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Fifth Circuit Vacates No Surprises Act Payment Methodology

On August 11, 2026, the U.S. Court of Appeals for the Fifth Circuit, sitting en banc, vacated central portions of the federal rules governing how health insurers calculate the "qualifying payment amount" (QPA) under the No Surprises Act (NSA).[1] The decision in *Texas Medical Association v. U.S. Department of Health and Human Services* (TMA III) is the latest in a string of provider victories reshaping the NSA's out-of-network payment framework. This Health Capital Topics article reviews the statutory framework, the incentives independent dispute resolution (IDR) process has unintentionally created, the court's holdings, and the resulting state of play.

The No Surprises Act Framework

Enacted as part of the Consolidated Appropriations Act, 2021 and effective January 1, 2022, the NSA bars balance billing for most out-of-network care a patient cannot reasonably avoid.[2] Patients owe only in-network cost-sharing, and the balance is left to the provider and the plan.

If the parties cannot agree during a 30-business-day open negotiation period, either may initiate the federal IDR process within the following four business days.[3] IDR is "baseball-style" arbitration: each side submits a final offer, and a certified IDR entity selects one of the two.[4] The NSA defines the QPA as the median of the in-network rates an insurer has contracted to pay for a given service, grouped by provider specialty and geographic region, with each rate counted at the "total maximum payment" the insurer would owe.[5] The QPA sets the patient's cost-sharing obligation and is the first factor an arbitrator must consider.[6]

Not every out-of-network bill reaches federal IDR. Only "qualified IDR items or services" are eligible: emergency and post-stabilization services, non-emergency services furnished by out-of-network providers at in-network facilities, and air ambulance services.[7] Claims priced by a specified state surprise billing law or an All-Payer Model Agreement go to the state process instead; ground ambulance services, which Congress left out of the NSA, are not covered; and Medicare, Medicaid, and other federal programs fall outside the statute. A dispute is also ineligible if the parties skipped open negotiation, filed outside the four-business-day window, or filed within the 90-day cooling-off period following a determination between the same parties over the same or similar services.[8]

The statute left the calculation methodology to regulation. The Departments of Health and Human Services, Labor, and Treasury (the Departments) supplied the details in an interim final rule published July 13, 2021 (the July 2021 Rule), issued without notice and comment.[9]

Unintended Incentives

The NSA has largely achieved its consumer protection goal, but the arbitration apparatus behind it has far outgrown expectations. The Congressional Budget Office (CBO) reported that roughly 3.4 million disputes were filed between 2022 and mid-2025, against an initial projection of approximately 22,000 per year.[10] The Fifth Circuit put it more bluntly, noting that arbitration volume "dwarfed the agencies' expectations by a factor of 84."[11]

Outcomes have skewed sharply toward providers. In the second half of 2025, parties initiated over 1.37 million disputes, 16% more than in the first half, and certified IDR entities issued over 1.14 million payment determinations.[12] Providers prevailed in approximately 85%, and the prevailing offer exceeded the QPA roughly 87% of the time.[13]

Award size matters as much as the win rate. Emergency services accounted for 52% of determinations, with median awards of 324% of the QPA in the third quarter of 2025 and 334% in the fourth.[14] Median surgical awards reached 1,449% and 1,503% across the two quarters, while neurology and neuromuscular procedures, spanning more than 66,000 determinations, produced medians of 2,394% and 2,585%.[15]

Activity is concentrated: HaloMD, TeamHealth, and SCP Health together accounted for 38% of filings, and Texas alone generated 524,630 disputes.[16] TeamHealth and SCP Health are large physician staffing groups supplying emergency medicine, hospital medicine, and anesthesiology clinicians; HaloMD is a technology and administrative services intermediary that files and manages IDR disputes on providers' behalf. Researchers have noted that the largest initiating parties are mostly private equity backed.[17] Insurers have sued HaloMD in several jurisdictions alleging misuse of the process, without success to date.[18]

CBO has warned that these dynamics may invert the law's fiscal effect. Its original score projected $17 billion in deficit reduction from 2021 through 2030 and a roughly 1% premium reduction, premised on arbitration

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restraining out-of-network prices.[19] If providers can reliably win large awards through IDR, CBO now observes, "they have an incentive to remain out of network or demand higher in-network rates." Parties have also spent nearly $900 million in arbitration fees through 2024, and insurers are expected to pass higher costs to employers and consumers.[20]

The Fifth Circuit's Decision

The plaintiffs, including the Texas Medical Association, Tyler Regional Hospital, and several air ambulance operators, challenged three features of the QPA methodology. The U.S. District Court for the Eastern District of Texas ruled for them and vacated the July 2021 Rule and related guidance; a Fifth Circuit panel reversed; and the full court granted rehearing en banc, wiping out the panel opinion.[21] The en banc court agreed with the plaintiffs on two issues and with the Departments on the third.

Ghost Rates

The July 2021 Rule directed insurers to treat "each contracted rate for a given item or service" as a single data point "regardless of the number of claims paid at that contracted rate."[22] Insurers typically hand providers a form contract with a default fee schedule for every covered service, and providers negotiate only the rates for services they intend to furnish. The resulting contracts carry unnegotiated "ghost rates," which can run as low as $0, for services the provider never performs. In August 2022 guidance, the Departments directed insurers to drop $0 rates while leaving rates as low as $1 in place.[23]

The court held the methodology contrary to the statute, which limits the QPA to items and services "provided by a provider" and "furnished" in the relevant region.[24] A $1 ghost rate, the court reasoned, is no more the product of negotiation than a $0 rate.[25] Citing survey evidence that 57% of primary care professionals hold contracts with rates for services they never provide, the court concluded that "[t]he inclusion of ghost rates in the QPA calculation is no minor problem."[26]

Bonus and Incentive Payments

The July 2021 Rule required insurers to exclude "risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments" from the QPA.[27] Because the statute keys the calculation to the "total maximum payment" under a plan, the court held that excluding such payments leaves providers with less than the statutory benchmark.[28]

Single-Case Agreements

The court sided with the Departments on excluding one-off, case-specific agreements from "contracted rates," a question of particular importance to air ambulance providers. Such agreements arise precisely because a provider sits outside the network, and folding those surprise rates into a benchmark meant to approximate in-network rates, the court reasoned, "makes little sense."[29]

The court ordered vacatur, meaning the offending portions of the rule and guidance are wiped off the books entirely rather than merely declared unenforceable against these plaintiffs. Vacatur is the default remedy in the Fifth Circuit when an agency violates the Administrative Procedure Act. Rejecting the Departments' warning that erasing the methodology would disrupt IDR, the court observed that the statute "does not embrace a too-big-to-vacate principle" and that agencies "cannot survive judicial review simply by making mistakes that are so colossal that the sky will fall if a court reviews them."[30] Vacatur would not produce "all-out chaos," the court added, because the Departments may exercise enforcement discretion to let insurers keep using existing QPAs until new ones are calculated.[31] The court affirmed in part, reversed in part, and remanded to the Eastern District of Texas for further proceedings consistent with the opinion.[32]

Current State of Play

On August 13, 2026, the Departments posted a notice confirming that they are "reviewing this opinion and judgment and anticipate issuing guidance shortly," and that "[t]he Federal Independent Dispute Resolution process remains operational."[33] No compliance deadline for recalculated QPAs has been announced, and the Departments retain the option to seek further review.

Both surviving holdings push QPAs upward. Removing unnegotiated ghost rates strips the lowest values out of the median, and adding bonus and incentive compensation raises those that remain. Higher QPAs lift the baseline for arbitration and for initial payment offers and, because cost-sharing is calculated from the recognized amount, may raise patient out-of-pocket costs as well.

The ruling lands alongside the Departments' Federal Independent Dispute Resolution Operations final rule, published June 4, 2026 and effective August 3, 2026.[34] For disputes initiated on or after June 11, 2026, the rule cut the administrative fee from $115 to $15 per party, a reduction of more than 85%.[35] It also loosened batching, the practice of combining multiple claims into one arbitration so the parties pay a single set of fees and receive one determination. Claims may now be grouped when they involve one patient in a single encounter, share the same or a comparable service code, or fall within the same Category I CPT range for anesthesiology, radiology, pathology, or laboratory services. The rule tightened the process in other respects, capping a batched dispute at 50 line items, refusing to let providers batch different patients' emergency medicine evaluation codes together, and requiring certified IDR entities to resolve eligibility within five business days. Open negotiation notices must now run through the federal portal, and plans and issuers must register.[36] Whether these changes, combined with a higher QPA, moderate or accelerate filing volume remains an open question.

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Conclusion

The en banc decision removes the last significant judicial defense of the Departments' original QPA methodology and confirms a pattern in which courts, rather than the agencies, have set the terms of the NSA's payment machinery. For providers with heavy out-of-network exposure, particularly in emergency medicine, radiology, anesthesiology, and neuromonitoring, it points toward higher reimbursement and revised revenue expectations; for insurers and employers, toward higher claims costs at a time when CBO has already questioned whether the NSA will deliver its projected savings. The pace of that shift will depend on the Departments' forthcoming guidance.

1 "Texas Medical Association, et al. v. United States Department of Health and Human Services, et al." Case No. 23-40605 (5th Cir., August 11, 2026), En Banc Opinion, p. 18.
2 "Consolidated Appropriations Act, 2021" Pub. L. No. 116-260, Div. BB, Title I, 134 Stat. 1182 (December 27, 2020); "Preventing Surprise Medical Bills" 42 U.S.C. § 300gg-111.
3 "Independent Dispute Resolution Process" 45 C.F.R. § 149.510(b)(1)(i), (b)(2)(i).
4 "Preventing Surprise Medical Bills" 42 U.S.C. § 300gg-111(c)(5)(A); "Independent Dispute Resolution Process" 45 C.F.R. § 149.510(c)(4)(i).
5 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I).
6 *Ibid*, § 300gg-111(a)(1)(C)(iii), (c)(5)(C)(i)(I).
7 45 C.F.R. § 149.510(a)(2)(xi).
8 *Ibid*, § 149.510(a)(2)(xi)(A), (b)(2)(i), (c)(4)(vii)(B); "Payment Disputes Between Providers and Health Plans" Centers for Medicare & Medicaid Services, https://www.cms.gov/nosurprises/help-resolve-payment-disputes/payment-disputes-between-providers-and-health-plans (Accessed 8/14/26).
9 "Requirements Related to Surprise Billing; Part I" Federal Register, Vol. 86, No. 131 (July 13, 2021), p. 36872, 36917-18.
10 "A Call for New Research on the No Surprises Act" By Jessica Hale, Tamara Hayford, and Daria Pelech, Congressional Budget Office, June 15, 2026, https://www.cbo.gov/publication/62491 (Accessed 8/14/26).
11 Case No. 23-40605 (5th Cir., August 11, 2026), En Banc Opinion, p. 8.
12 "Federal IDR Public Use File Supplemental Background: 2025 Q3 – 2025 Q4" Centers for Medicare & Medicaid Services, July 22, 2026, https://www.cms.gov/priorities/innovation/data-and-reports/2026/federal-idr-supplemental-background-2025-q3-2025-q4 (Accessed 8/14/26).
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14 "New Data on No Surprises Act IDR Cases Show Providers Won Often in 2025" By Nick Hut, Posted on Healthcare Financial Management Association, July 27, 2026, https://www.hfma.org/payment-reimbursement-and-managed-care/no-surprises-act-idr-data-provider-wins/ (Accessed 8/14/26); "Independent Dispute Resolution Reports" Centers for Medicare & Medicaid Services, https://www.cms.gov/nosurprises/policies-and-resources/reports (Accessed 8/14/26).
15 *Ibid*.
16 *Ibid*.
17 *Ibid*; "The No Surprises Act IDR Process: An Early Look At 2025 Data" By Jack Hoadley, Kennah Watts, Katie Keith, and Ellie DeGarmo, Center on Health Insurance Reforms, Georgetown University, March 20, 2026, https://chir.georgetown.edu/the-no-surprises-act-idr-process-an-early-look-at-2025-data/ (Accessed 8/14/26).
18 Hut, Posted on Healthcare Financial Management Association, July 27, 2026.
19 "CBO's Approach to Estimating the Budgetary Effects of the No Surprises Act of 2021" Congressional Budget Office, March 7, 2024, https://www.cbo.gov/publication/59878 (Accessed 8/14/26).
20 "A Call for New Research on the No Surprises Act" By Jessica Hale, Tamara Hayford, and Daria Pelech, Congressional Budget Office, June 15, 2026, https://www.cbo.gov/publication/62491 (Accessed 8/14/26); "5th Circuit Strikes Down No Surprises Billing Benchmark in Win for Providers" By Rebecca Pifer Parduhn, Healthcare Dive, August 13, 2026, https://www.healthcaredive.com/news/5th-circuit-vacates-nsa-qpa-ghost-rate-tma-ruling/827771/ (Accessed 8/14/26).
21 Case No. 23-40605 (5th Cir., August 11, 2026), En Banc Opinion, p. 3; "Texas Medical Association v. United States Department of Health and Human Services" 120 F.4th 494 (5th Cir., 2024), reh'g en banc granted, opinion vacated, 138 F.4th 961 (5th Cir., 2025).
22 "Requirements Related to Surprise Billing; Part I" Federal Register, Vol. 86, No. 131 (July 13, 2021), p. 36889.
23 Case No. 23-40605 (5th Cir., August 11, 2026), En Banc Opinion, pp. 4-5.
24 *Ibid*, pp. 5-6.
25 *Ibid*, p. 6.
26 "*Ibid*, p. 7.
27 "Methodology for Calculating Qualifying Payment Amount" 45 C.F.R. § 149.140(b)(2)(iv).
28 Case No. 23-40605 (5th Cir., August 11, 2026), En Banc Opinion, pp. 10-11.
29 *Ibid*, pp. 13-14.
30 *Ibid*, p. 17.
31 *Ibid*.
32 *Ibid*, p. 18.
33 "Notices" Centers for Medicare & Medicaid Services, August 13, 2026, https://www.cms.gov/nosurprises/notices (Accessed 8/14/26).
34 "Federal Independent Dispute Resolution Operations" Federal Register, Vol. 91, No. 107 (June 4, 2026), p. 33900.
35 "Federal Rule Takes Aim at Health Care Bureaucracy, Reducing Dispute Fees, and Boosting Transparency" Centers for Medicare & Medicaid Services, Press Release, May 28, 2026, https://www.cms.gov/newsroom/press-releases/federal-rule-takes-aim-health-care-bureaucracy-reducing-dispute-fees-boosting-transparency (Accessed 8/14/26).
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