COALITION AGAINST
SURPRISE MEDICAL BILLING

# Ineligible Claims From Some Providers Creates Significant Arbitration Bottleneck

While the *No Surprises Act* has successfully prevented approximately 1 million surprise medical bills per month from health care facilities, providers, and air ambulances, certain providers are flooding the federal arbitration process—also known as the independent dispute resolution (IDR) process—with ineligible claims. Overall claims volumes continue to exceed initial projections, and the surge of ineligible claims is delaying dispute resolutions and straining IDR entities (IDRE), health plans, and providers.

**The Impact of Ineligible Claims**

Despite the Tri-Agencies' increasing the participation administrative fee from **$50 to $350** per party, case volume has continued to rise. While resolution rates have improved, the influx of ineligible claims continues to overwhelm the system, limiting the effectiveness of the IDR process.

According to data from the Centers for Medicare & Medicaid Services (CMS), a total of 317,873 federal disputes were initiated in the last quarter of 2023, with **111,431 (36%) challenged as ineligible**. **Of the 104,227 disputes that were closed, 24,905 (24%) were dismissed as ineligible.**

The influx of ineligible, incomplete, or incorrect claims—coupled with the overwhelming volume of cases in the IDR system—has made it challenging for federal agencies and IDREs suggest that it has been challenging to assess eligibility efficiently, slowing case resolution and creating complications for health plans and employers. In its first year, **the IDR portal faced a caseload 14 times higher than expected, with only 32% of cases successfully resolved**.

As claims continue to overwhelm the arbitration process, caseloads will only increase, creating costly bottlenecks for health plans, employers, and the federal government. The Coalition Against Surprise Medical Billing has urged the Trump Administration to implement safeguards that enhance the efficiency of the arbitration process by reducing the influx of ineligible claims. Common-sense reforms include:

- Mandating that IDREs provide employers and health plans all the relevant information needed to process payment determinations;
- Preventing ineligible claims—including Medicare, Medicaid, state-arbitration claims, in-network claims, and claims that have already been through arbitration—from being entered into the arbitration portal and prohibit IDREs from issuing payment determinations on these ineligible claims;

- Establishing timely processes for correcting or addressing errors on non-eligible claims;
- Ensuring clear and timely communications to all parties involved with IDR via a dynamic portal maintained by CMS;
- Requiring and enhancing training and oversight for IDREs on the *No Surprises Act* statute and guidance to ensure compliance and mitigate instances of abuse or misuse; and
- Mandating timely and transparent disclosures on IDR utilization by individual providers, as well as transparency on IDREs' performance to ensure objective decision-making.

For more information on the *No Surprises Act,* visit https://stopsurprisebillingnow.com/.