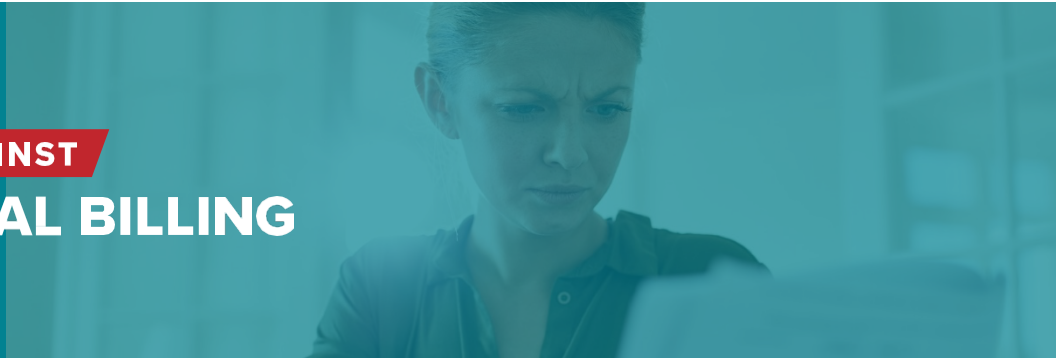
COALITION AGAINST
SURPRISE MEDICAL BILLING



Setting the Record Straight on the *No Surprises Act's* IDR Process

A few health care provider associations recently wrote to federal officials urging changes to the *No Surprises Act's* Independent Dispute Resolution (IDR) process. These associations represent the provider specialties most likely to profit from the IDR process, so it is not surprising that **the letter presents a selective reading of outdated data, omits critical findings from independent researchers, and misidentifies the real source of the dysfunction threatening the law's long-term success.** Further, the provider groups behind the letter endorse policy changes that, if adopted, would drastically raise costs for patients, employers, and families.

The *No Surprises Act* was designed to protect patients from unexpected out-of-network bills while lowering health care costs. Unfortunately, a small number of private equity-backed providers and revenue cycle managers have systematically turned the IDR process into a profit center. As a result, IDR has *added* **at least $5 billion in costs that ultimately hit employers and consumers.**

Myth: The *No Surprises Act* is achieving its intended objectives, including lowering health care costs.

Fact: While the *No Surprises Act's* patient protections are working, the IDR process has been systematically exploited in a way that Congress never intended, driving up costs that now threaten the law's long-term success.

The *No Surprises Act* has prevented over one million surprise bills every month, but the law's secondary goal of lowering health care costs is under serious threat. When Congress designed the IDR process, federal officials projected approximately 17,000 disputes per year. **However, the latest research estimates that 4.8 million disputes have been filed through the end of 2025, more than 280 times the original estimate.** During the first six months of 2025 alone, parties submitted 1.2 million new disputes to the IDR portal, more than double the volume from the same period in 2024.

Supporters of IDR often point to a Government Accountability Office (GAO) report that analyzed claims data **only through 2023,** before the full scale of IDR abuse and misuse was in effect and without the impacts of the deluge of IDR disputes that have gone through the process since then. **IDR volume surged in the second half of 2024,** which tells a very different story. By mid-2025, cumulative disputes had reached 4.8 million, with 1.2 million new disputes filed in just the first six months of the year. The market dynamics the GAO captured bear little resemblance to the cost trajectory the system is now on.

The recent letter also greatly simplifies what the GAO found. On in-network participation, the results were highly varied and inconclusive: participation rose for emergency department and air ambulance services but was essentially flat for radiology and anesthesiology, and air ambulance participation actually decreased in 2023 after rising in 2022. Taken together — and compounded by the use of older data — there are not enough facts to support the directional trend the letter implies.

The letter also omits a key GAO finding: emergency medicine physician payments decreased after the *No Surprises Act* took effect, continuing a pre-existing trend, while **emergency department facility payments increased**. The GAO data explicitly does not show costs falling across the board. It shows divergent trends by specialty and place of service. The letter flattens this nuance into a talking point.

Myth: Physicians and clinicians use the IDR process sparingly and appropriately, resorting to arbitration only when health plans fail to offer fair payment.

Fact: A persistent group of private equity-backed provider groups and IDR middlemen are responsible for the overwhelming majority of IDR filings, overwhelming the system and winning awards of up to nine times market rates.

The claim that IDR is used "sparingly" cannot be squared with the scale shown in the actual data. When Congress designed the IDR process, federal officials projected approximately 17,000 disputes per year. **The system has since logged 4.8 million disputes through the end of 2025, more than 280 times that estimate.** And that volume is not distributed evenly. In the first six months of 2025, just four entities, HaloMD, Team Health, Radiology Partners, and SCP Health, accounted for 56 percent of all disputes filed. HaloMD, a billing intermediary specifically created to maximize out-of-network reimbursement through IDR, went from initiating 1 percent of disputes in 2023 to 22 percent of all disputes by the second quarter of 2025.

Provider win rates have also reached record highs, with providers winning 88 percent of disputes in the first half of 2025, up from 85 percent in 2024 and 81 percent in 2023. Radiology Partners prevailed in 92 to 95 percent of its cases, and Team Health won 94 percent. Award amounts tell a similar story: HaloMD secured median awards of 920 percent of the qualifying payment amount (QPA) in Q1 2025 and 835 percent in Q2 2025. Radiology Partners received 582 to 594 percent of QPA, and SCP Health received approximately 370 percent. It is clear IDR is a business model for the same groups that used surprise billing as a business model. The Emergency Department Practice Management Association's (EDPMA) upcoming annual conference clearly illustrates the point: its agenda includes dedicated sessions on "strategies to maximize success rates in IDR" and how emergency medicine groups can anticipate and counteract payer approaches.

Myth: QPAs are inaccurate and misleading benchmarks that dramatically understate true market rates, and overall health care costs are not increasing under the *No Surprises Act.*

Fact: The QPA is functioning as Congress designed it. The real driver of rising costs is the systemic exploitation of the IDR process, which has already generated at least $5 billion in total costs and continues accelerating rapidly.

The letter cites an analysis by ndp Analytics claiming that the median in-network rate is nearly 300 percent higher than the reported QPA. This comparison is methodologically flawed. The QPA is anchored by statute to an insurer's 2019 median contracted rate, adjusted for inflation using the consumer price index (CPI). ndp Analytics compared this 2019-anchored benchmark to 2024 contracted rates from Transparency in Coverage data. Where contracted rates have grown faster than CPI since 2019, current rates will naturally exceed the QPA — but that is the statute's design, not a flaw. The paper frames a design feature as a calculation error.

What is actually driving rising costs is the explosion of IDR volume and the inflated awards coming out of the process. **Administrative fees alone reached $844 million in just the first six months of 2025, nearly equal to the total $885 million in administrative fees for all of 2022 to 2024 combined.** Researchers estimate that the IDR process has generated at least $5 billion in total costs through the end of 2024, a figure that will rise substantially by the time full 2025 data are available. These costs are ultimately passed on to patients and employers through higher premiums, higher deductibles, and higher out-of-pocket expenses.

Myth: Declining out-of-network reimbursement rates demonstrate that the IDR process is not driving costs up for patients and employers.

Fact: The reimbursement decline cited by the letter is overwhelmingly a pre-*No Surprises Act* story. IDR was barely operational during the period the data covers, making it a misleading basis for claims about IDR's cost impact.

The letter cites RAND Corporation research showing that out-of-network reimbursement for emergency department services declined by 47.7 percent between 2018 and 2022 and uses this trend to suggest that provider payment is falling, not rising, under the law. This framing conflates two distinct time periods and overstates what the data can support.

The IDR process did not begin until April 2022. During the remainder of that year, the system was barely operational: the ineligibility rate for disputes was 69 percent, the federal portal suffered repeated backlogs, and the volume of disputes was a small fraction of what it would later reach. **Citing a payment trend that runs through 2022 to characterize IDR's cost impact is simply not valid.**

Myth: Health plans refuse to engage in good faith with open negotiation, and their failure to disclose eligibility information drives providers into IDR.

Fact: Both the low open negotiation rate and the high volume of ineligible filings reflect the extraordinary financial incentives built into IDR — not insurer bad faith or systematic non-disclosure.

The letter relies on survey data from Americans for Fair Health Care (AFHC), an organization funded by provider interests, to claim that health plans respond to open negotiation offers only 50 percent of the time and rarely provide counter-offers. These figures have not been independently verified by the Centers for Medicare & Medicaid Services (CMS), the GAO, or any neutral regulatory body.

The structural economics of IDR better explain the low open negotiation resolution rate. **A provider expecting an 88 percent chance of winning an IDR award at three to nine times the QPA has little incentive to accept a negotiated rate aligned with the market.** In addition, when guardrails on what is eligible for IDR are not followed and inflated awards are made on many of these cases, there is an incentive to flood the process.

Improving eligibility transparency is a commonsense, shared goal, and CASMB supports efforts to clarify state versus federal IDR pathways. But the evidence does not support the claim that insurer non-disclosure is the primary driver of ineligible filings. Health plans challenged 40 percent of cases as ineligible in the first half of 2025, similar to prior years. IDR entities themselves deemed 17 percent ineligible, a rate federal officials attribute partly to misaligned incentives for IDREs to find cases eligible in order to drive their own volume and revenue.

Ongoing litigation reveals a pattern of deliberate ineligible filing. Anthem's lawsuit against HaloMD alleges that 55 percent of HaloMD's dispute submissions were ineligible and that HaloMD knowingly bypassed system guardrails to submit them, with screenshots of the federal IDR portal included in the complaint. Anthem's separate lawsuit against SCP Health alleges that nearly 60 percent of more than 27,000 disputes were ineligible, including 943 of 954 disputes submitted in a single day. Health plans regularly receive cases that are duplicates, already adjudicated, or filed for Medicare and Medicaid services. These are not the hallmarks of good-faith confusion about eligibility rules.
