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WHITE PAPER

No Surprises Act and the Individual Market: Initial Findings and Notable Trends

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EXECUTIVE SUMMARY

The Federal Independent Dispute Resolution (IDR) process under the No Surprises Act (NSA) has experienced substantial growth in dispute volume and payment awards since its implementation in 2022. While the process was intended to constrain out-of-network reimbursement and reduce commercial healthcare reimbursement costs, recent research suggests it has instead become a significant source of additional healthcare spending.

The Individual Market represents a relatively small share of total Federal IDR activity (3.7% of total disputes), yet the resulting payment awards may represent a meaningful component of Individual Market claims costs. Wakely estimates that in 2025, total payments made by Individual Market issuers following resolutions of IDR disputes were equivalent to approximately 0.6% of national Individual Market allowed claims. Of this amount, approximately 0.5% of allowed claims represented the incremental reimbursement cost of IDR awards above comparable in-network reimbursement levels. Payments as a percentage of total allowed claim dollars vary substantially by state, with Arizona, Texas, and New York estimated to be the most impacted. Wakely's analysis estimates that total Individual Market IDR payout on a raw dollar basis increased by more than 800% in 2025 compared to 2024, suggesting that IDR exposure has become an increasingly important consideration for issuers.

The IDR process may affect Individual Market premiums through both higher direct claim reimbursement costs and administrative expenses and fees associated with participating in the IDR process. What has been less discussed is the uncertainty the IDR process may bring to projecting future liabilities. For example, outstanding IDR payment liabilities may not be captured by standard claims completion methodologies, and financial reporting, risk adjustment transfers, and reinsurance recovery calculations may be affected by delays in claim resolution. Further, providers' growing success in the IDR process may strengthen their negotiating position with issuers. This could contribute to higher in-network reimbursement rates, increased claims reimbursement costs, and potential network adequacy challenges. These pressures may be particularly significant in states with greater IDR exposure.

Ongoing litigation, the release of the Federal IDR Operational Final Rule, proposed changes to legislation, and changes to the certified IDR entities are all on the horizon and have potential to further affect future IDR dispute frequency and payouts. As actuaries develop 2028 premium rates, they should evaluate whether historical experience adequately reflects both direct and indirect NSA-related costs, or whether adjustments are necessary to capture forthcoming cost pressures.

INTRODUCTION

Effective January 1, 2022, the No Surprises Act (NSA) was designed to protect individuals with employer-sponsored insurance and Individual Marketplace coverage from unexpected out-of-network bills for emergency care, air ambulance services, or treatment by out-of-network providers at an in-network facility. Members in these situations are generally responsible only for the applicable in-network cost sharing, while the health plan and provider must resolve remaining payment amounts directly, either through an open negotiation or the Federal Independent Dispute Resolution (IDR) process.[1]

When the NSA was enacted, policymakers expected the law to reduce, rather than increase, healthcare costs. The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimated that the IDR process would reduce commercial premiums by approximately 0.5% to 1.0% each year due to constrained out-of-network reimbursement.[2] However, recent research conducted by Health Affairs estimated that the IDR process has generated $15.6 billion in payment amounts above comparable in-network rates from 2022 through 2025, plus a $6.9 billion increase in administrative expenses and fees not accounted for in CBO and JCT savings estimates.[3] Further, the Centers for Medicare & Medicaid Services (CMS) reported more than 7 million disputes initiated through July 2026—a stark increase from the 17,000 annual dispute volume originally estimated by the Department of Health and Human Services (HHS).[4,5] These developments raise important questions about how the NSA and IDR process affect payer reimbursements, administrative expenses, and premium amounts.

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[1] Centers for Medicare & Medicaid Services. What Are the New Protections? Available at: https://www.cms.gov/nosurprises/consumer-protections/what-are-the-new-protections.

[2] Congressional Budget Office. Estimate for Divisions O Through FF. January 14, 2021. Available at: https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf.

[3] Hoadley J, Watts K. Spending on IDR Process Pushes No Surprises Act Costs to More than $22.4 Billion Over Just Four Years. Health Affairs. August 26, 2026. Available at: https://www.healthaffairs.org/content/forefront/spending-idr-process-pushes-no-surprises-act-costs-more-than-22-4-billion-over-just.

[4] Centers for Medicare & Medicaid Services. Independent Dispute Resolution Reports. Available at: https://www.cms.gov/initiatives/no-surprise-billing/overview/policies-resources/independent-dispute-resolution-reports.

[5] National Archives and Records Administration. Requirements Related to Surprise Billing; Part II. Available at: https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii#citation-187-p56056.

Previous analyses have examined the accelerating costs associated with the NSA arbitration process for private health coverage broadly. However, fewer studies have evaluated how the NSA is affecting premiums. We are unaware of any analyses specific to its impact on the Individual Market. This white paper estimates historical Federal IDR reimbursement costs in the Individual Market, identifies states with greater IDR exposure, considers where current pricing may understate those costs, and evaluates how future trends and changes could affect 2028 premium rates.

BACKGROUND

The IDR Process

To understand how the NSA arbitration process can contribute to claims costs, it is important to examine how it works. When a member receives a service subject to the NSA, the health plan will generally issue an initial payment or denial to the out-of-network provider. If the provider disagrees with the payment, the two parties enter into a 30-business-day open negotiation period to try to reach an agreement directly.

If an agreement is not reached within 30 days, either party can enter the dispute into the IDR process provided the claim is eligible.[6] In this process, both parties submit payment offers and additional information to support their offer to a third-party arbitrator, referred to as a certified IDR entity. Upon receipt of the two offers, the IDR entity will select one of the two offers as the "prevailing offer," rather than determining an intermediate payment.[7,8]

The Qualifying Payment Amount (QPA) concept is central to the IDR process. Calculated on a geographic specific basis, it generally represents the health plan's median contracted rate under the plan for the same or similar service on January 31, 2019, indexed for inflation. Certified IDR entities are required to consider the QPA in making the payment determination. Given that the QPA is intended to resemble an in-network rate, the prevailing offer is compared to the QPA as a proxy for payment above in-network rates throughout this white paper.

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[6] Federal Hearings and Appeals Services. Common and Avoidable Ineligibility Errors: In IDR Filings, Details Matter. February 26, 2026. Available at: https://www.fhas.com/resources/industry-updates/common-and-avoidable-ineligibility-errors-in-idr-filings-details-matter/.

[7] Centers for Medicare & Medicaid Services. About Independent Dispute Resolution. Available at: https://www.cms.gov/initiatives/no-surprise-billing/overview/engaging-idr/about-independent-dispute-resolution.

[8] For purposes of this white paper, "prevailing offer," "payment award," and "payment determination" are considered synonymous and refer to the amount a health plan is instructed to pay the out of network provider upon resolution of an IDR dispute.

Methodology and Limitations

To analyze the effects of IDR arbitration awards on the Individual Market, we used CMS's public use file (PUF) data for Q1 2023 through Q4 2025, which as of the writing of this paper, was the most recent data available. Wakely relied on this data to complete this analysis. Wakely also used Unified Rate Review Template (URRT) and CMS Risk Adjustment Report (RAR) data to analyze allowed costs in the Individual Market.

This analysis is subject to several sizable limitations related to the structure and timing of the available data. CMS IDR payment data do not directly identify health plan type or state, which requires assumptions to be made in order to allocate estimated Individual Market and state-level results.[9] Wakely allocated metropolitan statistical areas (MSA)-level IDR data to states using county-level Census population shares for multi-state MSAs. Wakely adjusted the data to an Individual Market basis by applying dispute volume and relative cost adjustments at the year, quarter, state, and service code (CPT) level.

In addition, IDR geography reflects service location while URRT and risk adjustment data generally reflect member residence, which may create geographic mismatches in state-level comparisons. Timing differences may also affect results, as IDR costs were generally summarized by resolution date while market claims data reflect incurred periods, and recent claims experience may not yet capture ultimate IDR payments because of long settlement lags.

Costs reported in this analysis reflect only estimated reimbursement costs and do not include administrative expenses, operational costs, or fees paid to IDR entities. Individual Market allowed claims from 2024–2025 were estimated and may not represent actual market costs due to lack of reported data from carriers that have since exited the market. This introduces additional uncertainty into the resulting cost percentages.

Detailed methodology and limitations regarding the use of the data are described in detail in **Appendix A**.

[9] The "QPA and Offers" tables of the IDR data, which include dollar figures, do not include state and health plan type fields.

HISTORICAL PAYMENT DETERMINATIONS

Individual Market Experience

The Individual Market represents a relatively small share of total Federal IDR activity. Across the period analyzed, Individual Market disputes represented approximately 3.7% of total disputes. However, the relatively low aggregate dispute count does not necessarily imply a negligible impact on Individual Market claims experience.

Wakely estimates that IDR payment awards and payment awards above the QPA are an estimated 0.6% and 0.5% of national Individual Market allowed claims dollars in 2025, respectively. As shown in **Table 1**, these figures increased substantially between 2024 and 2025. Wakely estimates that the total payment award dollars in the Individual Market increased by more than 800% in 2025.

Table 1. Estimated Individual Market Payment Awards as a Percentage of National Allowed Claims

Metric	2023	2024	2025	Average 2023–2025
Payment Awards	Negligible	0.1%	0.6%	0.3%
Payment Awards Above the QPA	Negligible	Negligible	0.5%	0.2%

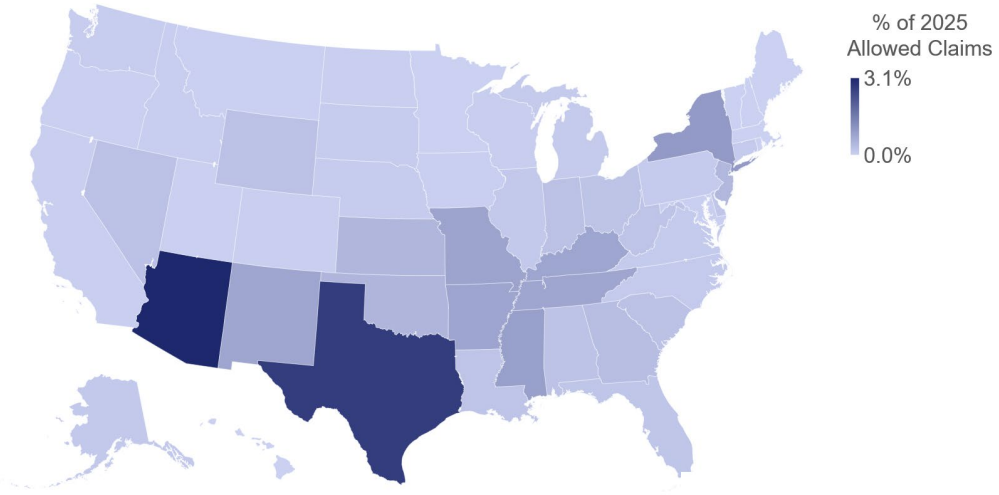
While detailed data for 2026 has not yet been released by CMS, CMS high-level reporting indicates that dispute activity remains elevated in 2026. In fact, July 2026 alone saw an increase in initiated disputes over June 2026 of 24%.[10] This may suggest that the high trend experienced from 2024 to 2025 will continue into 2026, absent changes in the program.

Geographic Variation

National averages also mask meaningful differences between states. As shown in **Figure 1** on the next page, our analysis examines Individual Market IDR experience as a percentage of allowed claims by state and identifies markets where experience appears to be more adverse than the national average.

[10] Centers for Medicare & Medicaid Services. Independent Dispute Resolution Reports. Available at: https://www.cms.gov/initiatives/no-surprise-billing/overview/policies-resources/independent-dispute-resolution-reports#:~:text=In%20July%202026%2C%20394%2C140%20disputes%20were%20initiated%2C%20a%2024%25%20increase%20from%20June%202026%20(318%2C421). Based on CMS-reported values through July 31, 2026. Metrics reported by CMS are not specific to the Individual Market.

Figure 1. Estimate of Individual Market Prevailing Payment Awards as a Percentage of Allowed Claims by State, 2025



The data suggest that the relative impact of the IDR process payouts are most substantial in Arizona, Texas, and New York, with payouts in each of these states exceeding 1% of total allowed claims in the same year, as shown in **Table 2** on the next page. In six other states—Arkansas, Kentucky, Missouri, Mississippi, New Mexico, and Tennessee—2025 payment awards as a percentage of allowed claims exceed the national average.

Table 2. Estimated Individual Market Payment Awards as a Percentage of State-Specific Allowed Claims, 2025

State	Payment Awards % of Allowed Claims	Payment Awards in Above the QPA % of Allowed Claims
Arizona	3.1%	2.5%
Texas	2.7%	2.3%
New York	1.0%	0.9%

There are significant limitations associated with summarizing the IDR data at the Individual Market and state level. Data limitations and suggestions to improve IDR data reporting are discussed in detail in **Appendix A**. It's possible the results presented above may not represent true Individual Market IDR reimbursement costs. Further, state-level impacts may represent what a single issuer is experiencing. Finally, it is possible that trends in IDR impacts will change going forward relative to historical data.

IMPLICATIONS FOR INDIVIDUAL MARKET PRICING

There are a variety of reasons why IDR exposure may not be uniform by state or issuer. Federal IDR exposure can vary based on state surprise billing laws, provider market dynamics,[11] network structure, and the concentration of specialties frequently using IDR, among other factors.

For health plans operating in the states identified above, current rates may not fully capture emerging NSA-related costs if those costs were not specifically considered during premium rate development. In addition to the direct claim reimbursement cost impact of IDR payment determinations, other indirect sources of financial pressure may exist that are not reflected in the IDR data. Actuaries should consider these components when developing premium rates.

- **Claims reserves and financial reporting.** For some disputes, there are significant timing lags between the original date of service and the final resolution of an IDR payment due to large dispute backlogs within the IDR entities. These lags can extend well beyond an ordinary claims adjudication period, such that base period claims data may not contain the ultimate IDR payment at the time of rate development. In this case, actuaries should consider NSA-specific exposure in development of claim reserves as standard completion methodologies may not fully capture an emerging reimbursement mechanism whose development pattern differs from traditional claims. Beyond rate development, this dynamic could impact whether issuers are in a rebate-paying position following Medical Loss Ratio (MLR) reporting and may influence year-end Statements of Actuarial Opinion (SAO).

Summary statistics on the length of payment determinations for the Individual Market are presented in **Table 3** on the next page. While it appears the average payment determination has decreased since 2023, the range of payment determinations has widened, with the 90th percentile of determinations at 97 business days (about 4.6 months on a calendar basis) and a maximum of 783 business days (about 36 months on a calendar basis).

[11] Sources indicate that providers backed by private equity disproportionately file disputes.

Table 3. Individual Market IDR Length of Payment Determination (in Business Days)

Year	Minimum	10th Percentile	Mean	Median	90th Percentile	Maximum
2023	12	33	94	76	173	329
2024	7	18	83	34	219	604
2025	6	18	48	29	97	783

- **Risk adjustment transfers.** If NSA-eligible claims are denied when initially submitted, they may not be eligible for inclusion in EDGE or the risk adjustment calculation, even if they contain diagnoses associated with hierarchal condition categories (HCCs). If the dispute is not resolved before the final EDGE submission deadline and the claim is not subsequently reprocessed, issuers could miss the opportunity to capture additional HCCs that might otherwise improve risk adjustment transfers.
- **Reinsurance recoveries.** Because of the timing lag in resolving IDR disputes, some claims may not be finalized in time to be reflected in state or commercial reinsurance recovery calculations. As a result, issuers could experience lower reinsurance recoveries than if the claims had been resolved earlier.
- **In-network reimbursements.** Providers are gaining a lot of momentum in the IDR process. If providers can consistently obtain reimbursement through IDR that exceeds what they could negotiate for the same service in-network, providers either have the upper hand when entering a negotiation conversation with issuers or can threaten to go out of network, both of which have implications on premium rate development and may present a risk for network adequacy on a large scale.[12] This may have downstream consequences on product offerings, member benefits, and could create less predictable reimbursement costs for issuers.
- **Administrative expenses.** While not the focus of this paper, there are significant administrative expenses and fees associated with participating in the IDR process. IDR entity fees, which are due to the arbitrator for their role in the dispute, are borne by the losing party, which is the health plan in 88% of Individual Market disputes from

[12] Barwick PJ, Li A, Xia T, Yu S. The No Suprises Act's Surprises: Arbitration, Provider Network, and Insurer Pricing. National Bureau of Economic Research. Available at: https://www.nber.org/system/files/working_papers/w35717/w35717.pdf.

2023–2025.[13] The fees are set by each IDR entity every year. In 2026, the fee for single disputes ranges from $425 to $800, with batched dispute fees up to $1,125.[14] Administrative fees are $15 per party per dispute beginning June 3, 2026, down from $115 in prior years. Issuers also incur operational costs to employ the resources necessary to participate in this process, although that cost varies by issuer.

Beyond the items above, claims that do not reach the IDR process, such as those for which providers accept the initial payment or the parties reach agreement during open negotiation, are generally not represented as completed Federal IDR determinations and, therefore, are not reflected in the IDR data. As a result, the actual costs incurred by health plans may be understated by considering the payment awards alone.

FUTURE UNKNOWNS

Historical IDR data only tells part of the story. There are several developments on the horizon—including ongoing litigation, changes to the NSA rule, and proposed legislation—that could shape the frequency and severity of IDR costs in coming years.

Ongoing Litigation

Several lawsuits brought by the Texas Medical Association and other provider groups have challenged how the Departments implemented the QPA and Federal IDR process. The most famous among those, *Texas Medical Association, et al. v. United States Department of Health and Human Services et al.* (TMA III), focused directly on how the QPA is calculated.[15] On August 11, 2026, the Fifth Circuit held that the QPA methodology could not include non-negotiated "ghost rates" for services providers do not actually furnish and should not exclude bonus and incentive payments.[16] The Departments responded suggesting they will release guidance regarding the judgment, but as of the writing of this paper, no guidance has been released.[17]

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[13] Calculated on a dispute-line basis.

[14] Hoadley J, Watts K. Spending on IDR Process Pushes No Surprises Act Costs to More than $22.4 Billion Over Just Four Years. Health Affairs. August 26, 2026. Available at: https://www.healthaffairs.org/content/forefront/spending-idr-process-pushes-no-surprises-act-costs-more-than-22-4-billion-over-just.

[15] Keith K. The No Surprises Act: A Litigation Status Check. Health Affairs. August 26, 2025. Available at: https://www.healthaffairs.org/content/forefront/no-surprises-act-litigation-status-check.

[16] United States Court of Appeals for the Fifth Circuit. Texas Medical Association v. HHS, 23-40605 (5th Cir. 2026). Available at: https://law.justia.com/cases/federal/appellate-courts/ca5/23-40605/23-40605-2026-08-11.html.

[17] Centers for Medicare & Medicaid Services. Departments Announce Denial of Recertification for Two Federal Independent Dispute Resolution Entities. November 4, 2026. Available at: https://www.cms.gov/initiatives/no-surprise-billing/overview/notices.

Depending on how CMS responds to the litigation, the methodology change could result in higher QPAs for at least some services and markets. While this won't automatically result in an increase in IDR reimbursement, it will effectively re-anchor the benchmark around which providers make offers, settlements are negotiated, and IDR entities resolve disputes and therefore potentially increase payer reimbursement costs.

Federal IDR Operations Final Rule

In May 2026, the Departments finalized a new Federal IDR Operations rule.[18] The rule aims at improving communication among the parties involved in the IDR process and improving the efficiency of a process that experienced substantially more volume than originally anticipated. Some notable changes in the rule are:

- **Reduced administrative fees.** Effective June 11, 2026, the administrative fees for participating in the IDR process were reduced from $115 to $15 per party per dispute. Both payer and provider must pay this fee for using the IDR process.
- **Line limit on batched disputes.** Effective November 1, 2026, batched disputes may contain no more than 50 dispute line items. The rule also established limitations around which types of services can be batched under the same dispute.
- **Changes to the cooling-off period.** By law, the party that initiated a previous dispute generally must wait 90 calendar days before initiating another dispute against the same party for the same service. Effective November 1, 2026, the cooling-off period for batched disputes is being reduced from 90 to 30 days.[19]
- **Changes to eligibility determination.** Eligibility determinations are cited as one of the primary sources of delay in the Federal IDR process. Under the new rule, certified IDR entities will generally be required to make an eligibility determination within five business days of being assigned to the dispute.[20] To our knowledge, there are no penalties if the IDR entities fail to meet this deadline.

[18] Centers for Medicare & Medicaid Services. Federal Rule Takes Aim at Health Care Bureaucracy, Reducing Dispute Fees, and Boosting Transparency. May 28, 2026. Available at: https://www.cms.gov/newsroom/press-releases/federal-rule-takes-aim-health-care-bureaucracy-reducing-dispute-fees-boosting-transparency.
[19] Davis JL, Wong MA, O'Brien KL, Bucshon LD, Silverboard DM. Important Federal IDR Operational Updates Continue to Be Implemented This Month. Holland & Knight. November 3, 2026. Available at: https://www.hklaw.com/en/insights/publications/2026/11/important-federal-idr-operational-updates.
[20] National Archives and Records Administration. Independent Dispute Resolution Process. Available at: https://www.ecfr.gov/current/title-26/chapter-I/subchapter-D/part-54/section-54.9816-8#p-54.9816-8(c)(2)(i).

The net impact of these rule changes is uncertain. While operational changes like tighter eligibility procedures and batching limits could reduce the number of disputes, lower administrative fees and shorter cooling-off periods could make the process more accessible. Future dispute frequency may be affected by these rules but will likely take a long time to become visible in incurred claims due to existing dispute backlogs.

Proposed Legislation

Representative Frank Pallone of New Jersey proposed legislation that would eliminate the existing arbitration process under the NSA and instead pay providers the median in-network rate for services subject to the Federal IDR process, beginning in 2028. Pallone's argument is that doctors would lose leverage when negotiating in-network rates, which could lower healthcare spending across the board.[21]

Although the proposal has received criticism from providers, it could effectively make the QPA the required out-of-network payment amount if enacted as proposed. Absent changes to the QPA calculation, which the proposal does not prohibit, this change could significantly reduce historical rates of prevailing payments.

Changes in Certified IDR Entities

On November 4, 2026, the Departments of Health and Human Services, Labor, and the Treasury denied recertification of two IDR entities that have participated in the IDR process since its implementation in 2022 because they failed to meet performance standards. One of the companies, Island Peer Review Organization, had the highest provider-win rate of all the IDR entities at 96.5%.[22] While impacts to dispute resolution patterns, provider award rates, and administrative costs for issuers are uncertain, this action may serve as a reality check for other IDR entities with a disproportionately high provider-win rate.

[21] Levien SJ. Doctors Are Already Decrying Frank Pallone's No Suprises Fix. POLITICO Pro. October 8, 2026. Available at: https://subscriber.politicopro.com/article/2026/10/doctors-pallone-no-surprises-insurers-arbitration-01112774.

[22] Sanger-Katz, Kliff S. Trump Administration Moves to Oust Arbitrators as Doctor Payouts Soar. New York Times. November 4, 2026. Available at: https://www.nytimes.com/2026/11/04/health/arbitrators-medical-bills.html.

KEY CONSIDERATIONS FOR DEVELOPMENT OF PREMIUM RATES

The following questions highlight key considerations for actuaries during 2028 rate development when assessing whether potential NSA-related cost exposure is appropriately reflected in pricing assumptions.

- **What is already reflected in the experience period?** Determine whether the base period incurred data are comprehensive with respect to IDR award payments. If not, ensure that claims reserves are adjusted to reflect for outstanding dispute liabilities.
- **How has IDR exposure changed since the experience period?** Consider whether changes in product type or network makeup could contribute to greater dispute volume or severity in the projection period. Consider how rule changes may influence dispute volumes.
- **Could QPA methodology changes affect future payments?** Changes to the QPA methodology could make historical IDR experience less representative of future reimbursement costs. If forthcoming guidance results in higher QPAs, issuers may need to consider whether additional adjustments are appropriate when projecting future reimbursement levels.
- **Aside from IDR awards, which indirect financial pressures may we be subject to?** Should projected risk transfers or reinsurance reimbursements be adjusted to account for EDGE cutoff dates?
- **Could IDR affect contracted reimbursement more broadly?** Monitor network negotiations for NSA-related developments. If a provider moves out of network, ensure any adjustment for the resulting change in-network mix does not double count costs already captured in an NSA-specific adjustment for that provider.
- **Does our administrative expense projection consider costs of participating in the IDR process?** Consider whether an explicit adjustment to administrative expense should be made for operational burden, administrative fees, and IDR entity fees.

Wakely intends to publish additional IDR cost insights as additional data are released by CMS.

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ABOUT WAKELY

Founded in 1999, Wakely Consulting Group, an HMA Company, is well known for its top-tier healthcare actuarial consulting services. With nine locations nationwide, Wakely boasts deep expertise in Medicare Advantage, Medicaid managed care, risk adjustment and rate setting, market analyses, forecasting, and strategy development. The firm's actuaries bring extensive experience across all sectors of the healthcare industry, collaborating with payers, providers, and government agencies.

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APPENDIX A. DATA RELIANCE, METHODOLOGY, AND DATA LIMITATIONS

Data Reliance

Wakely relied on the following data sources for use in this analysis:

- Centers for Medicare & Medicaid Services (CMS) Federal Independent Dispute Resolution (IDR) Public Use Files (PUFs), 2023–2025, including:
  - The "QPA and Offers" tables
  - The "OON Emergency & Non-Emergency" and "OON Air Ambulance" tables, collectively referred to below as the "OON tables"
- Quarterly Census of Employment and Wages County-MSA-CSA Crosswalk, using the February 2013 CBSA delineations[23]
- US Census county-level population data, 2023–2025
- Unified Rate Review Templates (URRTs) for plan years 2023–2025
- CMS Risk Adjustment Reports (RAR) for 2024 and 2025

Methodology

IDR Payment Data

Wakely primarily relied on the CMS "QPA and Offers" tables to estimate IDR payment amounts. These tables include QPA amounts, payer and provider offers, and prevailing payment amounts for disputes resolved from Q1 2023 through Q4 2025. The "QPA and Offers" tables do not include fields identifying the applicable state or health plan type. As a result, Wakely applied a series of adjustments to allocate the data to states and estimate the portion attributable to the Individual Market.

Wakely first summarized prevailing payment amounts and QPA dollars by year, quarter, and geographic region across all health plan types.

[23] U.S. Bureau of Labor Statistics. Quarterly Census of Employment and Wages: QCEW County-MSA-CSA Crosswalk (for NAICS-Based Data). Available at: https://www.bls.gov/cew/classifications/areas/county-msa-csa-crosswalk.htm.

Allocation of Geographic Regions to States

The "QPA and Offers" data are reported using geographic regions generally based on metropolitan statistical areas (MSAs). Wakely allocated these data to states as follows:

- Single-state MSAs: Dispute volume, prevailing payment amounts, and QPA dollars were assigned directly to the applicable state.
- Multi-state MSAs: Dispute volume, prevailing payment amounts, and QPA dollars were allocated across states based on the relative county-level Census population within each state for the applicable year.

Adjustments to the Individual Market

Wakely used the CMS OON tables to estimate the portion of the "QPA and Offers" data attributable to the Individual Market. Unlike the "QPA and Offers" tables, the OON tables include health plan type and state, as well as measures of prevailing payments relative to QPA; however, they do not include the underlying dollar amounts needed for this analysis. Wakely was not able to identify a reliable, non-duplicative method to directly link records between the OON tables and the "QPA and Offers" tables.

To put data on an Individual Market basis, Wakely applied two adjustments at the year, quarter, state, and service-code (CPT) level:

- Dispute volume adjustment: Wakely calculated the share of total disputes attributable to the Individual Market using the combined OON tables and applied that share to the corresponding "QPA and Offers" data.
- Relative cost adjustment: Wakely adjusted for differences in payment levels between the Individual Market and all health plan types using the relationship between the "Mean Prevailing Party Offer as a % of QPA Adj. Factor" for the Individual Market and the corresponding value across all health plan types.

Together, these adjustments were used to estimate Individual Market prevailing payment and QPA amounts by state.

Comparison to Individual Market Allowed Claims

Wakely then compared estimated IDR costs with Individual Market allowed claims and premium by state and year.

- 2023: Allowed claims and premium were developed from aggregated carrier URRT experience by state.
- 2024: Because of changes in carrier participation reflected in the 2026 URRT, Wakely determined that the 2026 URRT data were not sufficiently representative for estimating total 2024 market allowed claims. Instead, total market premium by state was obtained

from the 2024 CMS Risk Adjustment Report, and historical state-level relationships between allowed claims and premium from 2021–2023 were used to estimate 2024 allowed claims.

- 2025: The same methodology used for 2024 was applied using premium information from the 2025 CMS Risk Adjustment Report.

These estimates were then used to express IDR-related costs as a percentage of Individual Market allowed claims.

Data Limitations and Suggested Improvements

The table below presents data limitations, potential implications on the interpretation of the analysis results, and provides suggestions for improvement of the IDR data where applicable.

Table A.1. IDR Data Limitations and Suggested Improvements

Limitation	Implication on Results	Suggested IDR Data Improvement
"QPA and Offers" data do not identify health plan type, prohibiting us from summarizing prevailing payment data for the Individual Market specifically	Approach taken to adjust data to Individual Market may not be fully representative of true Individual Market IDR costs	Add health plan type or a common dispute identifier to the PUF data that allows the "QPA and Offers" and OON tables to be mapped to one another
"QPA and Offers" data are provided at the MSA level only, not the state level. 2023 MSA definitions were used for all years in the IDR data despite an update to the crosswalk in 2024	Approach taken to allocate the data to state level may not be fully representative of true incurred costs. State allocations may be outdated for MSAs that changed state borders in 2024	Include state directly in the "QPA and Offers" table and use updated annual MSA definitions
IDR geography reflects service location, while URRT/RAR data generally reflect member residence	The IDR costs may be geographically misaligned from the denominator in the percentage of allowed cost calculation	Include both state of service and member home state fields in the IDR data

Limitation	Implication on Results	Suggested IDR Data Improvement
Incurred date was not available in all months of the IDR data, so IDR costs were summarized according to resolution date rather than incurred date	The IDR costs may be misaligned from the URRT/RAR costs which represent incurred year	IDR data contains incurred date beginning with 2025 Q3. Incurred data should be included in both the "QPA and Offers" and the OON tables
Recent URRT experience may not fully reflect ultimate IDR payments because of long settlement lags	Percentage of claims estimates may be overstated due to the denominator not capturing total claims volume	N/A
Some CMS observations are suppressed for privacy reasons	Percentage of claims results may be understated for some states due to data omission	N/A
2024–2025 Individual Market allowed claims and premium were estimated	True market costs may vary from our estimates	N/A