

SPECIAL INVESTIGATION | NO SURPRISES ACT | RADIOLOGY



The No Surprises Act Protected Patients. Its Arbitration System Outgrew the Forecast.

Providers filed 2.6 million disputes in 2025, and a Georgetown analysis estimated four-year costs at \$22.4 billion. Congress is asking whether the federal payment process has outgrown its design.

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The law places patients outside covered out-of-network payment disputes. The contest over what happens inside the arbitration room is now drawing congressional scrutiny. Original editorial illustration for Healthcare News Wire.

THE CENTRAL FINDING

Patient protection held. Arbitration exploded.

Congress built the No Surprises Act around a simple premise: patients should not become leverage in payment disputes they cannot control. Since 2022, the law has limited cost-sharing and prohibited balance billing for certain out-of-network emergency and facility-based care.

The available patient evidence is encouraging. In a 2025 BMJ quasi-experimental study of 17,351 adults with direct-purchase coverage in 24 states, the law was associated with a \$567 differential reduction in annual out-of-pocket spending (95% CI, \$102 to \$1,031 lower). The study found no differential change in premiums or in the share facing high spending burdens.

Why Congress is asking now

On September 3, Rep. Frank Pallone Jr. asked six certified independent dispute resolution entities for records due September 24. His questions extend beyond volume to include eligibility decisions, default judgments, staff qualifications and compensation, and whether firms use AI in case review.

The scale broke the forecast

Providers initiated 2.6 million federal disputes in 2025, 77% more than in 2024. The original federal estimate was roughly 22,000 a year. In the first half of 2026, another 1.75 million disputes were filed, 50% more than in the same period in 2025. A mechanism designed as a backstop now functions as a routine revenue-cycle channel for some organizations.

REPORTING NOTE | \$22.4 billion is a Georgetown estimate, not a CMS spending total. Provider groups contest the QPA baseline and the quality of CMS files. Treat the figure as an audit target, not a settled verdict.

“The patient should remain outside the fight. The fight itself must become auditable.”

HEALTHCARE NEWS WIRE ANALYSIS

INSIDE THE INVESTIGATION | patient protection, IDR scale, cost methodology, provider objections, radiology concentration and an executive action list.

THE EVIDENCE

Three numbers frame the inquiry

\$22.4B
ESTIMATED IDR-ATTRIBUTABLE COST, 2022-2025

2.6M
DISPUTES INITIATED IN 2025

445%
MEDIAN WINNING PROVIDER AWARD AS SHARE OF QPA, 2025

How the estimate was built

Georgetown attributed approximately \$15.6 billion to awards above qualifying payment amounts, \$4.2 billion to internal payer and provider administration, and \$2.7 billion to fees. It estimated \$16.6 billion in 2025 alone. This is not the net cost of the entire law. It is a modeled cost of the arbitration pathway relative to the QPA baseline and reported fees.

What providers contest

ACEP argues that the QPA can be artificially low or missing, and that CMS public-use files contain clerical errors and possible double-counting. It also points to \$0 or \$1 payer offers and delayed payment after awards. Those are material objections, but advocacy claims still require independent reconciliation.

What the public data show

Providers prevailed in about 85% of 2025 decisions. Three filing organizations accounted for 77% of resolved lines. Operational speed improved: by year-end, 98% of disputes were resolved or less than 30 business days old; median determination time fell to 25 days in Q4 2025 from 96 days in Q3 2024.

WHY RADIOLOGY MATTERS

Imaging sits near the center of the dispute economy

Radiology represented 29% of resolved dispute lines from 2023 through 2025, second only to emergency medicine at 41%. Its 2025 median winning award equaled 468% of QPA. Georgetown estimated about \$1.03 billion in radiology awards over 2023-2025; Radiology Partners won 96% of its 2025 decisions.

Concentration is not proof of abuse

High filing volume may reflect a specialty structure, weak payer offers, outsourced expertise, strategic case selection, or a combination of these. It does not, by itself, establish improper conduct. The oversight test is whether eligibility and statutory factors were applied consistently, and whether QPA inputs and awards can be audited.

What leaders should do now

- Preserve patient protections while payment policy is reviewed.
- Reconcile disputes by CPT, site, geography, payer, and filing agent.
- Separate initiated, eligible, defaulted, won, paid, and collected cases.
- Audit QPA inputs, initial offers, fees, award timing, and time to payment.
- Model contracting with and without IDR; do not treat episodic awards as core margin.

The final judgment

The law is neither a failure nor an unqualified success. It placed patients outside covered payment fights, but its arbitration system expanded to a scale Congress did not design for. The right response is not to weaken the patient shield. It is to require transaction-level auditability, consistent eligibility, transparent reasoning, enforceable payment deadlines, and a corrected QPA methodology before imposing new caps or benchmarks.

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