NO SURPRISES ACT: WHAT THE PAYMENT DATA SHOW

Emergency Care Reimbursed Less Than Before the NSA

IDR awards help sustain medical practices, but actual dollars still fall short of pre-NSA payments.

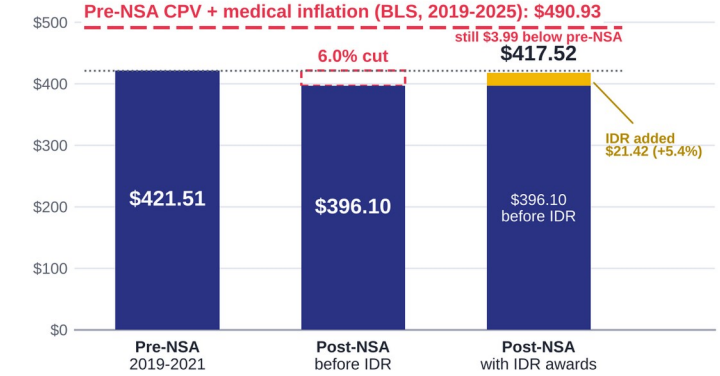
Congress, the Congressional Budget Office (CBO), and the Administration are asking whether the No Surprises Act (NSA) should be raising premiums.

Part I tracked one of the most frequent emergency visit codes (CPT 99284) in the NSA's Independent Dispute Resolution (IDR) process. Part II widens the lens to every visit, using the practice's average commercial cash per visit (CPV) before and after the NSA. EDPMA's members collectively serve approximately 60% of US emergency department visits.

Measured in real dollars, these data show that even with IDR awards included, commercial cash per visit is less than pre-NSA levels, with or without an adjustment for inflation.

Following the emergency practice's cash per visit through the NSA

Weighted average commercial cash per visit (CPV), in-network + out-of-network, all visit levels



The Bottom Line

6.0% cut in cash per visit

Cash per visit dropped significantly. Average commercial CPV fell from $421.51 to $396.10, before any IDR activity.

−$3.99 per visit

IDR awards provide important practice resources, but do not restore payments to pre-NSA levels. IDR raised CPV 5.4%, to $417.52, still $3.99 below pre-NSA.

−$73.41 per visit with inflation

Far short of inflation-adjusted pre-NSA amounts. Post-IDR CPV ($417.52) is $73.41 below the average pre-NSA inflation-adjusted CPV, which is $490.93 (inflation: +16.5%, 2019-2025).

✕ What Has Been Said	✓ What the Payment Data Show
"Clinicians win about 85% of IDR disputes, so IDR is driving up costs."	**Win rates refer to numbers of disputes but do not address actual dollars.** Across all emergency visits, IDR added $21.42 to average commercial cash per visit, leaving it 15.0% less than it was before the NSA, when adjusted for inflation.
"Level 4 is one code. The rest of the ER tells a different story."	**It tells the same story.** Part II covers every visit level. After IDR, the practice's commercial cash per visit is $417.52; that's below the $421.51 paid before the NSA, or the inflation-adjusted $490.93.
"IDR awards are a windfall for physicians."	**Many awards have not even been paid.** $78.3 million in IDR awards owed to survey respondents remained unpaid as of August 2026. $22.2 million of it was more than a year old.
"Physicians are gaming IDR to raise prices."	**Significantly low initial payments drive physicians' need for IDR.** Out-of-network reductions cut cash per visit 6.0% after the NSA. **IDR results help, but still net less than pre-NSA amounts, even before inflation.**

NOT INCLUDED: IDR FEES. Although IDR fees are significant, these results do not account for them. Physicians pay an unrefunded administrative fee to enter IDR, the full "loser pays" IDR entity fee on the 15% to 20% of claims they lose, and other internal costs. **Those costs make emergency care payment rates even less sustainable than these data show.**

WHY THIS DATA MATTERS

An accurate view of the NSA's impact matters. In actual dollars, ER physicians are paid less than before the NSA.

These data come from actual physician practices.
Other data show only part of the story, or a distorted view of the actual impact on costs. Publicly available data show only IDR results, not underpaid claims that never went to IDR.

IDR adds little per visit.
$21.42 per visit on average, not enough to reach pre-NSA levels.

Awards are not payments.
$78.3 million in awards was still unpaid in August 2026.

Patients rely on sustainable access to emergency care.
Emergency physicians treat everyone, regardless of ability to pay. Emergency practices need the resources to provide these critical services.

How EDPMA Tracked It

Part II asked Part I respondents for their overall commercial cash per visit, in network and out of network combined, with the underlying visit volumes for each year from 2019 through 2025. That allowed a weighted average for each year, tracked through the same three phases as the Level 4 visit in Part I.

PHASE 1
Pre-NSA cash per visit
$421.51
Baseline
Weighted average commercial CPV, in network and out of network, 2019-2021.

→

PHASE 2
Post-NSA, before IDR
$396.10
6.0% drop from Phase 1
Weighted average commercial CPV, 2022-2025, before any IDR results are included.

→

PHASE 3
Post-NSA, with IDR awards
$417.52
5.4% increase from Phase 2, still below Phase 1
The same CPV with all incremental IDR awards included, paid or not.

Awards Are Not Payments

$78.3 million in IDR awards owed but unpaid, by age

$22.2M (28%) is more than a year old

Owed to survey respondents as of August 2026

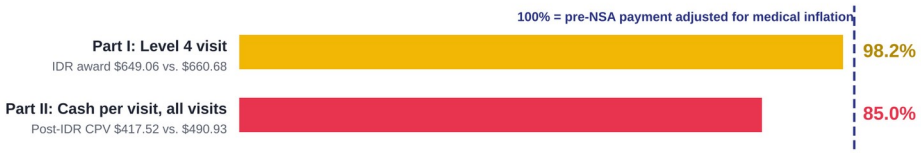


The NSA requires plans to pay IDR awards within 30 days. For the groups in this survey alone, $78.3 million was still owed in August 2026, and $5.4 million was more than three years old. Weak enforcement and the lack of clear penalties for plans that do not pay are the largest failures of the NSA's implementation. Because the post-IDR CPV counts unpaid awards as if paid, the cash practices actually received is lower still.

Part I and Part II Agree

Two views, one conclusion: after IDR, payment still falls short

Share of the inflation-adjusted pre-NSA amount reached after IDR



What It Means for Policy

- **All claims combined, emergency practices are paid less than before the NSA.** Even with every IDR award counted, average commercial cash per visit ($417.52) is below the pre-NSA level ($421.51), and 15.0% below the inflation-adjusted pre-NSA level ($490.93).
- **IDR awards provide important patient care resources,** but they do not restore payments to pre-NSA levels, even before inflation.
- **These results do not reflect the impact of IDR fees.** The unrefunded administrative fee to enter IDR, the full "loser pays" IDR entity fee on the 15% to 20% of claims clinicians lose, and other internal costs are significant factors. Those costs further reduce what physicians actually receive, making payments even less sustainable.
- **A common cost narrative does not hold for emergency medicine.** A 5.4% gain in cash per visit, after a 6.0% drop, directly contradicts claims that excessive IDR awards are driving premiums higher.
- **An accurate view of the NSA's impact requires analysis of all payments, not just those that went through IDR.** Of 6,170,300 out-of-network visits from 2022 to 2025, only 1,578,900 (26%) were submitted to IDR. Many of the rest were underpaid but not disputed because of administrative and resource constraints. A transparent, holistic view of all payments is critical to supporting thoughtful policy.

What Policymakers Should Do

1. **Measure the NSA in dollars, not win rates.** Premium and cost estimates, including CBO's, should use actual cash per visit compared with pre-NSA levels and medical inflation, and include underpayments to providers that never go through the IDR process.
2. **Enforce payment of IDR awards.** Hold plans to the statute's 30-day deadline, with clear penalties for plans that do not pay. EDPMA will brief Congress and CBO on its aggregate survey findings.
3. **Let IDR work as Congress wrote it.** IDR entities should weigh all of the statute's factors, with no single factor, including the QPA, presumed as primary for either payment or for analysis.
4. **Fix the root cause: low initial payments.** Fair initial out-of-network payments mean that fewer claims need to go through the IDR process, lowering administrative costs across the system and promoting more in-network agreements.

About the data. Figures are average commercial cash per visit (CPV) for emergency physician services, in network and out of network combined, weighted by annual visit volumes. Pre-NSA: 2019-2021. Post-NSA: 2022-2025. IDR awards not received as of survey submission (August 2026) are counted in the post-IDR CPV. All figures exclude IDR fees. Inflation benchmark: BLS medical care price data (in2013dollars.com calculator) applied to the $421.51 pre-NSA CPV through 2025. **Companion report: Following the Dollars, Part I: The Level 4 Visit.** Contact: Matt Clark, Executive Director, EDPMA | www.edpma.org