COALITION AGAINST
SURPRISE MEDICAL BILLING

No Surprises Act 101:

How IDR Was Intended to Work & How It's Been Misused

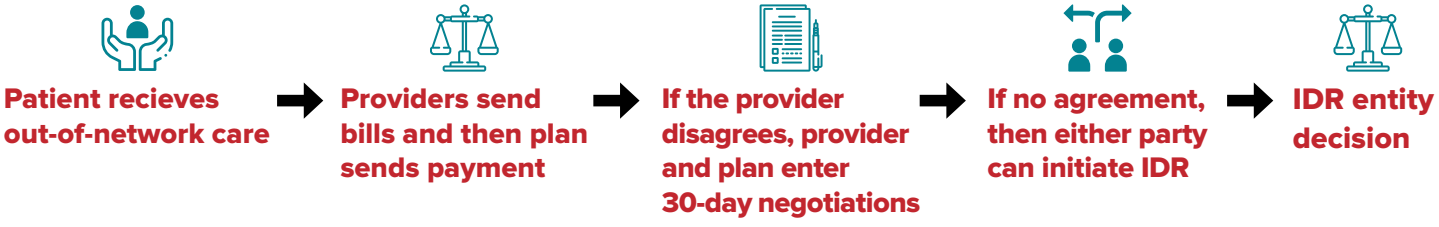
Congress and the Trump administration passed the *No Surprises Act* in 2020 with two simple goals: **protect patients from unexpected medical bills and lower costs for employers and employees**. The Independent Dispute Resolution (IDR) process — also known as arbitration — was intended as a "last resort" to resolve payment disputes between plans and providers. In practice, however, **implementation of the IDR process has strayed far from its intended goal** as third-party middlemen and a handful of private equity-backed providers increasingly exploit the system in ways that stray far from its original purpose.

HOW IDR WAS SUPPOSED TO WORK

IDR was designed as a backstop mechanism, one that was only intended to be used after health plans and providers attempted good-faith negotiations for out-of-network charges.

Under the *No Surprises Act*, when a patient receives emergency care or unknowingly is treated by an out-of-network provider at an in-network facility, that patient is protected from any surprise or unexpected out-of-network charges.

Health plans and out-of-network providers then have a 30-day negotiation period in which to determine payment for the respective services. If the plan and provider can't agree on payment, either party may initiate IDR. Both sides submit a proposed payment amount to a third-party arbitrator, who must choose one offer. IDR Entities must consider the qualifying payment amount (QPA) — defined as the plan's median in-network rate — along with additional circumstances, like provider qualifications, case complexity, and other circumstances. **The goal was to encourage reasonable negotiations, resolve disputes efficiently, and contain costs — all while keeping patients out of the middle**.



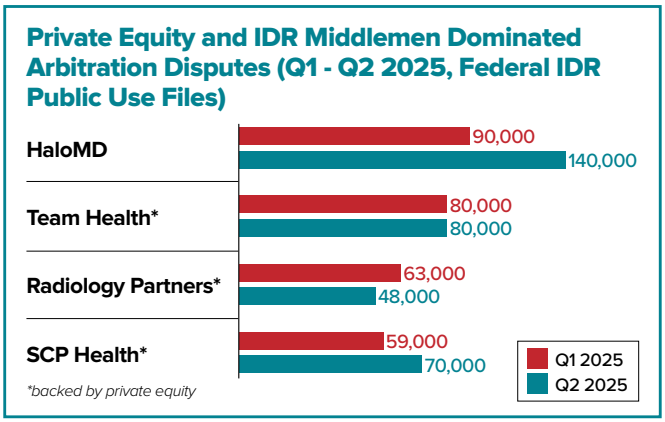
THE PRIVATE EQUITY FACTOR

What lawmakers did not fully anticipate was some entities would make a business model out of exploiting IDR — **some are the same private equity-backed bad actors that fueled the surprise billing crisis** — and some are new organizations created solely to exploit IDR for profit.

Over the past two decades, **PE firms aggressively acquired physician practices, particularly in specialties prone to surprise billing**, including emergency medicine, anesthesiology, and radiology. These firms built business models around **deliberately remaining out-of-network**, allowing them to demand higher payments from plans and employers. When the *No Surprises Act* eliminated their ability to bill patients directly, they pivoted, turning IDR into their primary revenue lever.

GAMING THE SYSTEM AT SCALE

The results have been dramatic and damaging. Federal regulators initially projected 17,000 IDR cases per year. Instead, nearly 2.3 million cases were filed between January–November 2025 — **more than 13,000% above expectations**. Recent analysis shows that PE-backed providers account for a disproportionate share of these filings. In the first half of 2025, **55% of all disputes were initiated by four parties: Team Health, Radiology Partners, and SCP Health — all of which are PE-backed — and HaloMD, an AI-powered middleman** that launched specifically to help providers "maximize" out-of-network reimbursements through aggressive arbitration.



This is not how IDR was intended to function. The process is designed to resolve occasional, good-faith disputes, not to serve as a high-volume, routinized business strategy. **PE-backed firms have instead operationalized arbitration, submitting tens of thousands of cases at a time**.

To make matters worse, **PE-backed entities now exert influence on both sides of the process, financially backing at least five of the 15 certified IDR entities** as of October 2025, effectively crowning themselves judge and jury.

WHY IT MATTERS

The IDR process was only intended to handle a limited number of disputes, however, the system is now overwhelmed by millions of disputes, including many ineligible disputes that should be rejected rather than receive payment determinations.

While patients are largely protected from surprise bills, **IDR generated more than $5 billion in excess costs** between 2022 and 2024. Those costs don't disappear, they are passed onto employers and families through higher premiums, deductibles, and out-of-pocket expenses, without delivering any additional value.

WHAT NOW?

To protect consumers from wasteful spending and price gouging, the Coalition Against Surprise Medical Billing urges the The Trump administration, which has the authority today to restore the *No Surprises Act* to its full potential, to implement common sense reforms to the process, including:

- **Reducing wasteful spending** from ineligible claims by verifying IDR claim eligibility upfront and preventing ineligible disputes from moving forward;
- **Eliminating conflicts of interest** by prohibiting IDR entities with financial ties to providers from becoming or remaining certified IDR entities;
- **Stopping provider behaviors** that inappropriately drive up costs for employers and employees; and
- **Increasing transparency and accountability** through better portal access, required explanations and rationales for arbitration decisions, sharing the information used to make determinations, and performance metrics with consequences for misuse.

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