

Why the No Surprises Act Can't Arbitrate Fair Healthcare Prices

Real market prices, not bureaucratic blind auctions, are needed to end surprise medical bills.

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Imagine going to the hospital for an urgent medical emergency. You even checked that the facility is in-network with your health insurance. But weeks later, you open the mail to find a devastating \$50,000 surprise medical bill! How could that happen? While the hospital itself was in your insurer's network, the specific attending physician assigned to care for you was not.

To shield patients from these kinds of out-of-network (OON) surprise medical bills, Congress passed the No Surprises Act (NSA) in 2020, which went into full effect in 2022. The legislation successfully prevented patients from getting these surprise medical bills by banning providers from balance billing patients for out-of-network care. Instead, it forced insurers and OON providers to resolve payment disputes through a government-mandated Independent Dispute Resolution (IDR) process. Under this system, if an OON provider believes an insurer's reimbursement is too low, the provider submits a claim to a certified arbiter to settle the score.

The bipartisan consensus behind the passing of the NSA into law was celebratory, hailed as a triumph of consumer protection. But the NSA has a fundamental flaw: it attempts to arbitrate "fair" healthcare prices in an environment where real market prices do not exist.

In a functioning economy, prices are discovered through open trade based on value, cost, and scarcity. In American healthcare, prices are merely artifacts of leverage, largely determined by regulatory capture rather than by free competition for a better deal. Insurers and hospital conglomerates engage in a perpetual game of high-stakes haggling — providers start prices absurdly high, insurers counter absurdly low, and they meet wherever their respective negotiating powers dictate. The party with the greater leverage (more government backing, larger dependent patient pool, etc.) wins; the party with fewer options loses. Long before the NSA was enacted, the notion of a fair, or market-based, healthcare price was simply a myth. Any price in the current market only reflects what one group can extract from another.

To be clear, independent dispute resolution systems can sometimes work. They are not an inherently flawed idea. For instance, they can work well in circumstances where the number of cases is manageable; where the disputes are large enough to justify the administrative costs of the process; and where there are real market-based prices that can serve as reference points and that are transparently shared in the arbitration process. Transparent, market-based prices are the primary foundation for any IDR process to even approach a fair resolution.

But as we've established, there are no real, transparent prices in healthcare. As a result, the NSA's IDR process did not fix the pricing problem with healthcare; it merely institutionalized the inherent unfairness that inevitably comes with the lack of real market prices.

To add insult to injury, the IDR process itself is fraught with poorly designed parameters that lead to gaming and the exploitation of conflicts of interest. For example, instead of both sides submitting reasonable offers, the law establishes a blind auction. Arbiters, heavily incentivized by the fee structures and a desire for repeat business, overwhelmingly sided with claimant providers, frequently validating vastly inflated out-of-network claims.

This failure forced federal regulators to scramble: adjusting arbiter fees, permitting the bundling of claims, and clamping down on ineligible submissions. Providers and insurers submit their final payment offers simultaneously, completely hidden from one another. The arbiter is legally barred from splitting the difference; he must select one offer or the other. Many providers now appear to have adopted IDR arbitration as a routine business strategy rather than an act of last resort.

These most recent administrative patch-ups merely make an unfair system slightly less extortionary. They fail to address the underlying problem: the IDR process rests on the false assumption that anyone can arbitrate a fair price in the absence of a market with real prices.

To build a fairer system, we must first address the OON exclusions that drive surprise billing, understand why they exist, and how they contribute to the unfair system we now have.

Exclusions of this nature are practically nonexistent in other industries that utilize insurance. Auto insurance handles catastrophic damages without trapping consumers in a web of hidden networks. You do not discover that the mechanic welding your chassis is "out-of-network." But health insurance, as it functions in American healthcare, is fundamentally distinct from every other insurance product.

True insurance protects against catastrophic, highly volatile, and unpredictable financial ruin—like a major car wreck. We do not use auto insurance to pay for routine oil changes or new tires. We do not deploy homeowners insurance to repaint the kitchen. Because consumers pay directly for these predictable, routine maintenance items, a vibrant and highly competitive cash market exists. Mechanics and contractors are incentivized to cut costs, maximize efficiency, and publish transparent, upfront pricing to attract paying customers.

Health insurance functions upside down. By expanding its scope to cover routine, predictable, and highly shoppable medical maintenance, we have systematically decoupled the consumer from the financial transaction. As a result, healthcare providers are not rewarded for developing clear, competitive prices to win over patients. They are actively penalized for it. If a hospital cuts its costs and openly lowers its list prices, it destroys its own leverage in the next round of closed-door negotiations with consolidated insurance networks.

If it weren't for our over-reliance on comprehensive insurance, these complicated insurance networks wouldn't exist, and most of the problem of surprise billing would go away. In-network status is a contractual arrangement in which a provider guarantees a discounted rate to an insurer in exchange for a steady stream of captive policyholders (patients). From this limited vantage point, an OON provider charging astronomical fees appears exploitative.

But providers don't always know whether or not they are out of network. In a system completely unmoored from market signals, billers are navigating blind when it comes to OON bills that haven't been previously negotiated. Because insurer contracts hide prices behind non-disclosure agreements and proprietary algorithms, it's impossible to know whether an OON charge is competitive, exploitative, or identical to what the insurer pays a favored in-network provider.

Fairness means giving someone *what they are worth*. Fairness therefore requires a *knowable world*. It demands an environment where honest trade is possible because data is public and rules are known. The NSA was bound to fail because the state cannot decree fair prices into existence while legally maintaining the shadows that hide them — the negotiations that occur behind closed doors between insurers, providers, employers, and all the intermediaries who stand to gain from expanding and maintaining upside-down comprehensive health insurance.

Real fairness does not mean forcing a government-sanctioned arbiter to choose between two arbitrary numbers concocted by blind corporate actors. Real fairness means voluntary exchange and advertising of your prices in a system that rewards excellent providers who offer superior value. Real fairness empowers patients to vote with their wallets.

Achieving fair, competitive prices requires shrinking the domain of third-party health insurance back to its rightful, catastrophic boundaries. For the vast majority of routine, outpatient, and predictable medical care, we need an actual market built on direct pay and true price discovery.

An affordable healthcare market with transparency, rather than surprise bills, is not an ideological pipe dream; it is an active, rapidly expanding reality. Across America, Direct Primary Care (DPC) clinics, cash-pay surgery centers, and cash-pay or transparently priced imaging facilities are thriving. In these clinics, surprise medical bills are impossible. Why? Because these providers post their prices openly and publicly. As a result of this transparency, they compete directly on the fairness of prices relative to access, quality, and outcomes rather than their ability to leverage and manipulate an inherently unfair pricing system.

The hard work of American healthcare reform is not found in endlessly tinkering with the mechanics of the IDR process or optimizing a blind bureaucratic auction. It lies in having the courage to dismantle the third-party distortions that make healthcare un-shoppable and expose patients to arbitrary and unfair surprise medical bills. True fairness is not a well-arbitrated illusion; it is a clear price, an honest transaction, and an empowered patient.

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