COALITION AGAINST
SURPRISE MEDICAL BILLING

Addressing Fraud & Abuse in the Federal IDR Process: Restoring Affordability and Accountability

THE PROBLEM

President Trump and Congress passed the *No Surprises Act* to shield patients from surprise medical bills and to lower healthcare costs. However, the federal Independent Dispute Resolution (IDR) process, intended to serve as a "last resort" for resolving payment for out-of-network care, has become a magnet for abuse, creating a healthcare affordability crisis for consumers and employers.

Increased Premiums from Misuse & Abuse: The estimated $5 billion-plus in IDR-related costs is driving higher premiums for consumers and employers. New York's Empire Plan attributes more than $200 million in additional claim payments — a primary driver of its nearly 10 percent premium increase this year — to this abuse,[1] and the United Service Workers plan, covering 20,000 trades workers, raised premiums an extra 1.75 percentage points to offset arbitration awards and fees.[2]

Flood of Disputes from Providers & IDR Middlemen: The latest data from CMS report over 6.3 million IDR disputes have been filed since 2022.[3] Providers and facilities have initiated 99.9 percent of all disputes, and just four organizations — HaloMD, TeamHealth, Radiology Partners, and SCP Health, the latter three backed by private equity — drove the majority of them, reinforcing IDR as a go-to profit center.

Excessive & Inflationary Awards: Providers prevailed in 88 percent of disputes in early 2025 — the highest win rate to date — and the resulting awards bear little relationship to in-network rates.[4] Radiology Partners secured median awards of 582 and 594 percent of the qualifying payment amount (QPA) in the first two quarters of 2025, and HaloMD's reached 920 and 835 percent. As researchers in Health Affairs conclude, "certain provider groups are receiving three to nine times in-network rates." These awards come at a direct cost to consumers and employers.

Misaligned Incentives for IDR Entities: The IDR entities (IDREs) that decide disputes profit based on how many cases they adjudicate. The initiating party — almost always the provider — names its preferred arbitrator, an immediate structural advantage,[5] and IDREs collect mandatory fees of $425 to $1,150 per determination, a direct incentive to maximize case volume.[6] They only receive these payments if they deem the case eligible and make a final award. All the incentives align toward ruling in favor of the provider, which keeps driving increased disputes to IDR.

A lack of enforcement related to conflict-of-interest rules leaves gaps that certain private equity-backed entities have consistently exploited. At least five IDREs are backed by private equity, including one that owns both a provider group and an IDRE — a clear conflict.[7]

FIXING SYSTEMIC IDR ABUSE

The current IDR structure does little to deter this conduct: with minimal upfront cost to initiate a dispute and no meaningful penalty for filing ineligible or bad-faith claims, the incentives run entirely in the wrong direction.

The IDR operations final rule works to address a subset of IDR issues, but it does not reach their structural drivers, and several components of the final rule risk compounding the current cost challenges. Policymakers must address:

The increased costs to consumers and employers that run directly counter to the intent of the law, driven by the escalating award amounts and high volume of claims.

Proposed solutions:

- Establish clear guardrails on arbitration outcomes to ensure awards remain anchored to market-based benchmarks.
- Close the scope-of-services loopholes by tightening the ancillary-services and eligibility definitions to keep scheduled and non-surprise care out of IDR.
- Require more comprehensive and transparent information on determinations – including how each statutory factor was weighed, the original submissions, and opportunities to solicit CMS review.

The subset of provider groups and middlemen that are operating in bad faith and are being left unchecked by the IDREs meant to bring rigor and neutrality to the process.

Proposed solutions:

- Screen eligibility automatically through the IDR Gateway Portal before assigning an IDR entity to a dispute.
- Address bad-faith initiation of disputes by establishing an upfront IDR eligibility fee and penalties for patterns of abuse by providers.
- Establish IDR entity performance metrics and enforce greater accountability and oversight for adherence to CMS guidance.
- Address conflicts of interest and strengthen oversight of IDREs by establishing meaningful IDRE certification and decertification standards, performance monitoring, and accountability mechanisms.

Left unchanged, the current IDR process will continue to drive higher premiums for families, higher healthcare benefit costs for employers, and higher spending across the system. The Trump administration and Congress should take immediate action to address the fraud, waste, and abuse in the IDR process by advancing commonsense reforms.

[1] https://www.budget.ny.gov/pubs/archive/fy27/ex/artvii/ppgg-memo.pdf (Part T, page 24)
[2] https://www.nytimes.com/2026/04/22/us/politics/doctors-insurers-arbitration.html
[3] https://www.cms.gov/nosurprises/policies-and-resources/reports
[4] https://www.healthaffairs.org/content/forefront/no-surprises-act-idr-process-early-look-2025-data
[5] https://www.cms.gov/nosurprises/help-resolve-payment-disputes/payment-disputes-between-providers-and-health-plans
[6] https://www.cms.gov/newsroom/fact-sheets/federal-independent-dispute-resolution-idr-process-administrative-fee-and-certified-idr-entity-fee
[7] https://pestakeholder.org/news/profiting-on-all-sides-private-equity-and-the-no-surprises-act/