COALITION AGAINST
SURPRISE MEDICAL BILLING

April 22, 2025

Director Vince Haley
Domestic Policy Council
Eisenhower Executive Office Building
Room 469
Washington, DC 20502

Secretary Lori Chavez-Deremer
Department of Labor
200 Constitution Avenue NW
Washington, DC 20201

Secretary Robert F. Kennedy Jr.
Department of Health and Human
Services 200 Independence Avenue SW
Washington, DC 20201

Secretary Scott Bessent
Department of the Treasury
1500 Pennsylvania Avenue NW
Washington DC, 20220

To Director Haley, Secretary Kennedy, Secretary Chavez-Deremer and Secretary Bessent,

The Coalition Against Surprise Medical Billing (CASMB), which represents leading employers, health plans, unions and health organizations, looks forward to continuing our work with you to uphold critical protections against surprise medical bills for millions of Americans. We commend President Trump for signing the *No Surprises Act* into law and urge you to ensure the law's implementation meets its intended goals: safeguarding patients and reducing costs for consumers, workers and American businesses.

Streamlining operations, cutting red tape and ensuring the *No Surprises Act* works as intended are clear examples of where the administration can increase efficiency. Unfortunately, to date, the arbitration process under the *No Suprises Act* has **driven up costs and contributed to inflationary pressure across the health care system**. We urge you to take the necessary regulatory actions to ensure that the law's intent—to lower costs for patients and consumers—is preserved.

New data from the Centers for Medicare & Medicaid Services (CMS) highlights how certain providers are overusing, and likely misusing, this process to maximize reimbursements. This is evidenced by the fact that under the Independent Dispute Resolution (IDR) process, in the first half of 2024 alone, approximately 610,000 arbitration cases were filed, 47% of which came from just four private equity-backed organizations: Team Health, SCP Health, Radiology Partners and Envision.[1]

Moreover, arbitration decisions disproportionately favor providers, who prevail in more than 80% of cases, often securing payments that far exceed the median in-network rate (the

[1] https://www.cms.gov/nosurprises/policies-and-resources/reports

qualifying payment amount [QPA]).[2] Researchers analyzing the public use file data found that when providers were the prevailing party in Q2 of 2023, the median payment determination was 322% of the QPA.[3]

Providers are also overwhelming the system by submitting ineligible, incomplete or incorrect claims. **Of the more than 450,000 arbitration disputes that were closed, nearly 20% were ruled ineligible.**[4] Moreover, a substantial proportion of IDR disputes are filed with incorrect or incomplete information, often resulting in default judgments in favor of the initiating party. Default decisions accounted for 16% of IDR determinations during the first half of 2024 and providers and facilities won these disputes 75% of the time.[5]

This deluge of improper filings drives up costs and creates significant burdens, complicating the timely processing and resolution of legitimate disputes and placing additional strain on health plans and employers trying to navigate the system. Further, arbiters, also known as IDR entities (IDREs), frequently issue payment determinations on ineligible disputes, indicating a lack of consistency and awareness of which claims are eligible for IDR. Payment determinations on ineligible claims cause undue expenses as part of the process and encourage providers to continue to submit ineligible cases.

To protect consumers from inflated arbitration awards and price gouging, **we urge the Trump administration to finalize an IDR operations rule that implements practical solutions**. Specifically, we urge you to issue regulations or guidance that will:

- Mandate that IDREs provide employers and health plans all the relevant information needed to process payment determinations;
- Prevent ineligible claims—including Medicare, Medicaid, state-arbitration claims, in-network claims, untimely claims, incorrectly batched claims and claims that have already been through arbitration—from being entered into the arbitration portal and prohibit IDREs from issuing payment determinations on ineligible claims and disputes initiated with incomplete or inaccurate information;
- Establish timely processes for correcting or addressing errors on non-eligible claims and a formal process to appeal payment determinations for non-eligible claims;
- Enable auditing of IDR entity performance and hold initiating parties accountable where there is a demonstrated pattern of making false or misleading representations to the government in the IDR process;

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[2] Ibid.

[3] Jack Hoadley and Kevin Lucia, *Report Shows Dispute Resolution Process in No Surprises Act Favors Providers*, The Commonwealth Fund, March 1, 2024, https://www.commonwealthfund.org/blog/2024/report-shows-dispute-resolution-process-no-surprises-act-favors-providers

[4] https://www.cms.gov/nosurprises/policies-and-resources/reports

[5] Supplemental Background on Federal Independent Dispute Resolution Public Use Files for 1/1/24-6/30/24, p. 4 (Supplemental Background on Federal Independent Dispute Resolution Public Use Files, downloaded on 4/17/25).

- Ensure clear and timely communications to all parties involved with IDR via a dynamic portal maintained by CMS;
- Require and enhance training and oversight for IDREs on the *No Surprises Act* statute and guidance to ensure compliance and mitigate instances of abuse or misuse; and
- Mandate timely and transparent disclosures on IDR utilization by individual providers, as well as transparency on IDREs' performance to ensure objective decision-making.

We appreciate your longstanding support for the *No Surprises Act*. We stand ready to work with you to ensure the law succeeds in its mission to lower costs while limiting excessive regulatory burdens.

Sincerely,
The Coalition Against Surprise Medical Billing