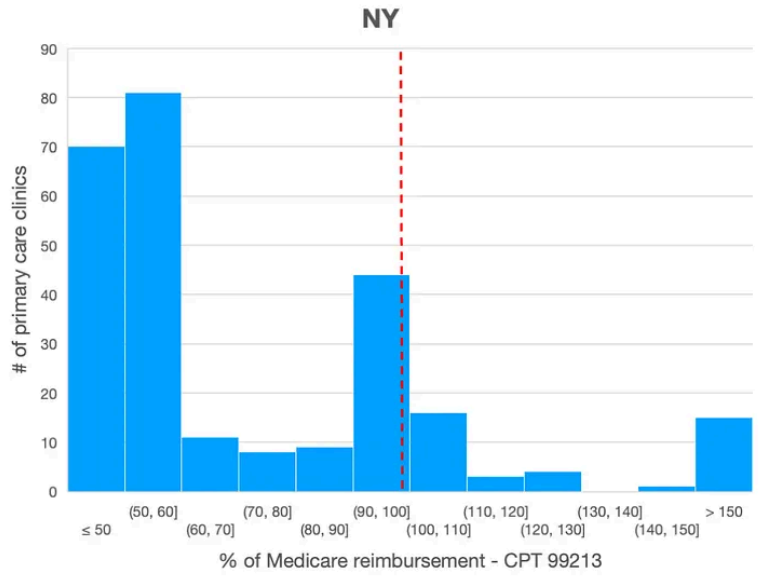
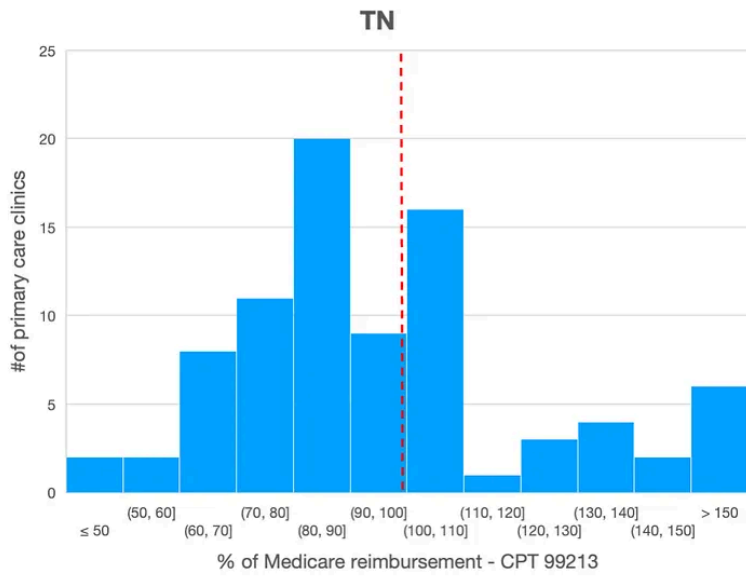


Exhibit: Commercial reimbursement rates for independent primary care physicians for a Level III Evaluation and Management (E&M) office visit.

Data is from the 2025 CMS Transparency in Coverage dataset. Filtered for independent primary care physicians. Median rates displayed. The red line is the

reference Medicare reimbursement rate.

Seth Glickman, MD, is a former insurance and health system senior executive. He now is a researcher and advocate for reform in the health care finance space.

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Restacks



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PJ Ortmann  Feb 18



Thank you for this article, and not to diminish any of what was shared on the Physician Business front, but as a Pharmacist for almost 50 years in multiple practice settings, I have worked for 3 family pharmacies which closed due to under-reimbursement.. Independent Pharmacies (and even chains such as RiteAid) are closing at a sinful if not critical rate due to under reimbursement from PBMs and their vertically integrated Insurers. Not only are PBMs not paying anything near the overhead required to operate a Pharmacy, they are not even covering the cost of the drug which must be purchased by the Pharmacy in order to fill the patients' prescriptions, and Pharmacy revenue is solely based on dispensing a product, and not for any professional services (Ever try to

"just ask a question" of a lawyer without receiving a bill?). In addition to supporting the big 3 PBM (controlling 80% of all Rx's filled) multi-billion dollar middlemen, these business closing are creating Pharmacy deserts where patients no longer have access to a local pharmacy/pharmacist for their medications and services. For-profit Healthcare is financially unsustainable - Break up these Monopolies NOW!

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1 reply



Gloria J. Maloney  Feb 18



What do you mean by the healthcare finance space? The U.S. has been financialized to death. Apparently, your industry, the healthcare financial solutions market, is a 130 billion dollar industry. Why can't we have single-payer universal healthcare? What is government for? Isn't it supposed to be to provide collectively what we cannot provide for ourselves individually? Enough with the band-aid add-ons to healthcare in the U.S. Pay healthcare providers a decent wage after publicly funding their education. Simple and done!

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2 replies

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No Surprise: The Volume of NSA Disputes Was Predictable

How the No Surprises Act's Volume Crisis Was Baked In From the Start



PATRICK VELLIKY

MAR 23, 2026



“Flooding the system” is a line you read in almost every piece of journalism about the *No Surprises Act* (NSA) and efforts by doctors to obtain fair reimbursement under its Independent Dispute Resolution (IDR) process. Recent academic and insurer studies have tried to recast usage of IDR as profiteering, with the discrepancy between initial estimates and real-world usage presented as “abuse.” HaloMD has repeatedly faced these claims. While this talking point appears academic and evidence-based on its face, it’s premised on a foundation of bad data.

A few years ago, in [Health Affairs Forefront](#), I argued that one of the most persistent implementation challenges for the NSA has been volume — not because the law is flawed, but because the methodology the federal government used to estimate its usage was. This is not my subjective opinion, but rather, **objective fact**. Avoidable mistakes in methodology led to a dramatic underestimation of how many disputes the system would actually need to process.

That miscalculation continues to shape the debate today. It’s been repeated by well-intentioned observers, but weaponized by disingenuous opportunists.

If we want to improve the functionality of the NSA and the IDR process, we have to start by revisiting how the tri-departments — Health and Human Services, Labor, and Treasury — arrived at their original projections. There will be math, but stick with

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A Modeling Error That Built the Backlog

Before the NSA went into effect, the tri-departments estimated that the federal IDR system would see roughly 17,000 disputes annually.

In reality, the system received 489,000 disputes in its first 14.5 months — an annualized run rate of roughly 405,000 disputes per year. It's currently on track to surpass 2 million annual disputes.

That is not a marginal miss. It is an orders-of-magnitude error. The question is, “why?”

The answer is, the departments based their estimate entirely on New York's IDR experience. They took the approximately 1,000 annual disputes observed by New York and scaled them nationally by calculating New York's share of the employer-sponsored and privately insured population — roughly 5.7 percent of the national total — yielding the 17,000 figure.

So, what's wrong with this approach? First, the Departments failed to differentiate between New Yorkers enrolled in state-regulated plans (and therefore subject to the state's balance billing law) and those with plans regulated by the federal Department of Labor (which cover the majority of Americans and are NOT subject to state law), when determining the denominator for the volume estimation. But much worse, the methodology ignores the fact that New York's law was not an apples-to-apples model.

New York's law required the use of FAIR Health data as the benchmark for out-of-network reimbursement and effectively carved out emergency medicine disputes by

tying those out-of-network payments to an independent external standard known as “usual and customary” rates. The federal NSA did not adopt that structure. Instead, disputes across all relevant medical specialties, including emergency medicine, are resolved by an independent arbitrator that must consider a range of factors when making its decision.

That difference matters.

New York’s system structurally eliminated disputes from the specialty most likely to result in an out-of-network visit: emergency medicine. The federal system does not, and unsurprisingly, over half of all federal disputes involve emergency medicine. Forget apples-to-oranges, this is more like comparing apples-to-omelets.

The Model that was Ignored

Texas offered a more relevant model, and [usage data](#) was readily available.

Texas’ balance billing law had:

- An arbitration process,
- No carve-out or anchor for emergency medicine,
- A structure more generally analogous to the federal NSA.

In its first year after enactment in 2020, the Texas Department of Insurance received nearly 49,000 dispute resolution requests. That law applied to approximately 5.8 million Texans.

Let’s walk through the math, using the exact same underlying methodology used by the Departments, but substituting New York’s data for Texas’. Texas’ law applied to about 5.8 million Texans, who were enrolled in state-regulated insurance plans. At the same time, the national employer-sponsored and privately insured population was approximately 183 million people, so:

5.8m covered Texans \div 183m insured nationally = .0317, meaning Texas' experience represents about 3.17% of the relevant national insured population

49,000 disputes \div .0317 = **1,546,000 estimated annual disputes**

That is the volume the federal government might have anticipated had it selected Texas as its baseline rather than New York.

Instead, the system was built for 17,000.

The Consequences of Underestimating Volume

When a system is built for 17,000 disputes and receives hundreds of thousands, predictable failures follow:

- Misaligned administrative cost projections
- Uninformed policy making
- Eligibility delays
- Backlogs are measured in months, not days

These failures are then mischaracterized as the result of “abuse” rather than model error. Volume has become a controversy. But the volume was predictable.

Overall Impact

The debate around the IDR process has often framed high volume as evidence of provider overuse or something even more nefarious.

But if the system was underbuilt from the beginning because it relied on a structural suppressed model, then volume is not an aberration; it's something we can forecast

Texas should have been the focus because:

- It applied to all of the same specialties as the NSA
- It utilized an IDR process structured similarly to the NSA's
- Usage data was readily and publicly available

The proposed reforms to strengthen IDR infrastructure — including enhanced eligibility determination and improved portal transparency — are necessary. But they also reflect a recognition that the original capacity assumptions were flawed.

We cannot fix what we misdiagnose. Those who continue to rely on a misdiagnosis to treat a problem should be viewed with significant skepticism, as they are either uninformed or intentionally attempting to deceive.

If we continue treating volume as abuse rather than as a foreseeable outcome of flawed modeling, we risk undermining the very reforms the NSA created.

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Chief External Affairs Officer, HaloMD. Former House and Senate staff. Health policy sponge. No Surrogate Act and Independent Dispute Resolution expert. Nerd. Opinions are my own.

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How Private, For-Profit Health Insurance Fails the Most Basic Test of Economics

How profit-driven incentives and structural market failures have shaped the U.S. health insurance system and why it continues to fall short for patients.



WENDELL POTTER

APR 16, 2026

111

78

48

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Today, I will be speaking at a University of Chicago forum with the provocative title, "Can Capitalism Be Popular?" I'll be on a panel that will explore health care, life expectancy and quality of life in the U.S. and how we stack up with other rich countries. Spoiler alert: We don't fare well in international comparisons, but I think most of you know that already. We'll be talking about why that is and why it has been this way for decades now.

This is not the first time I've been here. I've met with faculty members and spoken to graduate students several times over the years at the Booth School of Business. One of the things we've talked about is how the U.S. system of health insurance is as good of an example of market failure as you can find anywhere in the world and at any time in history. Or to be more precise, it is a failure for people who need health care. It is by no means a failure for health insurance company executives and shareholders.

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It is somewhat ironic that this forum is at the same university that gave us Milton Friedman, the economist who in 1970 argued that the sole purpose of a publicly traded company is to increase its profits and maximize returns for its shareholders. Friedman believed that social issues should be addressed by individuals and governments, not by corporate executives in their business roles. His views became gospel on Wall Street, and he won a Noble prize.

I know of no industry that has embraced Friedman's doctrine more than the executives of big health insurance companies. When I was at Cigna, my colleagues and I were evaluated annually on how well we met our "major job objectives," and at the very top of those MJOs was "enhancing shareholder value". And that wasn't just *my* top objective. It was everybody's top objective.

In my humble opinion, that slavish devotion to meeting the needs first and foremost of shareholders is the main reason the health insurance industry has failed us in so many ways. Let me explain why I believe that is.

Americans are told, over and over, that the solution to whatever ails our health care system is more competition, more choice, more market forces. It's a seductive argument — markets have proven to be powerful engines of efficiency and innovation in countless industries. But this argument rests on a fatal flaw that many economists, including many here at the University of Chicago, recognized decades ago: health

insurance is not, and cannot be, a normal market. It is, in the precise technical language of economics, a case of market failure — and a nearly perfect one at that.

As most of you all know by now, I spent nearly two decades as a senior executive in the health insurance industry — four years at Humana, then almost sixteen at Cigna. I'm not here to single out any one company. What I witnessed was not unique to either of them. It is how the industry works, by design, across the board.

What Markets Require — and What Health Insurance Lacks

For a market to function efficiently, a few basic conditions have to hold. Buyers and sellers need roughly equal information. Consumers need to be able to choose freely — or walk away. Competition needs to be real. And prices need to reflect actual costs.

Private health insurance fails every one of these tests. This isn't a progressive talking point. It's the conclusion of mainstream economics, and it started with a 1963 paper that every health economist in the world has read (and I bet Milton Friedman read it too).

Kenneth Arrow — who like Friedman was a Nobel laureate — published "[*Uncertainty and the Welfare Economics of Medical Care*](#)" in the *American Economic Review* that year. His argument was technical, not political: health care markets are structurally different from ordinary markets, riddled with the kinds of information problems and uncertainty that make the standard competitive model break down. That paper has never been seriously refuted. It gets assigned in Econ 101 at universities across the country. The health insurance industry just prefers you haven't read it — (and even I hadn't read it until late in my corporate career).

The specific failure Arrow identified first is information asymmetry. The insurer knows vastly more than you do about what your policy actually covers, how your claims will be adjudicated, what your insurer's network restrictions really mean, and how prior authorization works in practice. You find out what you actually bought only when you get sick — precisely when you're least able to shop around or switch. That's not a market. That's a trap with a welcome packet.

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A related problem is adverse selection: the people who most need insurance are the most motivated to buy it, which drives up costs, which drives out healthier enrollees, which drives costs higher still — the so-called “death spiral.” This dynamic is so well understood that every functioning insurance system in the world uses some mechanism to counteract it: a mandate, a public option, or direct government provision. The ACA’s individual mandate (which was scuttled when Republicans took back control of Congress) wasn’t a liberal invention. It was a direct policy response to a textbook economic problem that even conservative health economists had long acknowledged.

The Consumer Who Cannot Walk Away

Markets depend on exit, meaning that if you don’t like the product, you stop buying it. Or you switch. Or you go without.

Health care eliminates all three options.

You can’t negotiate the price of an emergency appendectomy. You can’t comparison-shop for a cardiologist mid-heart attack. And you can’t go without coverage if you have any assets to protect — because the financial exposure is catastrophic. Research by David Himmelstein and colleagues, [published](#) across multiple studies in the *American Journal of Public Health*, has consistently found that medical debt is a leading contributor to personal bankruptcy in the United States — a problem that simply has no parallel in peer nations.

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Economists call this inelastic demand: prices can rise sharply without much reduction in how much people use the product, because the alternative is suffering or bankruptcy. When demand is inelastic and the product is a necessity, producers have enormous power. Insurers can raise premiums, hike deductibles, narrow networks,

tighten prior authorization — and most enrollees have no real choice but to absorb it. This is not a functioning market. It is a captive one.

Monopoly Power Dressed Up as Competition

You've probably seen the ads. Every major insurer presents itself as your partner in health, competing fiercely for your trust and your business. The reality is rather different.

The American Medical Association publishes an [annual report](#) on health insurance market competition, and the findings are consistent year after year: by federal antitrust standards, the majority of U.S. metropolitan insurance markets are highly concentrated, meaning one or two insurers hold dominant market share. In many rural areas, there is effectively one insurer. That, folks, is not competition.

The consequences are exactly what economics would predict. Harvard Business School economist Leemore Dafny has [documented](#) in peer-reviewed work that insurer mergers are associated with *higher* premiums — not lower ones. The efficiency gains the industry promises from consolidation don't materialize for consumers. What materializes is pricing power.

The nominal competition that does exist is often a race to enroll healthy people and avoid sick ones — risk selection — which generates profits for shareholders without producing a single unit of medical value for patients. When your business model's most profitable strategy is to avoid delivering your core product, you are not in a normal market.

The Profit Motive, Inverted

A company that makes a better product more efficiently earns more money, and everyone benefits. That feedback loop is what makes markets powerful. But in health insurance, the loop runs backward.

An insurer earns more profit by collecting premiums and not paying claims (as in, by denying coverage, delaying reimbursement, shrinking networks and deploying AI systems designed to find technical grounds to reject care. What's being sold is the

promise of coverage while the profit comes from limiting how much of that promise gets kept.

In 2023, the five largest U.S. health insurers (UnitedHealth Group, Elevance, CVS Health/Aetna, Cigna and Humana) reported more than \$70 billion in operating profits. Over the same decade, the Kaiser Family Foundation's annual [Employer Health Benefits Survey](#) found that average family premiums for employer-sponsored coverage rose more than 50% which far outpaced both inflation and wage growth. Shareholders did well. Patients did not.

Economists call this a "principal-agent problem." The insurer is nominally your agent which is the entity managing your health care on your behalf. But its financial incentives run directly against yours. That's baked into the business model across the entire industry.

The ACA's [Medical Loss Ratio](#) (MLR) rule (which requires insurers to spend at least 80–85% of your premium dollars on actual medical care) was a direct legislative acknowledgment of this failure. Think about what that rule implies: Congress had to pass a law to force an industry to deliver its own product. When regulation has to exist just to make a market approximate its basic function, that market has failed.

The Costs Everyone Else Pays

Markets also fail when the real costs of a transaction fall on people who had no say in it — what economists call negative externalities. The private insurance system produces these by the truckload.

When a patient is denied coverage and delays treatment, they often end up in an emergency room — at everyone else's expense. EMTALA, the federal law requiring ERs to treat all patients regardless of ability to pay, exists precisely because society decided it would not let the insurance market's failures play out to their logical conclusion in hospital parking lots. The cost of that moral decision gets distributed across hospital budgets, public programs, and your premium.

Job lock — staying in a job you'd otherwise leave because you can't afford to lose your coverage — is another hidden cost with real economic consequences. Brigitte Madrian's [research](#), published in the *Quarterly Journal of Economics*, showed that

employer-based insurance meaningfully reduces labor market mobility, suppressing the kind of dynamic, fluid labor markets that economic theory promises. The insurance industry doesn't pay that cost. Workers do.

And the tens of billions in annual uncompensated care — treatment delivered to uninsured and underinsured patients who can't pay — gets cost-shifted to private payers and publicly subsidized. Insurers collect the premium. Society absorbs the spillover.

What the Evidence Actually Shows

The economic case against the current system is not fringe. It is mainstream, durable, and empirically overwhelming.

Uwe Reinhardt, the Princeton health economist and perhaps the sharpest analyst the American system ever produced, spent decades making this argument with meticulous rigor and zero tolerance for ideological hand-waving from either direction. His posthumously published book, *Priced Out* (Princeton University Press, 2019), is the most devastating single-volume indictment of American health care financing you can read — and it was written by a man who had no interest in scoring political points.

The Commonwealth Fund's annual international comparisons [tell the same story with data](#). The United States consistently ranks dead last or near-last among high-income nations on access, equity, and administrative efficiency — while spending roughly twice as much per capita as comparable countries. We pay more. We get less. We leave tens of millions uninsured or underinsured. And we do it in the name of market competition that the data show isn't actually happening.

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Every other wealthy country has responded to these market failures with universal coverage — through single-payer systems, tightly regulated multi-payer models, or robust public options. All of those countries are capitalist countries. None of them have abandoned market mechanisms entirely. They've simply recognized that some goods are too essential, and too prone to the specific failures I've described, to be left to unregulated private profit.

The United States has not made a different economic calculation. It has made a different political one — shaped by decades of industry lobbying, campaign contributions, and the kind of sophisticated public relations infrastructure that I spent nearly twenty years helping to build and operate — not at one company, but as a practitioner of an industry-wide playbook.

The market isn't failing because we haven't tried hard enough to fix it. It's failing because it was never designed to serve patients. It was designed to serve shareholders. And by that measure — as every quarterly earnings call confirms — it has been a spectacular success.

The question was never whether we can afford to change the system. The question is how much longer we can afford not to.

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AL Sny Apr 16 Edited



"The question was never whether we can afford to change the system. The question is how much longer we can afford not to."

Wendell and team, I would urge you to share all your articles on LinkedIn and other social platforms for wider audience. Thank you.

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1 reply



Ginny Crisp Apr 16



Everything you've described about the health insurance side plays out with remarkable precision on the pharmacy benefit side too.

The information asymmetry you're naming is, if anything, worse in pharmacy benefits. Most employers don't know what their PBM is actually paying for their drugs. They don't know what spread is being retained. They don't know how their rebate share is calculated, or against what baseline. They signed a contract that technically discloses terms, but the terms are structured so that understanding what you're actually getting requires expertise most employers don't have and aren't told they need.

Your point about the profit motive running backward is the one I keep coming back to. A PBM's most profitable position is often the one that costs the plan the most: higher-cost drugs with larger rebate spreads, specialty pharmacy steering that benefits the PBM's own subsidiary, formulary decisions driven by manufacturer rebate revenue rather than clinical value. The employer thinks they have an agent managing their pharmacy benefit. They have a counterparty.

The three largest PBMs control roughly 80% of the market. That concentration produces exactly the pricing power dynamics you described on the insurance side.

The employers I work with aren't waiting for systemic reform. They're reading their contracts, auditing their claims, and demanding transparency now. But it shouldn't require a forensic review of your own vendor's contract to find out whether they're working for you or against you.

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Court Rejects Anthem's Attempt to Relitigate Arbitration Losses Under No Surprises Act

Judge Karen Scott dismisses federal claims against HaloMD, signaling that insurers can't use RICO and ERISA suits to bypass the law's dispute resolution process.



WENDELL POTTER

APR 20, 2026

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8 UNITED STATES DISTRICT COURT
9 CENTRAL DISTRICT OF CALIFORNIA
10
11 ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, et al.,
12 Plaintiffs,
13 v.
14 HALOMD LLC, et al.,
15 Defendants.

Case No. 8:25-cv-01467-KES
MEMORANDUM OPINION AND ORDER

16
17
18 I.
19 INTRODUCTION
20 In July 2025, Anthem Blue Cross Life and Health Insurance Company and
21 Blue Cross of California d/b/a Anthem Blue Cross ("Plaintiffs" or "Anthem") filed
22 this civil lawsuit. (Dkt. 1.) The operative First Amended Complaint ("FAC" at
23 Dkt. 50) names the following Defendants:
24 (1) HaloMD, LLC ("HaloMD") and its president, Alla LaRoque
25 (collectively, the "HaloMD Defendants");
26 (2) MPOWERHealth Practice Management, LLC and its CEO, Scott
27 LaRoque (collectively, the "MPOWERHealth Defendants");
28 (3) Bruin Neurophysiology, P.C.; iNeurology, PC; N Express, PC; and

18 v.
19 CONCLUSION
20 Based on the foregoing, **IT IS ORDERED** that (1) the motions to dismiss
21 (Dkt. 69, 73, 76, 77) shall be granted for the reasons stated above; (2) all other
22 pending motions (Dkt. 68, 72, 74, 78) shall be denied as moot; and (3) the FAC
23 shall be dismissed in its entirety, without leave to amend.
24
25 DATED: April 9, 2026
26 *Karen E. Scott*
27 KAREN E. SCOTT
28 United States Magistrate Judge

Movants	Briefs ¹
Sound Physicians Providers	Oppo: 93 Reply: 117
MPOWERHealth Practice Management, LLC	Oppo: 93 Reply: 123
MPOWERHealth Practice Management, LLC and LaRoque Family Providers	Oppo: 93 Reply: 124
HALOMD	Oppo: 93 Reply: 120
Alla & Scott LaRoque	Oppo: 93 Reply: 121
Sound Physicians Providers	Oppo: 92 Reply: 118
HALOMD Defendants	Oppo: 92 Reply: 122
MPOWERHealth Practice Management, LLC and LaRoque Family Providers	See above

134 (presentation decks.) For reasons explained:
Court held oral argument. (Dkt. 127 (minutes):

Last month, I wrote about an industrywide litigation campaign — a coordinated series of federal lawsuits by Anthem/Elevance, UnitedHealthcare, and Blue Cross Blue Shield affiliates targeting the providers, hospitals, and billing companies that have used the No Surprises Act's Independent Dispute Resolution process to seek appropriate payment for care already delivered. The lawsuits deployed nearly identical legal arguments — RICO violations, ERISA claims and fraud allegations. So far, that strategy doesn't seem to be working for Big Insurance.

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On April 9, Magistrate Judge Karen Scott of the U.S. District Court for the Central District of California **dismissed** the federal claims Anthem brought against HaloMD, a billing company, and its co-defendants.

Here's a quick refresher of what this is all about.

Congress passed the No Surprises Act in 2020 to address a genuine patient nightmare: you go to an in-network hospital but later get a bill for thousands of dollars from a doctor who treated you there but, to your surprise, was not in your insurer's physician network. The law eliminated most of those surprise bills and established an Independent Dispute Resolution process — essentially arbitration — to settle payment disputes between insurers and out-of-network providers.

The IDR process was designed to be the endpoint: Insurers and providers submit their best offers and a neutral arbitrator decides what a fair payment should be.

As it turns out, insurers have been losing many of the arbitrations. Rather than accept that outcome, Anthem went to federal court and argued that HaloMD, which helps providers navigate the IDR process, was gaming the system — specifically, by submitting thousands of disputes Anthem claimed were ineligible and labeling them as eligible, and by deliberately flooding the system with more disputes than Anthem could respond to. Anthem also argued that arbitrators themselves were financially compromised, since they only get paid when a dispute is found eligible — creating, in Anthem's telling, an incentive to rubber-stamp ineligible claims.

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Judge Scott was not persuaded. In her ruling, she found that the No Surprises Act allows courts to review arbitration decisions only under very narrow circumstances — corruption, fraud, or misconduct that could not have been discovered during the arbitration itself, such as bribery, undisclosed bias, or willfully destroyed evidence. Anthem, the judge said, had not met that bar.

She also noted that Anthem's own complaint revealed the flaw in its argument: the IDR process already allows participants to flag disputes they believe are ineligible directly to the arbitrator. The remedy Anthem claimed it needed federal courts for already existed within the system Congress built. As Judge Scott wrote, if courts adopted Anthem's position, "nearly every eligibility determination disputed by an [independent dispute resolution] participant would be subject to review in federal court" — which would gut the entire streamlined process the statute created.

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On the arbitrator incentive argument, the judge was equally direct. The fee structure Anthem complained about was established by Congress. That, she wrote, is "not akin to bad faith or bribery."

The state law claims were dismissed without prejudice, meaning Anthem could attempt to refile them in California state court. But the federal claims — the heart of the case — are gone.

In a statement after the ruling, Anthem called the decision "procedural", said it "did not address most of the company's arguments" and that it would appeal Judge Scott's ruling.

To be sure, the California ruling doesn't end the industry's litigation campaign. Three parallel suits brought by Blue Cross Blue Shield affiliates — in Texas, Georgia, and Ohio — remain active. Similar cases from UnitedHealthcare continue in other jurisdictions. And Anthem's announced appeal means this California case will now head to the Ninth Circuit, where the stakes will be higher and the precedential implications broader.

There's also a separate front worth watching: a case before the Fifth Circuit involving the Texas Medical Association that could reshape how the qualifying payment amount

— the benchmark insurers use in IDR — is calculated. A ruling in that case won't just affect arbitration; it could directly raise patient out-of-pocket costs for out-of-network care.

One thing Judge Scott's ruling accomplish is this: it establishes that federal courts are not the appropriate venue for insurers to relitigate arbitration outcomes they don't like. Judge Scott's reasoning — that the IDR process contains its own mechanisms for raising eligibility disputes, and that Congress deliberately limited judicial review — is now part of the legal landscape that other courts will have to contend with.

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Gary Edwards 6d Edited



Shame on these insurance company litigants

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Ginny Crisp 6d



The piece most plan sponsors miss in this litigation pattern: when a fully insured plan loses an IDR arbitration, the insurer pays the award. When a self-funded plan loses, the employer does. Anthem is pursuing ERISA theories in federal court nominally on behalf of plans whose sponsors often do not know the strategy exists, let alone whether it is being pursued in their interest.

The Fifth Circuit QPA case deserves the same employer lens. If the calculation has been systematically depressed, self-funded plans have been underpaying out-of-network claims for years, and the correction will land on plan reserves. The carrier does not carry that risk. The plan sponsor does.

Grateful for the coverage.

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