

The Remit

BY NSA IDR NAVIGATOR

ISSUE 1

Sunday, October 11, 2026

Out-of-network payment, from the provider side.

The Remit is for physician groups, facilities and the billing teams that chase the money. Issue 1 covers what the 85% win rate leaves out, what the Fifth Circuit did to the QPA, the award-payment gap, the new IDR calendar, five fronts where providers are pushing back, and six numbers to track this month. Every figure carries its source type. Payer data and advocacy-group data are labeled as such.

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THE LEAD

The 85% win rate has a second half: plans often do not show up

In 2025, health plans made no offer on one in four decided line items.

Payers and their vendors read provider win rates as proof of gaming. Claritev's sponsored piece in Becker's Payer on Oct. 7 repeats the frame: providers prevailed in roughly 85% of cases, with a median award more than four times the qualifying payment amount.

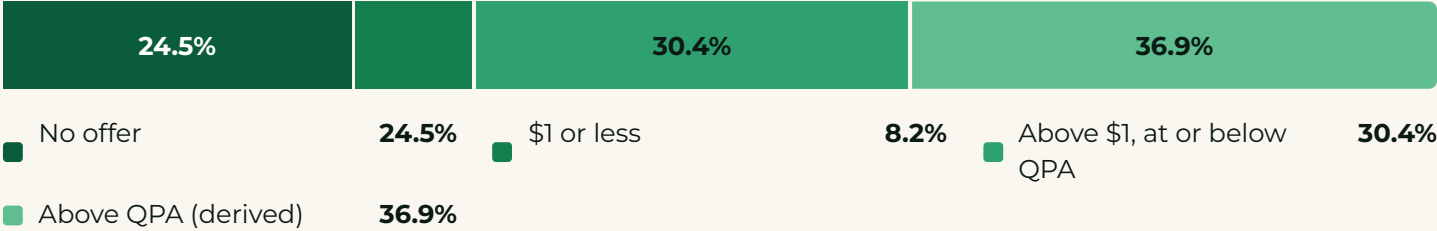
The same federal data has a plan-side view. In an analysis shared with Becker's on Sept. 22, the American Society of Anesthesiologists, the American College of Emergency Physicians and the American College of Radiology reviewed 4,667,944 line items decided in 2025 in which the health plan was the non-initiating party.

What plans offered on 4,667,944 decided line items, 2025

Share of line items by the best offer the plan made. Plan was the non-initiating party.

32.7% never received a genuine offer

63.1% never drew an offer above the QPA



▼ Table view

BEST PLAN OFFER	SHARE OF LINE ITEMS	LINE ITEMS
No offer	24.5%	1,144,168
\$1 or less	8.2%	382,114
Above \$1, at or below QPA	30.4%	not reported
Above QPA (100% minus 63.1%)	36.9%	derived

PROVIDER-GROUP ANALYSIS ASA, ACEP and ACR analysis of 2025 CMS federal IDR data, shared with Becker's ASC on Sept. 22, 2026. We did not reproduce it from the CMS public use files.

The mechanism is baseball-style arbitration: the arbitrator picks one of two offers. A plan that submits nothing, or \$1, hands the provider the win. The three groups say those numbers, not provider gaming, explain the high physician win rates.

The April 27 letter from the American Medical Association and more than 100 specialty and state societies makes a related claim. It cites a 2025 Congressional Research Service report for the point that the rise in provider win rates from 2023 to 2024 (80 to 85 percent) was largely attributable to default decisions.

WHAT TO DO

1. Record what the plan filed in every determination you receive: the offer amount, or no offer.
2. Score each plan every quarter: default rate, \$1-or-less rate, and share of offers at or below QPA.
3. Use the scorecard in negotiation and in complaints. The three groups ask Congress to “audit repeated extreme offers.”
4. When you initiate, document any failure to respond in open negotiation. The final rule requires the other party's formal response by business day 15, through the portal.

ITEMS 1 TO 4 ARE OUR RECOMMENDATIONS.

Sources: [Becker's ASC, Sept. 22](#) · [Becker's ASC, Oct. 9](#) · [Multisociety letter, Apr. 27, 2026](#) · [Becker's Payer, sponsored by Claritev, Oct. 7](#) · [Becker's Payer, May 28](#)

RULINGS

The Fifth Circuit took two things out of the QPA formula

Ghost rates and the blanket exclusion of bonus and incentive payments are out. Recalculation guidance has not arrived.

On Aug. 11, 2026, the full Fifth Circuit decided *Texas Medical Association v. HHS*, No. 23-40605 (TMA III). Seventeen judges produced four opinions. The court held that plans can no longer include non-negotiated “ghost rates” in the QPA, and cannot categorically exclude bonus, incentive, risk-sharing and other retrospective payment adjustments. It upheld the exclusion of single-case agreements and left the vacatur in place.

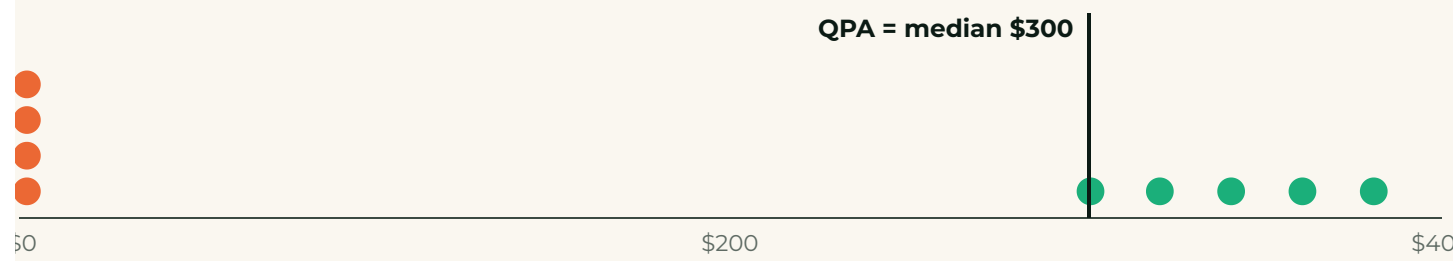
Ghost rates come from form contracts. A plan hands a provider a default fee schedule covering every covered service. The provider negotiates the rates it bills and leaves the rest untouched. The 2021 rule counted every

rate on the face of the contract. A 2022 FAQ removed only \$0 rates. The court saw no principled line between a \$0 rate and a \$1 rate.

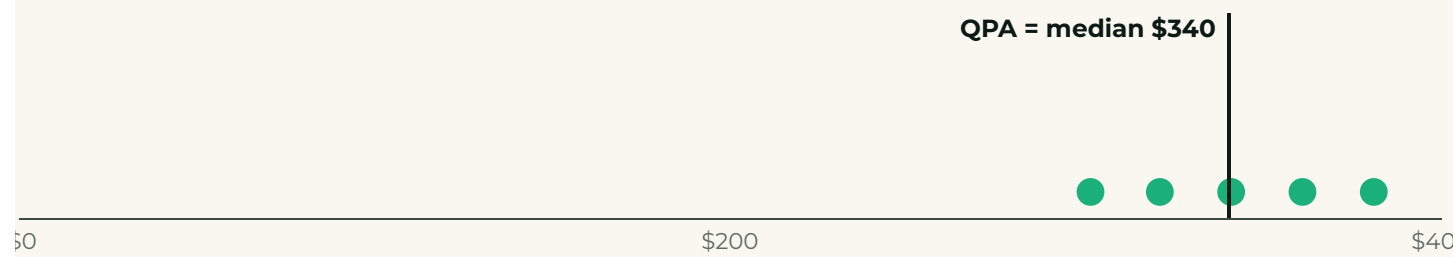
How placeholder rates pull a median down

Illustration with invented numbers, not data. One service, one plan: five rates the provider actually negotiated and four \$1 placeholders.

Counted as the 2021 rule allowed (nine rates)



After TMA III (five rates)



● Placeholder rate, \$1 ● Rate the provider negotiated

▼ Table view

CASE	RATES COUNTED	MEDIAN (QPA)
2021 rule	\$1, \$1, \$1, \$1, \$300, \$320, \$340, \$360, \$380	\$300
After TMA III	\$300, \$320, \$340, \$360, \$380	\$340

ILLUSTRATION Invented numbers. Real QPAs are set per service, market and plan.

“The APA, however, does not embrace a too-big-to-vacate principle. And administrative agencies cannot survive judicial review simply by making mistakes that are so colossal that the sky will fall if a court reviews them.”

Fifth Circuit en banc, as quoted by Polsinelli, Aug. 13, 2026. Quoted from Polsinelli; we did not read the opinion.

WHERE IT STANDS

FAQ Part 73 (Apr. 1, 2026) lets plans keep the 2021 methodology for items and services furnished before Oct. 1, 2026. The agencies said further

guidance follows the final decision. Polsinelli reported none as of Aug. 13. On Oct. 9 the physician groups said the agencies have yet to fully implement the ruling.

Unknown: whether relief was extended past Oct. 1, and whether corrected QPAs apply to past claims or completed determinations. Polsinelli states that nothing in TMA III currently authorizes reopening a completed determination over QPA methodology. It calls Supreme Court review plausible, not assured: the vote was close.

How wrong are QPAs today? Unknown at scale. Providers do not receive the rate-level data needed to reproduce the calculation. CMS's first published QPA audit (Aetna in Texas, air ambulance, services from January to June 2022) found the plan used claims paid instead of contracted rates and counted each claim as its own contracted rate. Georgetown's review counted five incorrect QPAs, about 2% of cases examined, with errors in both directions.

WHAT TO DO

1. Preserve every QPA disclosure, including any methodology statement. Request all available methodology information going forward.
2. Document which services your participating providers actually furnish. That is now the operative question for whether a rate belongs in the calculation.
3. Identify open disputes where the QPA is material. In final offers, state that ghost rates and the absence of bonus and incentive data depressed the QPA.
4. Preserve records on completed disputes.
5. Model both sides. A higher QPA also raises the recognized amount used for patient cost sharing. Neither the QPA nor the decision determines what an IDR entity selects.

ITEMS 1, 2, 4 AND 5 FOLLOW POLSINELLI. ITEM 3 FOLLOWS ARENTFOX SCHIFF.

Sources: [Polsinelli, Aug. 13](#) · [ArentFox Schiff](#) · [Health Affairs Forefront](#) · [FAQ Part 73](#) · [Becker's ASC, Oct. 9](#) · [Becker's Payer, CMS audit](#) · [Georgetown CHIR](#)

A determination is not a payment

Surveys disagree on how often plans pay awards on time. Nobody has audited it. Keep your own ledger.

Under the No Surprises Act, an IDR decision is final and binding, and payment is due within 30 days. Three sources report on whether that happens. They do not agree.

SOURCE	TYPE	WHAT IT REPORTS
AHIP and BCBSA survey, 25 plans, 154 million enrollees, 2024 data	PAYER DATA	Plans paid nearly three-quarters of awards within 30 days; 41% within 15 days. Delays most often traced to provider submission errors (wrong contact information, missing details) or volume.
Clinician survey across 45 states, cited in the Apr. 27, 2026 society letter	PROVIDER-GROUP DATA	22% of awards owed in 2023 and 11% in 2024 unpaid. Of 2024 payments made, 50% not within 30 days and 15% in an incorrect amount.
Earlier AFHC survey of 48,000 clinicians, as reported by Fierce Healthcare and HFMA	PROVIDER-GROUP DATA	52% of post-IDR payments not made; 49% of payments made not within 30 days; 33% in an incorrect amount.

Certainty: unknown. The samples and denominators differ. The gap is the reason to keep your own ledger.

SUING TO COLLECT

In the Fifth Circuit (Louisiana, Mississippi, Texas), private suits to enforce awards are closed. In *Guardian Flight v. Health Care Service Corporation*, the court held that Congress intended enforcement through HHS's administrative complaint process. The dispute covered 33 IDR payments HCSC allegedly never made, owing nearly \$1 million. The Supreme Court declined review in January 2026 (No. 25-441).

A federal district court in Connecticut went the other way in 2025 for air ambulance companies against Aetna and Cigna, who allegedly delayed or failed to make \$20 million in IDR payments. The insurers did not appeal. The No Surprises Enforcement Act (H.R. 4710) would penalize late payment at triple the gap between the initial payment and the award. It has not advanced.

AFTER THE AWARD

The society letter says some plans reprocess claims after a determination and send the patient a revised explanation of benefits, so the patient pays the difference. It cites a 2024 emergency-physician study in which 50 percent of respondents reported plans increased patient cost sharing after a determination. It also says some plans use June 2025 technical guidance to reopen final determinations and withhold payment. The Departments have warned plans against adjusting member cost sharing after a determination.

The 30-day clock, and the ledger that tracks it

Day 0 is the determination date. Day 30 is the statutory payment deadline. Day 31 is when you log the result and escalate.

1	2	3	4	5	6	7	8	9	10
11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30

Day 0: determination issued

Day 30: payment due

AWARD	DETERMINED	DUE (DAY 30)	PAID	STATUS
EX-1	Sep 1	Oct 1	Sep 24, full	● On time
EX-2	Sep 3	Oct 3	Oct 9, full	◆ 6 days late
EX-3	Sep 10	Oct 10	None	■ Day 31: escalate

TEMPLATE Example rows, not real claims. Add columns for plan, claim IDs, award amount and amount short.

WHAT TO DO

1. Enter every determination date in a ledger and compute day 30.
2. On day 31, mark each award paid in full, partial or unpaid, and record the amount short.
3. Keep the determination, the remittance and the claim IDs together for each award.
4. File a CMS complaint for each late or short payment and keep the complaint numbers. The Fifth Circuit relied on CMS “soliciting provider complaints and compelling payers to pay IDR awards where appropriate,” as quoted by HFMA.
5. Verify the payer contact information on every dispute. Payers attribute late payments to wrong contact data, and the payer registry in the new rule targets that problem.
6. Watch patient statements for changes after a determination. Send the examples to CMS and to counsel.

ITEMS 1 TO 3, 5 AND 6 ARE OUR RECOMMENDATIONS.

Sources: [AHIP and BCBSA survey, Oct. 2025](#) · [Multisociety letter](#) · [HFMA, Jan. 14](#) · [Fierce Healthcare](#) · [Reed Smith](#)

OPERATIONS

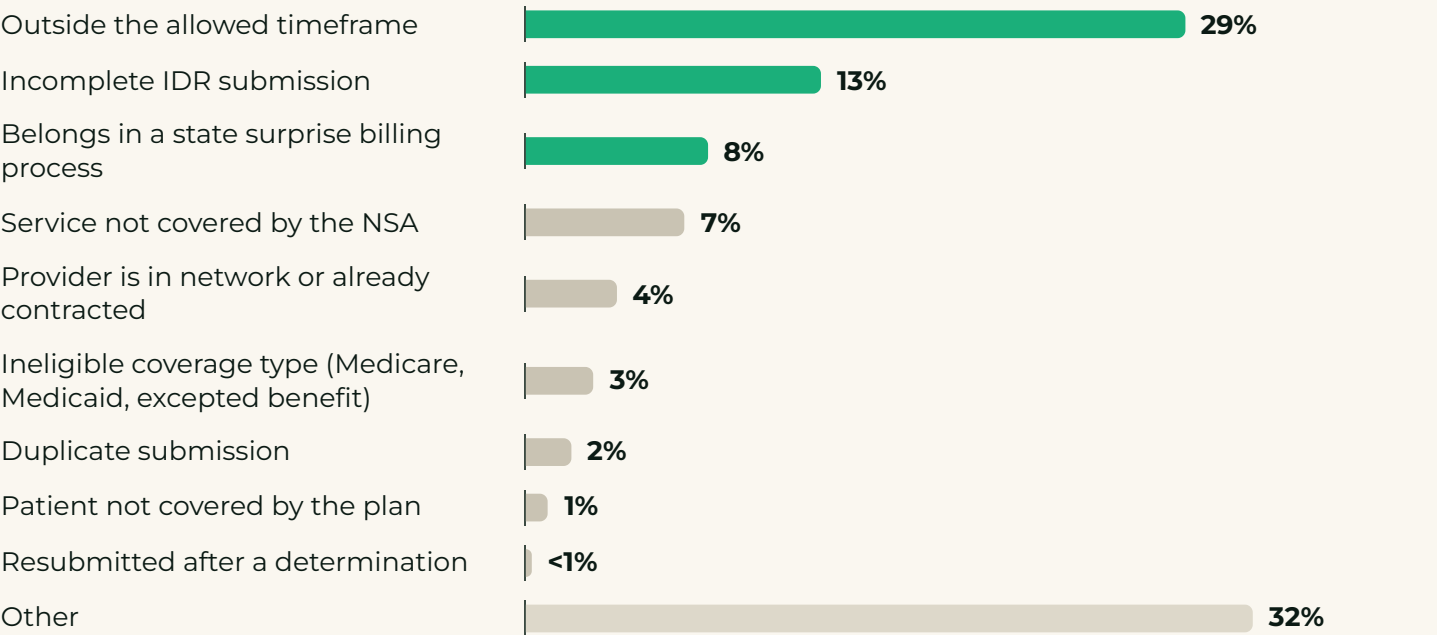
Do not hand the payer the ineligibility argument

Plans flag 39% of disputes as ineligible. The most common reasons are filing mistakes.

In the AHIP and BCBSA survey of 2024 data, plans identified 39% of 1.23 million disputes as ineligible. IDR entities deemed 17% ineligible. Federal data for the second half of 2025 shows more than 42% of disputes challenged by the non-initiating party and 19% ruled ineligible, down from 69% in the first half of 2022. Challenges mostly lose at the entity level. Each one still costs time, and each valid one hands the payer a talking point.

Why plans deemed disputes ineligible, 2024

Share of plan-identified ineligible disputes. Blue marks reasons an intake process controls (our classification).



▼ Table view

REASON	SHARE
Outside the allowed timeframe	29%
Incomplete IDR submission	13%
Belongs in a state surprise billing process	8%
Service not covered by the NSA	7%
Provider is in network or already contracted	4%
Ineligible coverage type	3%
Duplicate submission	2%
Patient not covered by the plan	1%
Resubmitted after a determination	<1%
Other	32%

PAYER DATA AHIP and BCBSA survey, fielded March to May 2025, 25 plans covering 154 million commercial enrollees. Plans classified their own challenges.

Timeframe, completeness and state routing add up to 50% of the reasons (29 + 13 + 8). HFMA adds two more frequent causes from the federal

departments: violating the 90-day cooling-off period, and filing federally when state surprise-billing law governs.

THE NEW CALENDAR

The IDR operations final rule was issued May 28, 2026. Polsinelli describes it as effective Aug. 3, 2026 and still phasing in.

The path from claim to payment under the final rule

- 1 Initial payment or denial**
The plan discloses the QPA with it.
- 2 Open negotiation: 30 business days**
Started through the federal portal. The other party must respond formally by business day 15.
- 3 Initiate IDR**
Within four business days after open negotiation ends. Unpaid fees at the offer deadline mean the offer is not considered received, and the debt remains.
- 4 Entity eligibility decision**
Within five business days of the entity's selection. Batches cap at 50 line items.
- 5 Determination, then payment**
Payment is due within 30 days. The per-party administrative fee falls from \$115 to \$15.

GOVERNMENT RULE Steps and figures from Becker's Payer's May 28 summary of the final rule. The four-business-day window is statutory; the coverage we fetched says "four days."

Batching widens. Claims can be grouped for a single patient on the same or consecutive dates of service billed together, for the same service code, or for anesthesiology, radiology, pathology and laboratory claims within the same CPT code section. A payer registry is coming: registration takes effect 90 business days after CMS issues guidance confirming the platform is live.

Small claims are the bulk of the work. Roughly 678,000 payment decisions in the second half of 2025, a majority, involved services with a QPA between \$100 and \$500. With a \$15 fee per party and 50-line batches, those disputes cost less to file. In that half-year, 62% of determinations came within 30 business days, against 37% in the first half.

WHAT TO DO

1. Add three gates before any filing: a timeline check, a completeness check and a state-law check.
2. Check the 90-day cooling-off period before filing a second dispute with the same payer for the same or similar services.
3. Start every open negotiation in the portal. Do not bundle thousands of items in one notice: federal officials found some notices doing that.
4. Pay the administrative and entity fees before the offer deadline.
5. Batch within the rule's categories and the 50 line-item cap.

ITEMS 1, 2 AND 4 ARE OUR RECOMMENDATIONS. ITEMS 3 AND 5 FOLLOW THE RULE.

Sources: [AHIP and BCBSA survey](#) · [HFMA, July 27](#) · [Becker's Payer, May 28](#) · [Polsinelli](#)

OFFENSE

Five fronts where providers are pushing back

Most are slow. All are open. Match the front to your exposure.

1. Antitrust

■ DISCOVERY · CLASS RULING NOT BEFORE 2027

The MultiPlan (now Claritev) MDL alleges the company pooled competitively sensitive data from roughly 700 plans and ran it through a pricing algorithm to suppress out-of-network rates. MultiPlan allegedly processes more than 80% of commercial out-of-network claims. The AMA and the Texas Medical Association are plaintiffs. The court largely denied dismissal in 2025 and has since added 17 insurers as defendants. On Sept. 21, 2026 a California appeals court revived the VHS Liquidating Trust's claims, holding that insurer reimbursements are prices subject to antitrust law.

Status: allegations. No liability finding.

Your move: ask counsel whether claims priced by MultiPlan or its platforms (Data iSight, Viant, NCN, ProPricer, MARS) fall in scope. Claims can reach back as long as 10 years from joining. Preserve claims and remittance data now.

2. IDR integrity suits

■ 3 PAYER SUITS DISMISSED · APPEALS PENDING

Elevance's Anthem Blue Cross (Apr. 9), BCBS Texas (May 22) and BCBS Georgia (July 10, with prejudice) sued HaloMD and provider groups over IDR volume and offers. All three were dismissed on the ground that judicial review of IDR outcomes is narrowly constrained. Appeals are underway or announced. Highmark (Pennsylvania) and Community Insurance Company (Ohio) cases remain pending.

Your move: audit your own attestations and offers. The Georgia complaint alleged false eligibility attestations and offers above billed charges. The case was dismissed, and it shows what payers look for.

3. The QPA rules

■ VACATUR STANDS · GUIDANCE PENDING

The ghost-rate and incentive-payment holdings reset the benchmark. See Rulings above.

Your move: preserve QPA disclosures, document services furnished, and put the depressed-QPA argument in every open final offer.

4. Congress and the agencies

■ BILLS PENDING · LETTERS FILED

Rep. Pallone's Lower Premiums, Faster Payments Act would eliminate IDR and let insurers calculate out-of-network payment. ASA, ACEP and ACR opposed it on Oct. 9. They ask Congress to use CMS data to flag outlier providers, insurers and IDR entities, audit repeated extreme offers, require payment within 30 days, and let the May 2026 rule take effect. The Apr. 27 letter asks the Departments for rigorous QPA audits with penalties.

Your move: give your specialty society your plan scorecard and ledger. File CMS complaints. Tell your members of Congress where the 30-day deadline fails.

5. States and network leverage

■ INDIANA LAW PASSED • CALIFORNIA SUIT FILED

Elevance's Anthem imposes a 10% penalty on facility claims that involve out-of-network clinicians in 11 states, effective Jan. 1, 2026, with possible network termination. Indiana passed a law in February banning such penalties. The California Hospital Association sued in May. Fourteen House members asked for a federal investigation. The Indiana law also lets a plan trigger mandatory good-faith negotiation after 25 or more IDR disputes in 90 days.

Your move: do not sign a form fee schedule with rates for services you do not furnish. Strike them. Document any contract-cut notice that cites the NSA and report it to your state regulator and specialty society.

EVERY "YOUR MOVE" IS OUR RECOMMENDATION. TALK TO COUNSEL BEFORE JOINING LITIGATION OR CHANGING CONTRACTS.

"Providers who can reliably beat QPA by those multiples in arbitration have little incentive to sign network contract rates that are anywhere near the market median."

Jennifer Forcash, assistant vice president of innovation and solution lifecycle, Claritev. Becker's Payer sponsored content, Oct. 7, 2026. A payer-side vendor describing your leverage in its own words.

RECEIPTS

The payment record, dated

Settlements are not liability findings. Rulings are labeled as what they are.

Apr. 27, 2007
SETTLEMENT

Love v. Blue Cross Blue Shield Association. The association and 23 plans funded a \$128 million settlement for about 900,000 physicians. Plaintiffs alleged claims systems paid for less intensive services than were provided, and conspired to delay and deny payment.

2021
LETTERS

Blue Cross NC. Letters to anesthesiology and other practices threatened termination unless they accepted cuts of 10 percent to more than 30 percent, citing the No Surprises Act before it took effect.

“Where Blue Cross NC may have previously contracted at what we deemed an inflated rate that is at least somewhat lower than charges in order to avoid paying at full charge, we are now able to seek to contract at a rate more in line with that we consider to be reasonable”

Letter text as reproduced by TechTarget; acquired by the ASA. We have not seen the letter.

Aug. 19, 2025
SETTLEMENT

In re Blue Cross Blue Shield Antitrust Litigation. Final approval of a \$2.8 billion provider settlement, covering claims back to 2008, resolving allegations that the Blues divided markets and lowered reimbursement. Opt-out providers continue to litigate.

July 10, 2026
DISMISSAL

BCBS Georgia v. HaloMD. Judge Thrash dismissed the insurer's IDR-fraud suit with prejudice and wrote:

“It is highly plausible to infer that the Plaintiff engages in a consistent practice of submitting lowball offers to out-of-network providers in an effort to maximize its profits.”

As reproduced by HFMA, July 27, 2026. A pleading-stage inference, not a finding of fact. We could not open the opinion.

Aug. 11, 2026
RULING

TMA III. En banc Fifth Circuit bars ghost rates in the QPA and categorical exclusion of bonus and incentive payments.

Sept. 21, 2026
RULING

VHS Liquidating Trust v. MultiPlan. California First Appellate District, unanimous, holds that insurer reimbursements to providers are prices subject to antitrust law and revives the claims.

Sources: [HFMA, MDL rulings](#) · [TMA, Apr. 6](#) · [MSMS, Aug. 2026](#) · [Insurance Business, Sept. 24](#) · [Becker's Payer, HaloMD dismissal](#) · [HFMA, July 27](#) · [Becker's Payer, May 28](#) · [Becker's ASC, Oct. 9](#) · [Becker's Hospital Review, Indiana](#) · [Fierce](#)

METRICS

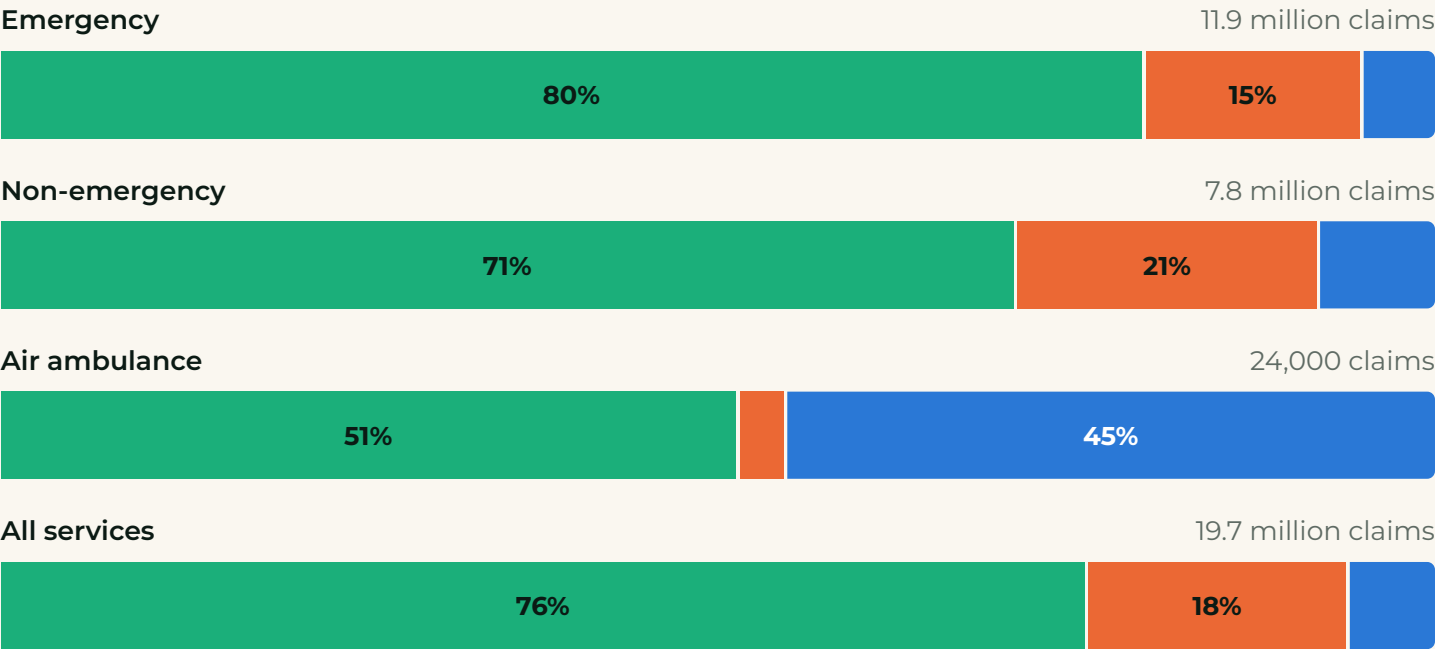
Six numbers to start tracking this month

The payer survey gives you a benchmark for your own claim mix.

In the AHIP and BCBSA data for 2024, 76% of 19.7 million NSA-eligible claims were paid without dispute. 18% resolved in open negotiation. About 6% entered IDR. Air ambulance is the outlier, at 45%. These are payer-reported figures. Use them to test whether your mix looks typical, not as proof of how claims should end.

Where NSA-eligible claims ended up, 2024

Share of qualified claims by outcome, by service type. Rows may not sum to 100% because of rounding.



Initial payment accepted

Resolved in open negotiation

Entered IDR arbitration

▼ Table view

SERVICE TYPE	CLAIMS	ACCEPTED	NEGOTIATION	IDR
Emergency	11,900,000	80%	15%	5%
Non-emergency	7,800,000	71%	21%	8%
Air ambulance	24,000	51%	3%	45%
All services	19,700,000	76%	18%	6%

PAYER DATA

 AHIP and BCBSA survey of 25 plans covering 154 million commercial enrollees, scaled to a national estimate by the authors.

TRACK THESE

- 1. Initial payment accepted rate**, by plan and service type. Compare to the benchmark above.
- 2. Initial payment as a percent of the disclosed QPA**, by plan. Plans must disclose the QPA with the initial payment or denial, and CMS's Aetna audit found a plan that did not always do so.
- 3. Days from service to initial payment**, by plan.
- 4. Default and \$1-or-less offer rate**, by plan, from your determinations.
- 5. Awards paid by day 30**, and dollars short, from your ledger.
- 6. Eligibility rejection rate**, with the reason, from your own filings.

THE METRIC LIST IS OUR RECOMMENDATION.

WATCH CONCENTRATION

Three filers (HaloMD, TeamHealth and SCP Health) accounted for 38% of all IDR filings in the second half of 2025. Payers answer concentration with lawsuits and policy: Elevance's 10% facility penalty is one. Track your revenue share by plan, and know what a termination notice does to that share before one arrives.

Sources: [AHIP and BCBSA survey](#) · [HFMA, July 27](#) · [Becker's Payer, CMS audit](#)

THE OTHER SIDE

What payers will say back, and what holds up

Know the strongest version of the opposing case before you walk into the room.

- 1. Awards exceed in-network rates, not only the QPA.** A study by authors affiliated with Elevance found median awards at 3.72 times the QPA and 2.04 times the median allowed amount on matched Elevance in-network claims, across 7,076 disputes. One author is an Elevance employee and stockholder. Georgetown CHIR reports a 2025 median prevailing award of 445% of QPA, and 1,771% at the 90th percentile.
- 2. Volume is concentrated.** Three filers made 38% of filings in the second half of 2025. A Health Affairs study found Radiology Partners and TeamHealth accounted for 43% of resolved line-item claims in 2023 and 2024, and the top five providers for 59%.
- 3. Ineligible filings are real.** 19% were ruled ineligible in the second half of 2025, and plans challenged more than 42%.
- 4. The bill is large.** Health Affairs researchers put total IDR-related costs at \$22.4 billion by the end of 2025, including \$4.2 billion in administrative costs and \$2.7 billion in IDR entity fees, and expect premiums to carry it.
- 5. The court wins are narrow.** The dismissals rest on limited judicial review of IDR outcomes, appeals are pending, and the Thrash sentence is an inference at the pleading stage. The BCBS settlements are not liability findings.

Sources: [Polsinelli](#) · [Becker's Payer](#), Georgetown CHIR · [Becker's Payer](#), Health Affairs study · [Fierce Healthcare](#) · [HFMA](#), July 27

WATCH LIST

What moves next

- 1.** Agency guidance on QPA recalculation after TMA III, and whether the Oct. 1 enforcement relief was extended.
- 2.** A possible Supreme Court petition in TMA III.

3. CMS guidance confirming the payer registry is live. It starts the 90-business-day clock.
 4. MDL class certification, not expected until 2027.
 5. Appeals of the HaloMD dismissals, and the Highmark and Community Insurance cases.
 6. Rep. Pallone's Lower Premiums, Faster Payments Act and the No Surprises Enforcement Act (H.R. 4710).
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The Remit by NSA IDR Navigator, Issue 1. October 11, 2026. This newsletter is informational and is not legal advice. Consult counsel before joining litigation, changing contracts or filing complaints.

How we label sources. “Payer data” comes from health plans, their trade groups or their vendors. “Provider-group data” comes from physician societies and advocacy groups. “Government rule” and court items come from the agencies and courts, as reported by the outlet linked. Where we quote text we did not read in the original, the caption says so. Illustrations use invented numbers and say so.

Not verified this issue. The CMS public use files behind the 2025 default analysis; the Georgia opinion text; the text of the Fifth Circuit opinion; the Federal Register publication date of the final rule.