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SYMPTOMS OF AN UNHEALTHY MARKET

What Texas and Federal Data Tell Us About the True Cost of Dispute Resolution

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Background on Texas and Federal Law

In 2019, the Texas Legislature passed Senate Bill 1264, removing consumers from the middle of billing disputes between health insurance companies and out-of-network providers with protections taking effect January 1, 2020.[1] A year later, Congress extended similar protections to the millions of Americans covered by group and individual health plans, including self-funded employer plans that state laws cannot reach, through the No Surprises Act, which took effect January 1, 2022.[2]

On the narrowest measure of their intent, removing patients from the middle of billing disputes, both laws have delivered. Consumer complaints about balance billing in Texas dropped from over 1,000 in 2019 to zero in 2023.[3] Patients who end up in an out-of-network emergency room are no longer on the hook for the full difference between what their insurer pays and what the provider charges.

But data from both the state and federal levels are telling a more complicated story. The independent dispute resolution (IDR) systems that both laws created to resolve payment disputes have generated new system-level costs, including arbitration fees and awards, that did not exist under the prior regime, when large bills fell on patients rather than on the system.

According to the American Academy of Actuaries, health insurance premiums reflect costs rather than drive them.[4] They are developed with forward-looking estimates of expected health care costs for the upcoming year and must account for federal and state rules. When the cost of resolving out-of-network disputes rises, that becomes part of the equation. The data suggest that in trying to solve one problem, another may have been created.

[1] Texas Legislature Online, "SB 1264 Bill History," 86th Regular Session, Texas Legislature. capitol.texas.gov

[2] U.S. Congress, "Consolidated Appropriations Act H.R. 133," 116th Congress. congress.gov

[3] Texas Department of Insurance, "Balance Billing Protections: Senate Bill 1264 Biennial Report," November 2024. tdi.texas.gov

[4] Susan Pantely, "Health Care Affordability: Testimony Before the Texas House Committee on Insurance," American Academy of Actuaries, May 1, 2026. actuary.org

How the system works

Surprise medical billing typically happens when a patient receives care from an out-of-network provider they have no ability to select. This can happen in emergencies, when a patient has no choice of hospital or treating physician. It also happens in planned care, like when a patient schedules an outpatient surgery at an in-network facility but the anesthesiologist on duty or the radiologist who reads their imaging turns out to be out-of-network. Before these laws, the patient was often stuck with the difference between what their plan paid and what the out-of-network provider billed. In some instances, this could be thousands of dollars.[5]

SB 1264 and the No Surprises Act both took patients out of the equation, for better and for worse. Under the Texas law, which according to TDI, covers individuals enrolled in state-regulated health plans – approximately 20% of Texans in 2023 – providers are prohibited from billing consumers more than their in-network cost-sharing amount.[6] Texas Farm Bureau plans and employer sponsored health plans that have opted into the SB 1264 balance billing law are covered. The federal law fills in the gaps left by SB 1264, extending protections to self-funded employer plans that states cannot regulate under federal ERISA law.

With patients excluded from the middle of the dispute, both laws needed a mechanism to determine what insurers would actually pay providers for out-of-network care. Texas created two tracks: arbitration for disputes between out-of-network providers and health plans, and mediation for disputes involving out-of-network facilities. The federal law uses a similar final-offer (baseball-style) arbitration process.

FINAL-OFFER ARBITRATION, STEP BY STEP

1 · Initial offer
The health plan makes an initial payment offer to the out-of-network provider.

→

2 · Negotiate
If the provider wants more, the two sides can negotiate during the informal period.

→

3 · Arbitrator decides
An independent arbitrator must choose one of the two offers — no splitting the difference.

In both the state and federal system, the health plan makes an initial payment offer to the out-of-network provider. If the provider wants more, they can negotiate. If the two sides can't agree, the case goes to an independent arbitrator who must choose one of the two offers. Arbitrators cannot split the difference or arrive at a middle-ground amount. At the federal level, Congress established a Qualified Payment Amount (QPA) representing the median contracted rate for each service as a reference point, though arbitrators are not required to treat it as the primary factor when choosing between the two offers.

[5] Ashley Lopez, "Faced With Surprise Medical Bills, Some Texans Have Recourse. But The System's Not Perfect," KUT, January 17, 2019. kut.org

[6] Texas Department of Insurance, "Balance Billing Protections: Senate Bill 1264 Biennial Report," November 2024. tdi.texas.gov

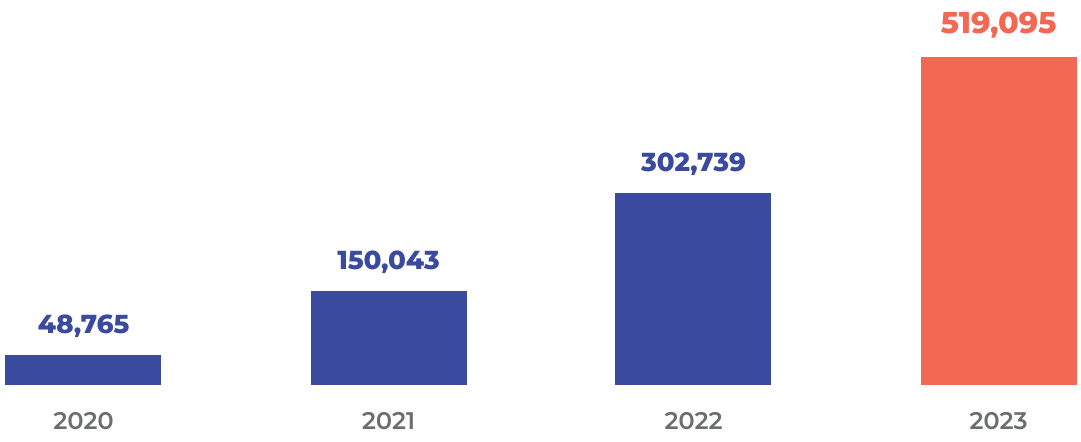
What the Texas data shows

According to the Texas Department of Insurance's 2024 Balance Billing Biennial Report, the dispute resolution system created by SB 1264 has grown rapidly and is consuming significant resources.[7]

From 2020 to 2023, TDI received over 1 million arbitration and mediation requests through its IDR portal. Of those, about 820,000 were eligible for the process. The growth has been substantial: total portal requests rose from roughly 49,000 in 2020 to over 519,000 in 2023. Originally representing only 7% of requests when the portal opened in 2020, mediation requests involving facilities have grown especially fast, surpassing arbitration requests in 2023. This growth indicates that the IDR system has become a central mechanism through which out-of-network payment disputes are resolved, rather than a marginal feature of the law.

IDR portal requests rose more than tenfold

Total arbitration and mediation requests received by TDI



Source: Texas Department of Insurance, Balance Billing Biennial Report (2024)

Uncapped fees are adding up

One of the most striking findings in the TDI report involves the fees paid to arbitrators and mediators. SB 1264 does not cap these fees and gives TDI no authority to set them. Each arbitrator and mediator sets their own fixed fee per case, and each party pays half after a case is assigned.

Through 2023, total arbitrator fees reached $106.4 million, with a median fee of $1,000 per case and fees as high as $4,750. Mediator fees totaled another $14.7 million. Combined, that is over $121 million in dispute resolution fees paid by health plans and providers in four years. The portion paid by the health plans flows into their overall cost structure, and would be a factor into the premiums they set.

[7] Texas Department of Insurance, "Balance Billing Protections: Senate Bill 1264 Biennial Report," November 2024. tdi.texas.gov

Over $121 million in dispute resolution fees through 2023

Cumulative fees paid to arbitrators and mediators by health plans and providers

Arbitrator fees — $106.4M Mediator fees — $14.7M

$121M

Combined, in four years

Source: Texas Department of Insurance, Balance Billing Biennial Report (2024). Median arbitrator fee $1,000 per case; highest $4,750.

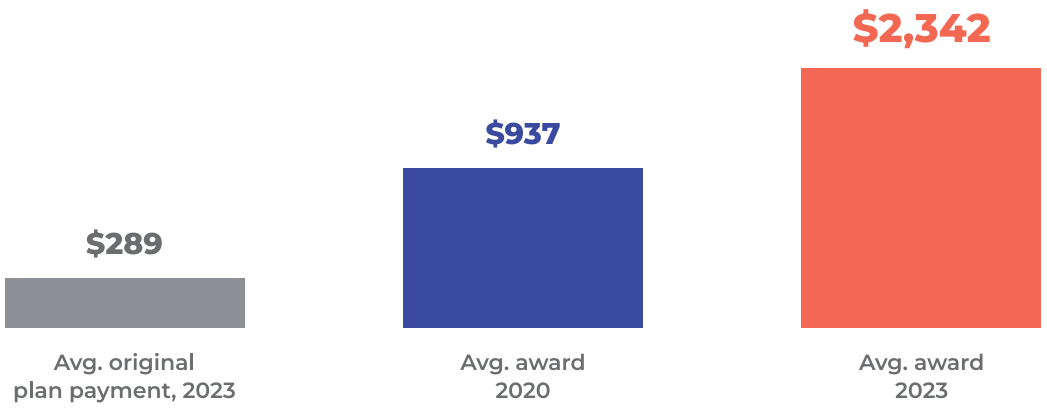
It is important to put these numbers into context. The TDI report collected billing data from 37 commercial health plan issuers, and total out-of-network billed amounts reached $4.6 billion in 2023. Against that scale, $121 million in cumulative IDR fees over four years is not, by itself, the dominating cost driver. Fees are one piece of a larger picture. The data suggests the most significant cost pressure comes from what the arbitration process is awarding.

Arbitration awards are growing

The data on how Texas disputes are resolved raises a more significant cost concern. Looking at single-claim arbitration cases decided by an arbitrator, the average award amount in 2023 was $2,342, up from $937 in 2020. Meanwhile, the average original payment from the health plan was just $289 in 2023. This means arbitrators awarded amounts roughly eight times the health plan's initial payment, on average. That comparison reflects the gap between opening positions in the dispute process, not contract in-network market rate. Though the federal data examined later in this brief suggests arbitration awards are also running above market benchmarks.

Awards average roughly eight times the initial plan payment

Single-claim arbitration cases decided by an arbitrator

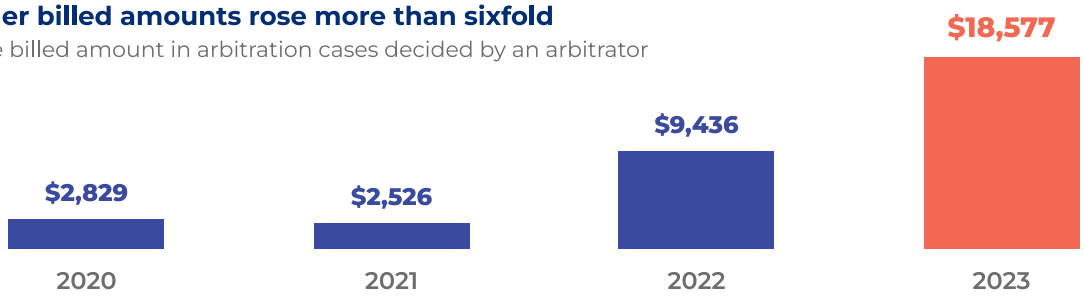


Source: Texas Department of Insurance, Balance Billing Biennial Report (2024)

The amounts that providers are billing in these cases have also grown significantly. In arbitration cases decided by an arbitrator, the average provider billed amount rose from $2,829 in 2020 to $18,577 in 2023. It is worth noting that only about 17% of arbitration cases reach an arbitrator's decision, as these are cases where neither side would settle, which likely skews the toward larger, more contested claims. That more than sixfold increase suggests two things: first, providers are submitting higher charges into the dispute process. Second, the cases making it all the way to an arbitrator's decision increasingly involve larger dollar claims rather than settling early in the negotiation period.

Provider billed amounts rose more than sixfold

Average billed amount in arbitration cases decided by an arbitrator



Source: Texas Department of Insurance (2024). Only ~17% of arbitration cases reach an arbitrator's decision.

Cases that settle during the informal 30-day negotiation period, which accounts for about 64% of arbitration cases and 75% of mediation cases, also result in payments well above the original offer. In 2023, the average arbitration settlement was $669 compared to an original payment of $149.

ORIGINAL PAYMENT		AVG. ARBITRATION SETTLEMENT, 2023
$149	→	**$669**

This pattern suggests that the mere existence of the arbitration backstop may influence settlement behavior. Providers have a credible threat: if a dispute proceeds to arbitration, the data indicates that they will likely receive significantly more than the initial plan payment.

The federal picture reinforces the concern

The federal No Surprises Act data provides important context because it shows the same structural dynamics playing out at a much larger scale, and with more granular cost data.[8]

According to a Kaiser Family Foundation analysis of CMS data, providers won over 85% of federal arbitration cases by the fourth quarter of 2024, up from about 68% in early 2023.[9] When providers win, they receive a median payment exceeding four times the QPA, the benchmark that Congress set to approximate the median in-network rate. Providers initiated 1.5 million billing disputes through the federal process by the end of 2024, more than 70 times the annual caseload regulators originally predicted. According to a Health Affairs Forefront analysis, total federal program costs have surpassed $5 billion through the end of 2024.[10]

[8] Lawson Mansell, "The No Surprises Act is Protecting Patients, but Not Containing Health Care Costs," Niskanen Center, March 26, 2024. niskanencenter.org

[9] Matt McGough, Nisha Kurani, and Michelle Long, "The Performance of the Federal Independent Dispute Resolution Process Through Mid-2024," Peterson-KFF Health System Tracker, May 29, 2025. healthsystemtracker.org

[10] Jack Hoadley and Kennah Watts, "The Substantial Costs of the No Surprises Act Arbitration Process," Health Affairs Forefront, August 25, 2025. healthaffairs.org

How structural incentives are being exploited

The data on who is using the federal IDR system and how raises a deeper concern about the system's design. A Brown University working paper theorizes that arbitrators themselves have a financial incentive to rule in favor of providers: they only get paid for eligible cases, and generous rulings encourage more filing.[11] The incentive structure systematically favors higher rewards, which in turn invites more filings, which generate more arbitrator revenue.

A STAT News investigation illustrates exactly how these structural incentives are playing out in practice.[12] The investigation profiles HaloMD, a Texas-based company that helps providers navigate the federal and state arbitration process and takes a cut of the award amount. According to the report, HaloMD filed more federal disputes than any other company in the first half of 2025 and claims to generate over $1 billion a year for itself and its clients. The investigation describes a strategy of flooding the overburdened federal system with thousands of disputes, many of which insurers allege are ineligible, and demanding amounts well above what providers originally charged. According to CMS data cited in the report, HaloMD's federal payouts were over nine times typical in-network rates in 2024, compared to a system-wide average of four times.

44%

of all federal disputes in the first half of 2025 came from just three companies — HaloMD, Team Health, and SCP Health.

9×

HaloMD's federal payouts ran over nine times typical in-network rates in 2024 — versus a system-wide average of four times.

HaloMD is not alone. The investigation notes that just three companies – HaloMD, Team Health, and SCP Health – accounted for 44% of all federal disputes in the first half of 2025. This is not a dispute resolution system being used occasionally by individual providers seeking fair payment. It is being leveraged at scale by sophisticated, well-resourced actors who have built business models around maximizing arbitration outcomes.

Critically, the investigation also exposes how the design of both the federal and state system might create openings for abuse. Eligibility attestations under the federal process require only a certification "to the best of my knowledge," creating minimal accountability for ineligible filings. There is no cross-referencing mechanism between the state and federal systems, which allegedly allowed overlapping disputes for the same services to be submitted thousands of times. And under both systems, the arbitrators and mediators are private, for-profit entities, with the Texas system imposing no fee caps and giving TDI no authority to set them.

The pattern that emerges is not one of bad actors operating outside the system's design. It is one of the rational actors responding exactly to the incentives the system created.

[11] Benjamin Chartock and Christopher Whaley, "Arbitration and Negotiated Prices: Evidence from Insurer–Doctor Disputes," Brown University Working Paper, 2026. repository.library.brown.edu

[12] Tara Bannow, "How a Texas Couple Is Getting Rich Off Out-of-Network Medical Bills," STAT News, March 18, 2026. statnews.com

What Texas data tells us about growing cost

The data from Texas strongly suggest that the IDR process is creating upward cost pressure on health plans. Because premiums reflect the expected costs of covering claims, growing IDR expenses are likely to contribute upward pressure on what employers and patients pay for coverage. What is not yet known is the magnitude of that relationship in the Texas market.

The IDR system is generating costs that did not exist before SB 1264 – over $121 million in arbitrator and mediator fees through 2023, plus arbitration awards and settlements that routinely exceed initial health plan payments. These costs are borne in part by health plans. Health plans set premiums based on their expected cost of covering claims, and when the cost of resolving out-of-network disputes increases, that becomes part of the equation.

The structural incentives in the system also warrant attention. Because arbitrators have consistently awarded amounts well above initial plan payments, providers have a financial incentive to stay out-of-network and use the IDR process to secure higher reimbursement. TDI data shows growing IDR filings despite improvements in network participation for some provider types. At the federal level, CMS data shows this dynamic clearly in the concentration of filings among large, well-resourced provider groups.

The IDR process is adding costs to the system, those costs are growing rapidly, the structural incentives favor continued growth, and premiums are the mechanism through which those costs are most likely passed on to employers and patients. What is missing is a study that quantifies the relationship between IDR outcomes and premium changes in the Texas market, and is something that policymakers should consider asking for.

RECOMMENDATIONS

Policy options for the Legislature to consider

1 Require disclosure of entities initiating IDR requests

Texas's biennial reporting requirement captures aggregate data on dispute volume, fees, and outcomes, but does not require disclosure of which entities, whether individual providers or third-party billing companies, are filing arbitration and mediation requests. The federal No Surprises Act's reporting framework has made it possible to identify that a small number of well-resourced companies account for a disproportionate share of filings, enabling targeted oversight. Requiring similar filer-level transparency in Texas would give TDI and policymakers the information needed to assess whether the IDR system is being used as intended or concentrated among actors who have built business models around maximizing arbitration outcomes. There is frequently a tension in system design between making the system easy to use for average users, while preventing manipulation and gaming by sophisticated entities. If a small number of power users are causing the bulk of the problems, it may be worth considering developing different tracks of system design based on the sophistication of the user.

2 Commission a study on the relationship between IDR outcomes and health insurance premiums in Texas

State IDR costs are growing – over $121 million in arbitrator and mediator fees through 2023, with rising award amounts and expanding caseload – but the direct relationship between those costs and premium changes in the Texas market has not yet been quantified. Directing TDI to commission a study that examines how IDR expenses flow through health plan cost structures and into employers and employees paying for coverage would give policymakers a clearer picture of the law's full fiscal footprint. Without this analysis, it is difficult to evaluate the tradeoffs of the current system or assess the cost implications of any reforms.

3 Make arbitrator and mediator fees a factor in selection

SB 1264 gives TDI no authority over the fees that arbitrators and mediators set for their services, and those fees have accumulated to more than $121 million over four years, with individual case fees reaching as high as $4,750. The Legislature should authorize TDI to create a structure that when arbitrators are chosen, fees are taken into account. This would require TDI to redesign the arbitrator selection process by making fees more transparent so they can be considered.

4 Reevaluate the IDR program's design and decision-making process

Should targeted reforms to the arbitrator selection process prove insufficient, the Legislature should be prepared to reevaluate how the IDR system operates more fundamentally, examining the arbitrator and mediator selection process, the factors arbitrators weigh when determining award amounts, and any other structural features that may be contributing to the pattern of awards significantly exceeding initial plan payments. Texas arbitrators have discretion to consider a broad range of factors, and it is not yet clear whether the current framework is producing outcomes that reflect fair market value or outcomes that reflect the structural incentives built into the process itself. Reevaluation would provide the foundation needed to determine whether targeted changes to program design could better align IDR outcomes with the law's original intent.

Looking ahead

Texas was one of the first to tackle surprise medical billing. By the measure of addressing surprise medical billing, SB 1264 has been a success.

But the data increasingly suggests that the dispute resolution system underpinning the law is not functioning to contain prices paid for health care. According to TDI data, it is generating growing expenses through uncapped arbitrator fees, rising award amounts, and a structural incentive for providers to pursue arbitration rather than accept initial plan payments or join networks. Because premiums reflect underlying health care costs, these growing IDR expenses are likely to contribute to upward pressure on what employers and patients pay for coverage.

It is worth acknowledging provider arguments that have found traction in the legal system. The Texas Medical Association has argued in federal court that the No Surprises Act's QPA methodology unlawfully deflates the benchmark by allowing insurers to include contract rates from providers who do not even perform the service in question, called "ghost rates."[13] A federal district court agreed and vacated the provision, though a Fifth Circuit panel subsequently reversed the ruling, and the case is now before the full Fifth Circuit. The broader concern stands regardless of how that litigation resolves. Manipulations on the benchmark rate are happening on both sides, insurers through QPA calculation and providers through billed charges and arbitration strategy, and together they are contributing to an inflationary dynamic that serves neither employers nor patients.

This should be a further consideration for policymakers reviewing this law going forward.

[13] Georgetown University Law Center Health Care Litigation Tracker. "Texas Medical Association et al. v. Department of Health and Human Services et al. (TMA III)." O'Neill Institute, last updated April 8, 2026. litigationtracker.law.georgetown.edu

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