Elevance Health | Public Policy Institute

The No Surprises Act: Dismissal Rates for Out-of-Scope and Ineligible Disputes

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Contents

Key Takeaways

- Under the No Surprises Act (NSA), payment for certain out-of-network services may be resolved through an independent dispute resolution (IDR) process.
- A majority of disputes submitted through the IDR process (69%) are out of scope of the federal law or are ineligible for IDR for procedural reasons, but only 36 percent of out-of-scope and ineligible disputes are dismissed by IDR entities (IDREs).
- Inclusion of out-of-scope and ineligible disputes in the IDR process contributes to unnecessary increases in healthcare costs; policy changes are needed to address this concern while preserving patient protections from surprise bills.

Overview

The volume of disputed claims submitted under the No Surprises Act (NSA) has increased sharply since 2022. A rising number of disputed claims are out of scope of the law's protections or are ineligible for the independent dispute resolution (IDR) process for procedural reasons. These disputes should be dismissed before going through the IDR process, but many are not.

For out-of-scope claims, this can result in health plans paying for services not intended to be covered under the NSA. As a result, these inappropriate IDR decisions contribute to rising healthcare costs. Ineligible claims, by contrast, involve services that are intended to be covered under the NSA but are procedurally deficient. Allowing these procedurally deficient claims to proceed through IDR undermines the procedural requirements and safeguards established for the process.

As federal lawmakers consider how to improve patient protections from surprise billing and contain healthcare costs, understanding how out-of-scope and ineligible disputes are handled will help improve the IDR process. This paper quantifies the rate at which out-of-scope and ineligible disputes were dismissed in 2025. Further, it examines dismissal rates by the reason a dispute was out of scope or ineligible (according to Elevance Health data), provider location, procedure type, and IDR entity (IDRE).

An increasing number of disputes are out of scope of the NSA or ineligible for the IDR process.

Background

The NSA, which went into effect in January 2022, protects patients nationally from surprise medical bills, which are charges for out-of-network care that patients did not anticipate or could not prevent.

The NSA covers facility-based emergency care, non-emergency care at in-network facilities, and air ambulance services. After a health plan makes an initial payment or provides a notice of denial of payment, the law allows for a provider and health plan to negotiate payment for the out-of-network service, and if negotiations fail, either party may submit the dispute to the IDR process.

After reviewing documentation submitted by the provider and health plan, the IDRE will first decide whether the dispute is eligible for the IDR process or if it should be dismissed as out of scope under the NSA or ineligible. If determined to be in scope and eligible, the IDRE will select either the provider or the health plan's offer as the final payment for the disputed service(s).

An increasing number of disputes submitted to the IDR process under the NSA are out of scope or ineligible. Reasons for being out of scope include: the claims are payable by government healthcare programs (e.g., Medicare, Medicaid), the services are not covered under the law (e.g., ground ambulance rides or non-emergency care at out-of-network facilities), the services were delivered by an in-network provider, or the services are covered by a state surprise billing law, among others.[1,2]

Disputes are considered ineligible for the IDR process if they fail to abide by procedural rules in the negotiation and/or IDR process. For example, providers cannot submit a dispute for items or services similar to those in a previously disputed claim within 90 days of a prior determination, also known as the "cooling off" period. Other reasons for ineligibility include failing to engage in negotiation within 30 days from the date of initial payment or notice of denial of payment, missing the four-day window to initiate the IDR process, or incorrectly batching or bundling claims.[2]

By law, IDREs are required to dismiss out-of-scope and ineligible disputes. However, IDREs are paid per dispute that results in a payment determination, but not for disputes that are dismissed, resulting in an incentive to accept disputes. It is possible that this incentive may lead IDREs to accept some disputes that should be dismissed for being out of scope or ineligible. Inappropriate dispute dismissal practices may result in payments to providers for services that are outside the scope of, or otherwise ineligible for payment under, the NSA.

Understanding variation in how out-of-scope and ineligible disputes are handled in the IDR process is important for informing policy recommendations to improve the NSA.

Methods

Data and Study Sample

By law, disputes that are out of scope or ineligible should be dismissed prior to payment determination.

This retrospective study used NSA IDR data from Elevance Health-affiliated plans (Elevance Health) for disputes received by IDREs between 1/1/2025 and 12/31/2025. The dispute data included the following information: month received, whether the dispute was resolved or open as of June 1, 2026, whether the dispute had payment determined or was dismissed, the dispute's ineligible or out-of-scope classification if applicable (as designated by Elevance Health), the reason the dispute was out of scope or ineligible, the procedure type, the IDRE assigned, and the provider's state.

Disputes were classified as out of scope based on Elevance Health's determination as to whether the dispute fell within the scope of the NSA. Disputes were considered ineligible if they failed to meet procedural or technical requirements in the IDR process. All other disputes were considered in scope.

Disputes with undetermined status (1,848 disputes, 0.9% of the original sample) were excluded. If a dispute contained claim lines that were both out of scope and ineligible, in scope and out of scope, or in scope and ineligible, they were also excluded from the analysis because the outcome was not clearly defined (3,674 disputes, or 1.8%). Likewise, if a dispute contained both resolved and unresolved claim lines (as of June 1, 2026), the dispute was excluded from the analysis (226 disputes, or 0.1%).

Outcomes and Analysis

The unit of analysis was the dispute since the eligibility determination is made at the dispute level. Claim lines were aggregated to the dispute level to calculate the dismissal rate.

The outcomes of interest were the volume of out-of-scope and ineligible disputes and the dismissal rate of these disputes. Outcomes were analyzed for resolved disputes only, except where noted for the annual totals and quarterly analysis, in which case open disputes were reported separately. Dismissal rates were calculated by dividing the dismissed disputes by the total number of resolved disputes. Heterogeneity in outcomes across dispute characteristics—including the reason a dispute was out of scope or ineligible, provider location, procedure type, and IDRE—are presented.

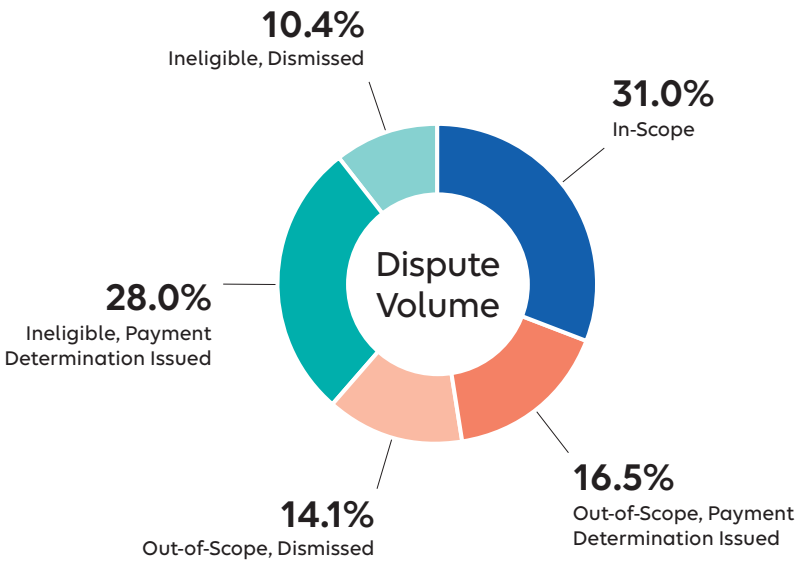
Results

Dispute Volume in 2025

In 2025, IDREs received 201,673 disputes for Elevance Health-affiliated health plans. Of these, 194,752 (97%) were resolved by June 1, 2026, while 6,921 (3%) remained open. Figure 1 shows the percentage of disputes that were in scope (and eligible), out of scope, and ineligible, as well as the percentage of disputes that had a payment determination or were dismissed among those classified as ineligible or out of scope. A majority of disputes received in 2025 were classified as out of scope or ineligible for arbitration under the NSA (38% and 31%, respectively). Nearly half (46%) of disputes classified as out of scope were dismissed and 27 percent of ineligible disputes were dismissed.

Figure 1

In-Scope, Out-of-Scope, and Ineligible Disputes, 2025



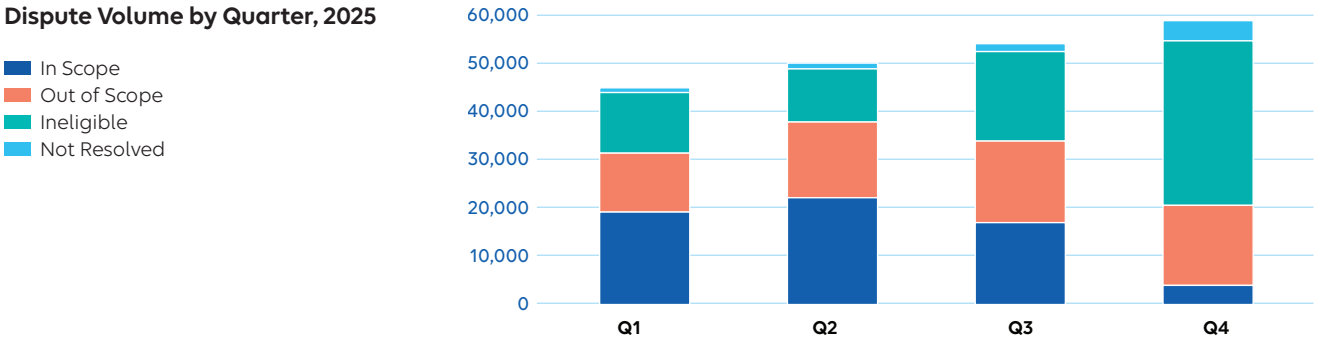
Examining the volume of disputes received by quarter showed that the total number of disputes increased over time (Figure 2). Most of the growth stemmed from ineligible disputes, while there was a decrease in in-scope disputes after the second quarter. The number of ineligible disputes in the fourth quarter was 31,804, compared to 12,460 in the first quarter.

Some of this increase in ineligible disputes in later quarters was due to a change in how Elevance Health categorized disputed claims submitted within the 90-day cooling off period beginning in August 2025. Given the complexity of identifying potential 90-day cooling-off violations, which requires evaluating current disputes against historical determinations and multiple eligibility factors, Elevance Health implemented additional technology and automation later in 2025 to more systematically identify and challenge these disputes. As a result, significantly more claims were identified as being submitted within the 90-day cooling off period following these system improvements in tracking ineligible claims.

The volume of out-of-scope disputes was lower in the first quarter of 2025 (n=12,011) compared to the other quarters (average=15,607 per quarter). The volume of in-scope disputes was substantially lower in the last quarter (n=3,935) compared to the first three quarters (average=19,327 per quarter).

Figure 2

Dispute Volume by Quarter, 2025

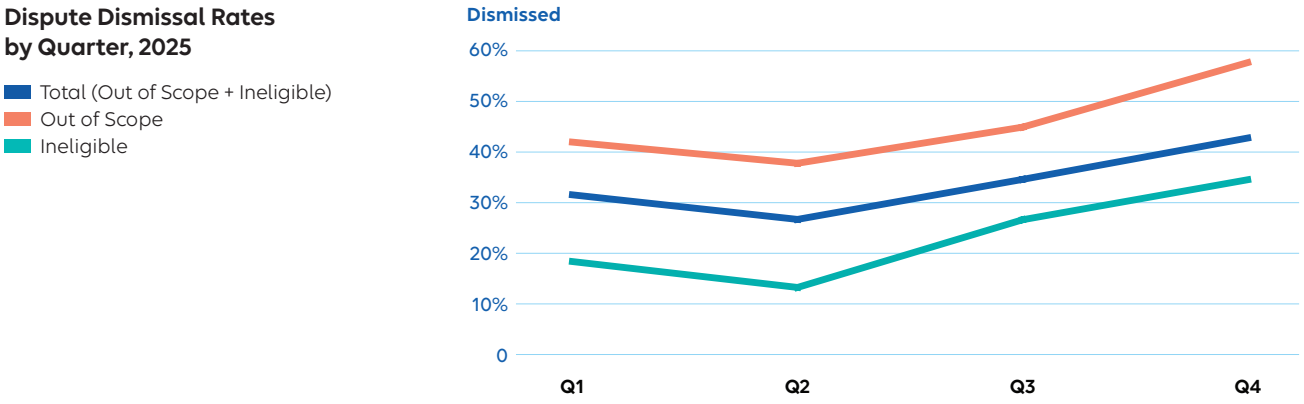


Dismissal Rates by Quarter

In 2025, 36 percent of out-of-scope and ineligible disputes were dismissed. The overall rate of dismissals for out-of-scope and ineligible disputes rose slightly in the latter half of the year, from 31 percent in Q1 to 42 percent in Q4 (Figure 3). For both out-of-scope and ineligible disputes, dismissal rates were lowest for disputes received in the second quarter and highest for disputes received in the fourth quarter. For out-of-scope disputes, the dismissal rates ranged from 39 percent in Q2 to 58 percent in Q4. For ineligible disputes, the dismissal rates ranged from 13 percent in Q2 to 34 percent in Q4.

Figure 3

Dispute Dismissal Rates by Quarter, 2025



Procedure Type

The majority of both out-of-scope and ineligible disputes were for evaluation & management (E/M) visits, with 32,147 out-of-scope disputes and 49,367 ineligible disputes submitted for this procedure type (Table 1); this was expected as E/M visits were also the most common dispute type for in-scope disputes. For out-of-scope disputes, dismissal rates ranged from 37 percent for anesthesiology to more than 61 percent for claims for multiple procedure types. For ineligible disputes, dismissal rates ranged from 26 percent for neurology to 37 percent for medicine, which includes immunizations, cardiovascular services, and other non-surgical procedures that do not fall under other categories.

Table 1

Number of Out-of-Scope and Ineligible Disputes and Dismissal Rates by Procedure Type

	Out of Scope		Ineligible	
	N	% Dismissed	N	% Dismissed
E/M	32,147	45%	49,367	27%
Surgery	7,207	44%	8,317	28%
Neurology	5,124	41%	7,125	26%
Anesthesiology	6,153	37%	5,475	35%
Medicine	385	49%	732	37%
Other	5,498	59%	2,217	26%
Multiple Procedures	4,017	61%	5,579	30%

Note. E/M = evaluation & management.

Provider State

By provider state, the largest number of out-of-scope and ineligible disputes originated from Georgia, followed by California, Virginia, Indiana, and New York. By state, dismissal rates ranged from 35 to 50 percent for out-of-scope disputes and 16 to 29 percent for ineligible disputes; Indiana had the lowest dismissal rates for both out-of-scope and ineligible disputes.

Reasons for Out-of-Scope or Ineligible Disputes

The most common reasons for a dispute being out of scope were that the claims were covered by a state surprise bill law, were submitted by an in-network provider, or were for services not covered by the plan (regardless of provider network status). There was some variation in the dismissal rates across different reasons cited; for example, 46 percent of disputes originating from in-network providers were dismissed, compared with 62 percent of disputes with claim numbers not corresponding to Elevance Health commercial claims (meaning that the disputes had incorrect information or were not for Elevance Health commercial members).

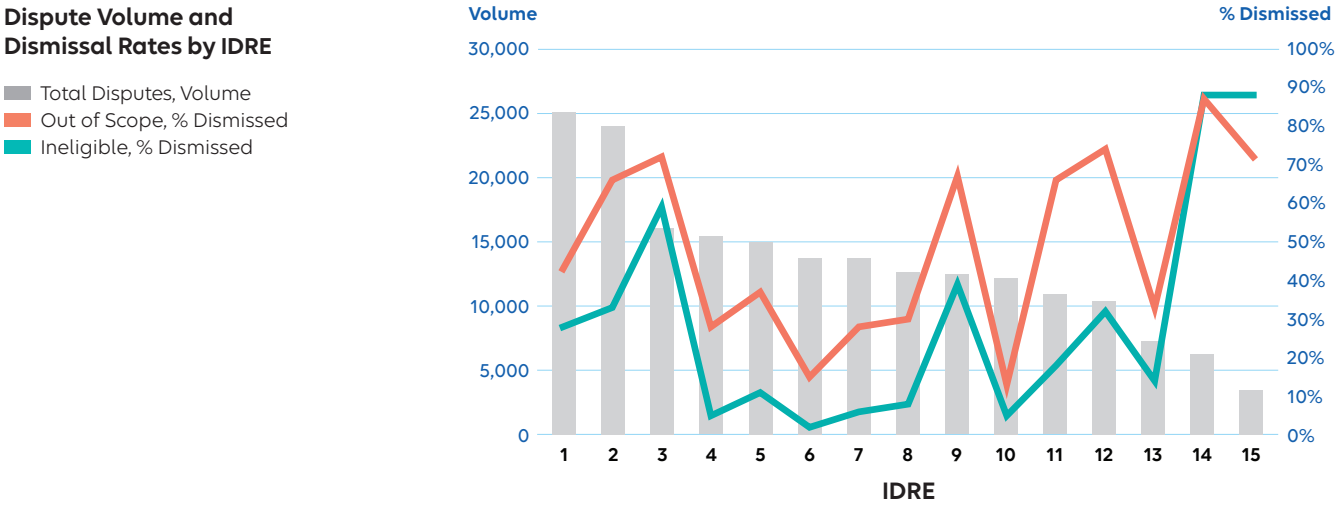
For ineligible disputes, the most common reasons cited were that the dispute was submitted within the 90-day cooling off period, the provider missed the four-day window to initiate IDR, the dispute was submitted within the negotiation period, or negotiation was not initiated within 30 days following the initial payment or notice of denial of payment. Among the reasons cited for being ineligible for IDR, disputes submitted within the 90-day cooling off period were dismissed at the highest rate (34%), and disputes where the provider missed the window to initiate IDR had the lowest dismissal rate (20%).

IDRE

Disputes were processed by 15 different IDREs in 2025 (Figure 4). Two IDREs received more than 20,000 Elevance Health disputes, 10 received between 10,000 and 19,999 disputes, and three received fewer than 10,000 disputes. Dismissal rates varied widely across IDREs. For out-of-scope disputes, dismissal rates ranged from 13 percent (IDRE 10) to 87 percent (IDRE 14), with a median rate of 43 percent. Dismissal rates for ineligible disputes ranged from 2 percent (IDRE 6) to 88 percent (IDREs 14 and 15), with a median rate of 18 percent. Notably, the two IDREs with the lowest volume of disputes had the highest dismissal rates for ineligible disputes (88%).

Figure 4

Dispute Volume and Dismissal Rates by IDRE



Note. IDRE = independent dispute resolution entity.

Discussion

This analysis highlights the high volume of disputes that Elevance Health identified as out of scope under the NSA or ineligible for the IDR process but that were nevertheless issued payment determinations by IDREs.

More than two-thirds of the disputes received in 2025 were classified by Elevance Health as out of scope or ineligible for the IDR process, but only 36 percent of those disputes were dismissed.

Prior research on IDR award amounts and provider win rates has demonstrated that providers win more than 85 percent of disputes that go through the IDR process.[3,4] This analysis provides additional context showing that many disputes that go through the IDR process should have been dismissed. This paper also shows that there is heterogeneity in the dismissal rates for these disputes by IDRE and other characteristics.

The high volume of out-of-scope and ineligible disputes determined by IDREs contribute to rising healthcare costs.

Over time, the volume of ineligible disputes submitted to the IDR process increased. In part, this reflects mid-year changes in Elevance Health's categorization of disputes as ineligible. These changes coincided with a higher rate of ineligible disputes being submitted and dismissed in late 2025. For out-of-scope disputes, the volume was consistent throughout 2025, while the dismissal rate increased from 39 percent in the second quarter to 58 percent in the last quarter. Across IDREs, medium-volume IDREs had the lowest dismissal rates for ineligible disputes, but that was not consistently the case with respect to dismissal rates for out-of-scope disputes.

The low dismissal rates for both out-of-scope and ineligible disputes may suggest misaligned incentives for IDREs as well as that some IDREs are unable to keep up with initial reviews given the volume of disputes filed. For Elevance Health-related disputes alone, the 15 IDREs received over 200,000 disputes in 2025. IDREs generate revenue from processing fees, and rule in favor of providers in more than 80 percent of disputes.[5] Inappropriate dismissal practices and high provider win rates contribute to high out-of-network payments for healthcare services and rising healthcare costs more broadly.

This analysis has some limitations. It was based on a dataset that reflected the status of disputes as of June 1, 2026. However, disputes can be reopened, which would change their status beyond the timeframe of this paper. Additionally, the classifications of ineligibility and out of scope were made based on Elevance Health analysis using internal administrative data; it is possible that others may disagree with some of these classifications.

Policy Recommendations

This study shows an increasing rate of ineligible and out-of-scope disputes going through the NSA's IDR process and the high rate at which IDREs issue payment determinations in these disputes rather than dismissing them as required by law. The following recommendations can reduce the number of out-of-scope and ineligible disputes that reach the IDR process.

Increase transparency in the IDR process.

There is a growing call to increase transparency in the healthcare system, which should extend to IDREs. Public reporting of IDREs' caseloads, number of workers, and methods for determining dispute resolutions would align with the IDRE certification practices and help identify areas to improve efficiency.

End IDREs' role in deciding whether a disputed claim is eligible.

IDREs are paid when they issue a payment determination; they are not compensated for dismissed disputes. This incentivizes IDREs to accept out-of-scope and ineligible disputes that should be dismissed. The IDRE intake portal should be used to automatically dismiss ineligible and out-of-scope cases. If this cannot be implemented, appointing a third party to determine whether a dispute is in scope and eligible would prevent this conflict of interest.

Pay IDREs for dismissed disputes as well as determined disputes.

If IDREs remain responsible for deciding dispute eligibility, they should be compensated for reviewing all disputes – both those that result in a payment determination and those that are dismissed as out of scope or ineligible. This would reduce or remove the incentives for them to accept out-of-scope and ineligible disputes. One mechanism could be to impose an eligibility-review fee. The fee would be paid upfront by the initiating party and credited toward the IDRE fee if the dispute is accepted but forfeited if it is dismissed. This would create a front-end deterrent to indiscriminate filing while compensating IDREs for eligibility review.

Allow for expedited CMS eligibility review and an appeal process.

If an IDRE allows a dispute to proceed despite credible evidence of it being out of scope or procedurally ineligible, the health plan should have a mechanism for expedited review by the Centers for Medicare & Medicaid Services (CMS) or the Department of Health and Human Services before the IDR process proceeds. The determination of the dispute should be halted and applicable deadlines paused during that review.

Audit IDRE dismissal rates to ensure that out-of-scope and ineligible disputes are properly dismissed.

Implementing an audit process to examine IDREs with low dismissal rates may improve accountability for appropriate dismissals and IDR process integrity. As part of this process, IDREs should be required to provide a written determination addressing material eligibility objections and identifying the basis for finding a dispute eligible or ineligible before offers are submitted. This would improve accountability and provide a record for CMS review. CMS should also track the frequency with which an IDRE's eligibility determinations are reversed on review.

Impose consequences to incentivize stronger IDRE accountability.

For IDREs with persistently low dismissal rates or high rates of reversal on eligibility determinations, CMS should impose consequences, including corrective action, enhanced monitoring, suspension, and ultimately decertification.

Fine providers who continuously submit out-of-scope or ineligible cases.

Providers, or their agents or representatives, who repeatedly submit out-of-scope or ineligible disputes should be fined. Currently, providers have little reason not to submit out-of-scope or ineligible cases since the cost of submitting a dispute is low and the resulting payment award is often high. Increasing the expected cost of the IDR process would disincentivize providers from misusing the system.

Policy reforms are needed to ensure that out-of-scope and ineligible disputes are dismissed when appropriate.

Conclusion

This analysis shows that a high proportion of disputed claims submitted to the IDR process under the NSA are out of scope of the law or ineligible for IDR, and that in most cases, IDREs are rendering improper payment determinations.

Policy changes are needed to ensure that the claims submitted for IDR are dismissed when required by law. As providers are awarded much higher payments than their in-network peers for most disputes that are resolved by the IDR process, out-of-scope and ineligible disputes contribute to unnecessary increases in healthcare costs.

Endnotes

[1] Centers for Medicare & Medicaid Services. (2023, January 13). Chart for Determining the Applicability for the Federal Independent Dispute Resolution (IDR) Process. Retrieved August 25, 2026, from https://www.cms.gov/files/document/caa-federal-idr-applicability-chart.pdf.

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