Employee Benefits Tracker, EXPERT INSIGHTS — No Surprises Act enters a new phase: What employers and group health plans need to know about the 2026 IDR rules, (Aug. 31, 2026)

Employee Benefits Tracker

Article by Tiffany Downs of Barnes & Thornburg LLP

Highlights

- **New Independent Dispute Resolution (IDR) procedures are taking effect.** The 2026 regulations standardize claim communications, restructure open negotiation, clarify batching rules, and impose tighter deadlines for determining IDR eligibility.
- **Self-funded plans must register.** Each self-funded group health plan will need its own federal IDR registration number once the new registry becomes operational — even if a third-party administrator (TPA) handles registration.
- **Employer oversight remains essential.** Delegating administration to a TPA does not transfer the plan's legal responsibility. Employers should review vendor agreements, dispute procedures, notice requirements, and decision-making authority.

The federal agencies responsible for implementing the No Surprises Act recently finalized significant changes to the federal independent dispute resolution process used to resolve payment disputes between group health plans and out-of-network providers. The final regulations became effective Aug. 3, although several requirements will not apply until supporting guidance and federal portal functionality are available.

The new rules do not materially change the No Surprises Act's core participant protections. Participants generally remain protected from balance billing and excessive out-of-network cost sharing when they receive emergency services, certain non-emergency services at participating facilities, or covered air-ambulance services. Instead, the regulations focus on improving the process through which plans and providers determine the appropriate out-of-network payment amount.

For employers sponsoring self-funded group health plans, however, these ostensibly administrative changes require attention. The plan — not its third-party administrator — remains legally responsible for compliance.

Why the Federal IDR Process Needed Attention

Under the No Surprises Act, participants generally pay only the applicable in-network cost-sharing amount for protected services. The participant is removed from the payment dispute between the plan and the out-of-network provider.

After the plan makes an initial payment or issues a denial, the plan and provider may enter a 30-business-day open negotiation period. If they cannot agree on a payment amount, either party may initiate federal IDR, commonly referred to as "baseball-style" arbitration because each party submits an offer and the certified IDR entity selects one of the two offers.

In practice, the IDR system has experienced substantial delays. Disputes frequently arise over whether a claim is

eligible for federal IDR, whether state law controls the payment amount, whether claims were properly batched, and whether the plan supplied sufficient information about its qualifying payment amount (QPA). The 2026 regulations are intended to standardize communications, screen out ineligible disputes earlier, and establish clearer procedural deadlines.

More Information Must Accompany Payments and Denials

Plans and insurers must provide additional information when issuing an initial payment or notice of denial for claims potentially subject to the No Surprises Act.

The disclosures will include:

(1) The legal business name of the self-funded group health plan or insurer;

(2) For a self-funded plan, the legal business name of the plan sponsor;

(3) The plan's or insurer's federal IDR registration number;

(4) Additional information concerning the QPA; and

(5) A statement explaining that a provider must notify the federal agencies when initiating open negotiation.

Plans and insurers also must use designated Claim Adjustment Reason Codes and Remittance Advice Remark Codes when communicating with out-of-network providers. These codes will indicate whether the claim is subject to the No Surprises Act and whether the federal IDR process is available. The agencies intend to issue additional implementation guidance concerning the required codes. CMS's summary of the final regulations.

For self-funded employers, this development warrants a review of whether the plan's TPA has the plan's correct legal name, sponsor information, funding status, and other data needed to generate compliant remittance notices.

Open Negotiation Will Become More Structured

The open negotiation process will become more formal and more visible to the federal agencies.

Under the revised procedure, the initiating party must submit the open negotiation notice both to the opposing party and through the federal IDR portal. The 30-business-day negotiation period will begin when the notice and supporting payment or denial information are submitted through the portal.

The responding party also will be required to furnish an open negotiation response notice by the 15th business day of the negotiation period. These notices must contain enough information to identify the claim, the parties, and the basis for asserting that federal IDR applies.

These requirements are designed to encourage genuine negotiation and create a reliable record of when the negotiation period began and ended. They may also reduce disputes over missed filing deadlines and premature IDR submissions.

The new open-negotiation procedures will not become applicable immediately. They will apply to negotiation periods beginning 90 days after the agencies announce that the necessary portal functionality is operational.

New Rules Govern Batching of Claims

The final regulations establish more flexible — but still limited — standards for combining multiple items or services in one IDR proceeding.

Claims generally may be batched when they involve:

(1) Items or services furnished to one patient on the same or consecutive dates and billed on the same claim form;

(2) Items or services billed under the same service code, or a comparable code under another coding system; or

(3) Certain anesthesiology, radiology, pathology, and laboratory services within the same Category I CPT code section.

A batch generally may contain no more than 50 qualified IDR line items. The revised batching definition applies to disputes with open negotiation periods beginning 90 days after Aug. 3. Other batching procedures depend on future portal guidance.

Greater batching flexibility may increase the financial importance of certain disputes, particularly for self-funded plans. Employers should determine whether their TPA has adequate controls to detect improperly batched claims and appropriately evaluate settlement opportunities during open negotiation.

Eligibility Decisions Must Be Made Earlier

Certified IDR entities will be required to determine whether a dispute is eligible for federal IDR within five business days after final selection of the IDR entity.

The IDR entity may request additional information from either party. A party generally will have five business days to respond. If the information is not provided, the IDR entity may proceed without it or close the dispute if it cannot make the required determination.

This short response period will require prompt coordination among the employer, TPA, legal counsel, and any other claims administrator. Agreements should clearly identify who monitors IDR notices, who maintains the relevant claims information, and who has authority to make settlement or offer decisions.

Plans Will Need to Register

The regulations establish a federal IDR registry for plans and insurers subject to the federal process. A self-funded plan must register at the individual plan level and will receive its own registration number. Fully insured coverage generally will be registered by the insurer.

A TPA or other service provider may register on behalf of a plan. Delegating registration, however, does not transfer the plan's legal responsibility for compliance. The final rule expressly confirms that the plan remains responsible for satisfying the No Surprises Act, including paying amounts awarded through IDR.

Registration information must be updated within 30 calendar days after a change and confirmed annually during the fourth quarter. The registration requirement will apply 90 business days after the agencies announce that the registry is available. Federal Independent Dispute Resolution Operations Final Rule.

Employers should not assume their TPA will automatically handle registration. The service agreement should assign responsibility for initial registration, annual confirmation, changes in plan information, and delivery of the registration number to claims administrators.

The Administrative Fee Has Been Reduced

The final regulations reduce the federal IDR administrative fee to $15 per party per dispute. The fee is nonrefundable even if the dispute is ultimately found ineligible.

The rules also codify an important consequence of failing to pay the administrative fee or certified IDR entity fee on time: the nonpaying party's offer will not be considered received, although the party will remain liable for the unpaid fees.

The reduced fee may make IDR more accessible, including for disputes involving relatively modest amounts. Plans therefore may experience an increase in provider-initiated disputes that previously were not economical to pursue.

Core Participant Protections Remain Unchanged

Although the new regulations focus heavily on provider-plan payment disputes, employers should continue monitoring the participant-facing requirements that have applied since 2022. Group health plans generally must:

(1) Apply in-network cost sharing to protected out-of-network services;

(2) Calculate participant cost sharing using the recognized amount required under federal or applicable state law;

(3) Count the participant's cost sharing toward the in-network deductible and out-of-pocket maximum;

(4) Avoid requiring prior authorization for protected emergency services;

(5) Cover emergency services without regard to whether the provider or facility is in network;

(6) Maintain appropriate continuity-of-care procedures when a provider's network status changes; and

(7) Make the required surprise-billing notice publicly available and include it on a public website maintained for the plan.

Employers should also remember that the federal No Surprises Act generally does not protect patients from bills for ground-ambulance services. State surprise-billing laws may provide additional protections.

Action Steps for Employers

Plan sponsors — particularly sponsors of self-funded plans — should consider taking the following steps:

(1) Confirm with the TPA how and when the new payment, denial, coding, and QPA disclosure requirements will be implemented.

(2) Assign responsibility for registering each self-funded plan when the federal registry becomes operational.

(3) Review TPA agreements to determine who controls open negotiation, settlement decisions, IDR offers, fee payments, and appeals or challenges.

(4) Require prompt notice of IDR disputes, adverse determinations, missed deadlines, and significant payment awards.

(5) Establish procedures for responding to requests from an IDR entity within five business days.

(6) Audit whether participant cost sharing for protected claims is being calculated correctly and credited toward in-network limits.

(7) Confirm that the current surprise-billing notice is posted on the plan's public website.

(8) Monitor future agency guidance because several of the most significant procedural changes will not apply until the agencies activate the necessary IDR portal and registry functions.

The Bottom Line

The 2026 regulations represent a shift from the No Surprises Act's initial implementation phase toward a more standardized and enforceable payment-dispute system. Although most of the new requirements will be administered operationally by insurers and TPAs, self-funded employers cannot treat IDR compliance as solely a vendor issue.

Plan fiduciaries should understand who is handling disputes, how payment decisions are being made, and whether the plan's service providers are prepared for the new registration, disclosure, coding, and procedural requirements. A documented oversight process can help protect the plan from missed deadlines, unfavorable default outcomes, excessive claim payments, and participant complaints.

Tiffany DownsBarnes & Thornburg LLP

One N. Wacker Drive Suite 4400

ChicagoIL 60606-2833

United States

Tel:+1 317 236 1313

E-mail: Justin.Scott@btlaw.com

URL: www.btlaw.com/

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