INDEPENDENT DISPUTE RESOLUTION PROGRAM PERFORMANCE: AN EVIDENCE-BASED REVIEW OF VOLUME, ELIGIBILITY, AND PAYMENT OUTCOMES

Commissioned by the Coalition of Independent Dispute Resolution Entities (CIDRE)

EXECUTIVE SUMMARY

Background

The No Surprises Act (NSA), enacted through the Consolidated Appropriations Act of 2021 and effective January 1, 2022, established federal patient protections against unexpected out-of-network (OON) billing across emergency services, nonemergency care delivered at in-network (INN) facilities, and air ambulance services. Prior to implementation, approximately 18% of emergency department visits and 16% of INN inpatient hospital stays among large employer enrollees generated at least one OON charge, affecting millions of commercially insured Americans annually. The NSA limits patient cost-sharing to INN rates for covered encounters and established an Independent Dispute Resolution (IDR) process to settle residual payment disputes between payers and OON providers.

Independent Dispute Resolution Framework

Under the IDR framework, disputes not resolved during a mandatory 30-business-day open negotiation period are submitted to a certified IDR entity (IDRE) for binding "baseball-style" arbitration. Arbitrators select between each party's final offer after weighing a defined set of statutory factors. The Qualifying Payment Amount (QPA), the median INN contracted rate for a given service and geography as of January 31, 2019 adjusted for inflation, is one such factor but is not accorded presumptive weight. Additional factors eligible for consideration include patient acuity, provider qualifications and experience, market share, prior contracting history, and good faith conduct during open negotiation. Arbitrators are expressly prohibited from considering Medicare or Medicaid rates, usual and customary charges, or billed charges. Patient cost-sharing is calculated from the QPA, independent of the arbitrated payment amount.

Dispute Volume

IDR dispute volume substantially exceeded initial federal projections of 17,000 to 22,000 annual disputes. Approximately 489,000 disputes were filed in the program's first 15 months, annual volume reached approximately 1.46 million in 2024, and cumulative filings totaled roughly 4.8 million through end of 2025. The projection shortfall is attributable in large part to a flawed baseline: the federal estimate relied on a 2018 New York State dataset that did not capture national OON exposure. The Government Accountability Office documented that INN claim rates for the four specialties most affected by the NSA declined from approximately 98% to 90% between 2019 and 2021, before the program launched, substantially expanding the eligible dispute pool. Applying published OON exposure rates to 2021 national utilization data yields an

estimated 7.5 to 8 million surprise billing instances annually, suggesting actual program scale was always likely to be closer to observed dispute volume than to the original projection.

Decision Rates and Qualifying Payment Amounts

Providers prevailed in approximately 80% of disputes in 2023 and 85% in 2024, with median prevailing offers in emergency service disputes documented at 312% of QPA. When payers prevail, median outcomes approximate 110% of QPA. These figures are frequently cited as evidence of program dysfunction. That interpretation depends on the QPA being the appropriate comparator for OON payment. The QPA captures rates that INN providers accepted in exchange for network membership and patient volume, contractual terms to which OON providers were not party. Congress considered and declined to set OON payment to the INN rate, opting instead for a multi-factor arbitration process. Awards above the QPA are therefore not, by themselves, evidence of arbitrator bias or process failure; rather it is a reflection of the program operating as dictated by statute.

Ineligible Claims

Ineligibility rates have been mischaracterized in published criticism. According to CMS public use data, the actual rate of ineligibility determinations throughout the life of the program (April 15, 2022 – May 31, 2026) is 17%. Widely cited estimates of 40% ineligibility conflate process-based technical eligibility objections with final arbitrator-based determinations. The most common grounds for ineligibility are procedural and jurisdictional rather than substantive: claims governed by state rather than federal law, timing errors, improper claim grouping, and incomplete documentation.

Patient Protection

The NSA has substantially achieved its primary objective, protecting patients from surprise OON bills. Research conducted by RAND with 35 provider and insurer representatives found broad agreement across both parties that surprise billing has been largely eliminated for covered services. Published quantitative evidence documents a 16.5% decline in patient out-of-pocket spending for NSA-covered service categories. Network participation trends have not deteriorated: the GAO documented increases in INN claim rates post-NSA for three of the four most-affected specialties, with payment trends largely continuing pre-existing trajectories.

Conclusion

The NSA has delivered on its core promise: patients are no longer subject to the surprise bills that were common before January 2022, and patient out-of-pocket spending has declined measurably for affected service categories. The IDR program's principal criticisms do not withstand scrutiny against the operational record. Dispute volume reflects pre-existing OON exposure; widely cited ineligibility rates conflate filed objections with final determinations; and characterizing awards above the QPA as failure applies a standard Congress declined to adopt.

I. Introduction

The No Surprises Act (NSA) was enacted in 2020 in response to a well-documented pattern of surprise out-of-network (OON) billing among commercially insured patients. At the time, approximately 18% of emergency department visits and 16% of in-network inpatient hospital stays among large employer enrollees generated at least one OON charge.[1] Public concern surrounding these bills was substantial, with 67% of Americans reporting worry about surprise medical charges and 78% supporting federal legislative intervention.[2]

Congress responded by passing the NSA through the Consolidated Appropriations Act of 2021, establishing nationwide protections effective starting January 1, 2022. The law extended coverage to OON emergency services, nonemergency services delivered at in-network facilities, and air ambulance services, the principal contexts in which patients historically lacked notice that all or components of their care would be delivered by OON service providers.[3]

The central tenet of the NSA is protection from OON bills for patients with most employer-sponsored, Affordable Care Act (ACA) marketplace, and certain private insurance plans. Patients covered under the NSA are only responsible for in-network (INN) cost-sharing rates for both emergency care and scheduled care at INN facilities where ancillary providers are involved without their knowledge or consent. To settle the remaining cost dispute, Congress embedded within the NSA's architecture a mandatory Independent Dispute Resolution (IDR) process governing the balance of financial liability between patients' insurers and the OON providers who delivered their care.

Under the law, when these two parties cannot reach agreement during a 30-day open negotiation period, either may submit the dispute to a certified arbitrator, referred to as an IDR entity (IDRE), for a binding determination.[4] The process employs "baseball-style" arbitration, in which each party submits a final offer and the IDRE selects between them after weighing a defined set of statutory factors.[5] Congress adopted this arbitration-based framework deliberately, rejecting alternatives that would have set out-of-network (OON) payments at a qualifying payment amount (QPA) or a Medicare multiple, on the grounds that a fixed administrative benchmark would function as de facto price-setting.[6]

Importantly, the IDR process was not designed as a price-setting mechanism, and the QPA was not established as a pre-determined payment rate or ceiling. IDREs are required to weigh the QPA alongside additional statutory criteria. These include case acuity, provider training, experience, and

[1] Karen Pollitz et al., "US Statistics on Surprise Medical Billing," *JAMA* 323, no. 6 (February 11, 2020): 498, https://doi.org/10.1001/jama.2020.0065.
[2] Pollitz et al., "US Statistics on Surprise Medical Billing," 498.
[3] Ryan J. Rosso and Wen W. Shen, *No Surprises Act (NSA) Independent Dispute Resolution (IDR) Process Data Analysis for 2024*, Congress.gov, 2024, https://www.congress.gov/crs-product/R48738.
[4] Centers for Medicare & Medicaid Services, "Overview of Rules & Fact Sheets | CMS," www.cms.gov, April 22, 2025, https://www.cms.gov/nosurprises/Policies-and-Resources/Overview-of-rules-fact-sheets.
[5] Rosso and Shen, *No Surprises Act (NSA) Independent Dispute Resolution (IDR) Process Data Analysis for 2024*.
[6] Rosso and Shen, *No Surprises Act (NSA) Independent Dispute Resolution (IDR) Process Data Analysis for 2024*.

quality outcomes, as well as party market share, facility characteristics, and prior contracting history. IDREs are also explicitly prohibited from considering usual and customary charges, billed charges, and public program rates such as Medicare or Medicaid payment amounts. Separately, patient cost-sharing obligations are determined by the QPA regardless of the arbitrated award, meaning that increases in IDR payment determinations do not translate into higher patient financial liability. [7]

Finally, the IDR process must also be understood as a narrow subset of all OON care. Fewer than 1% of all commercial claims are subject to IDR, and of those eligible, the majority were resolved through an initial payment.[8] By design and in practice, the IDR process functions as a backstop mechanism to protect patients when surprises occur, rather than the primary channel through which OON payment is determined. As a result, evaluations of the program's performance should be calibrated accordingly.

II. IDRE Framework

a. Dispute Lifecycle

Before a dispute can enter the federal IDR process, the parties must complete a mandatory 30-business-day open negotiation period. If open negotiation fails to produce agreement, either party may initiate IDR through the federal portal. The IDRE that will arbitrate the dispute is selected by mutual agreement between the insurer and provider; if the parties cannot agree, the Centers for Medicare and Medicaid Services (CMS) assigns an IDRE at random from the pool of certified entities.

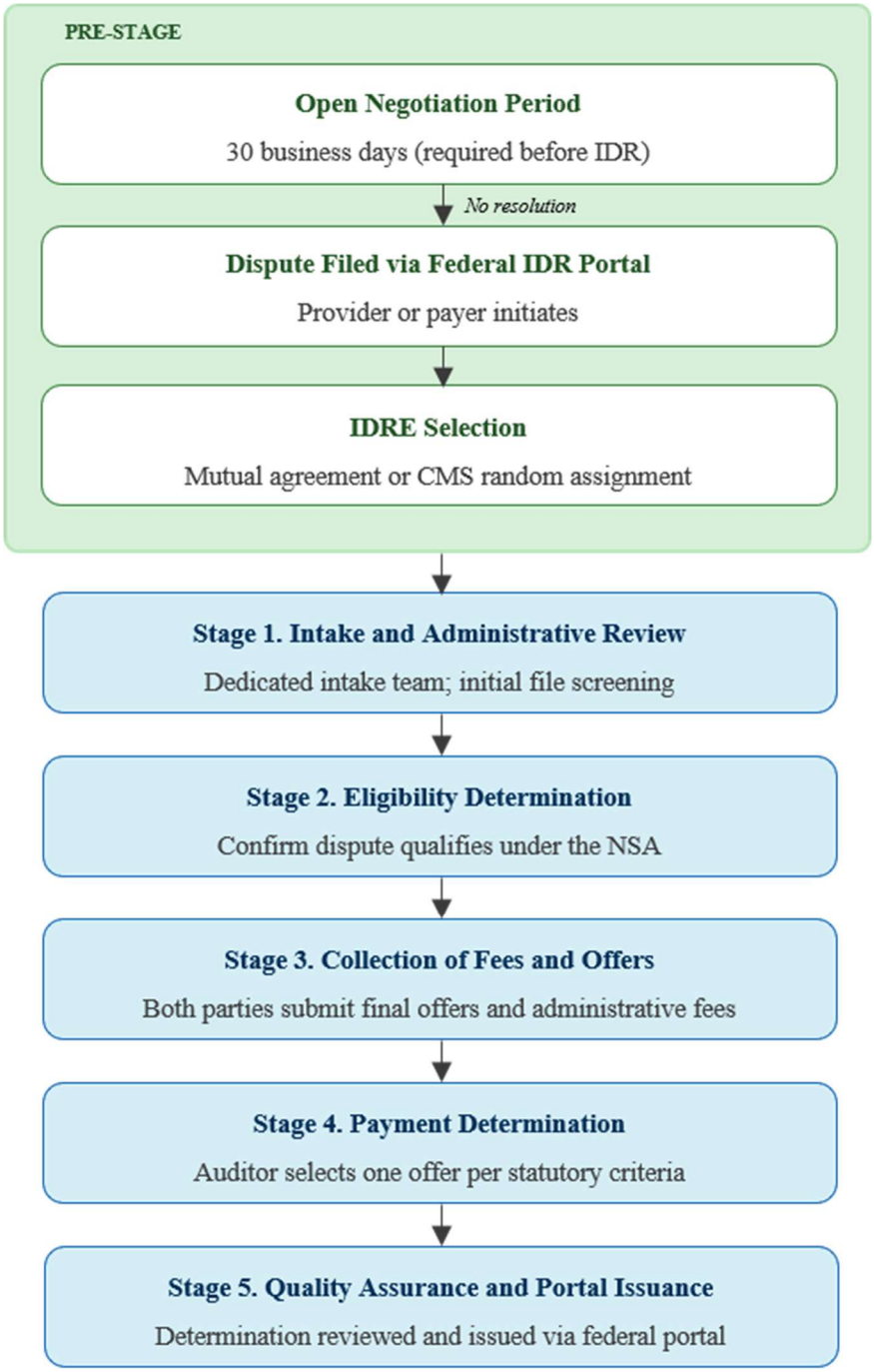
CMS Final Rule, CMS-9897-F, released in May 2026, has enhanced the open negotiation period through several administrative reforms. Under the new rule, the initiating party must submit an open negotiation notice to both the other party and CMS through the federal portal, and the 30-business-day period begins only upon submission of both the notice and the payment remittance or denial. The open negotiation notice must also include new required content elements to help parties identify the item or service at issue and assess whether the Federal IDR process applies.[9] These changes are intended to improve the efficiency of open negotiation and increase the share of disputes resolved before proceeding to arbitration.

Once a dispute is filed with an IDRE, it typically proceeds through five stages: (1) intake and administrative review; (2) eligibility determination; (3) collection of administrative fees and party offers; (4) payment determination; and (5) quality assurance and issuance of the determination through the federal portal *(Figure 1)*. While each IDRE may have a different staffing approach,

[7] Centers for Medicare & Medicaid Services, "No Surprises Act: Overview of Key Consumer Protections," revised November 2023, https://www.cms.gov/files/document/nsa-keyprotections.pdf.
[8] AHIP, "No Surprises Act Continues to Prevent More than 1 Million Surprise…," AHIP, 2024, https://www.ahip.org/resources/no-surprises-act-continues-to-prevent-more-than-1-million-surprise-bills-per-month-while-provider-networks-grow.
[9] Centers for Medicare & Medicaid Services, "Federal Independent Dispute Resolution Operations Final Rule," fact sheet, May 28, 2026, https://www.cms.gov/newsroom/fact-sheets/federal-independent-dispute-resolution-operations-final-rule.

segmentation of review teams to mirror this multi-stage process is a structural safeguard against conflicts of interest: staff involved in earlier administrative stages typically do not carry decision-making authority in later determination stages, reducing the risk that procedural or financial considerations inappropriately influence the outcome.

Figure 1. A generalized overview of the federal IDR dispute lifecycle, from mandatory open negotiation through IDRE administrative stages and final payment determination.



b. Arbitrator Qualifications

Arbitrators certified to conduct IDR determinations include attorneys, medical professionals, and experienced claims reviewers. They are subject to regulatory certification requirements and must complete CMS-provided training modules.[10] Consistent implementation of the standards has been a challenge, however, as legal challenges to the law's treatment of the QPA have unfolded in the years since implementation.

The NSA's implementing regulations originally directed IDREs to treat the QPA as the central reference point in payment determinations: arbitrators were required to consider the QPA first, presume its credibility, and document any weight given to non-QPA factors. The statute itself, however, lists the QPA as only one of several factors IDR entities must weigh when determining the appropriate out-of-network rate.[11] As a result, the Texas Medical Association (TMA), a nonprofit representing physicians and medical students in Texas, brought a series of legal challenges to these rules.

In Texas Medical Association v. United States Department of Health and Human Services (TMA I), the district court vacated the Departments' interim final rule requiring IDR entities to apply a rebuttable presumption in favor of the QPA, holding that the presumption conflicted with the statute's plain meaning.[12] Subsequent lawsuits, including TMA II and TMA III, further challenged the QPA's elevated role, with the Fifth Circuit ultimately affirming that the NSA does not direct IDR entities to weigh the QPA more heavily than any other factor and partially vacating the methodology used to calculate it.[13] In practice, IDR entities are now required to weigh the QPA alongside all other statutory factors without any prescribed hierarchy.

Beyond the QPA, IDREs are directed, but not required, to weigh a defined set of additional factors, including patient acuity and clinical complexity, the training and experience of the rendering provider, the payer's market share in the relevant geographic area, any prior contracted rates between the parties, and whether either party negotiated in good faith during the open negotiation period. Equally important are the factors arbitrators are prohibited from considering. Usual and customary rates, Medicare or Medicaid rates, the fact that the provider is OON, and any reference to what the provider charged before the NSA are all off-limits. These constraints mean that arbitrators deciding IDR disputes operate in a significantly more restricted environment than, for example, commercial arbitrators in contract disputes or even health plan medical directors reviewing prior authorization requests. This degree of constraint is directly relevant to evaluating claims of systematic bias.

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[10] Centers for Medicare & Medicaid Services, "Frequently Asked Questions Regarding the Federal Independent Dispute Resolution Process," February 2022, https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/guidance-faqs-federal-independent-dispute-reolution-process.pdf; *Requirements Related to Surprise Billing; Part II*, 86 Fed. Reg. 55980 (October 7, 2021).
[11] Kristen O'Brien et al., "Breaking down the New No Surprises Act FAQs Post-TMA III (June 2025 Update)," McDermott+, June 6, 2025, https://www.mcdermottplus.com/insights/breaking-down-the-new-no-surprises-act-faqs-post-tma-iii/.
[12] O'Brien et al., "Breaking down the New No Surprises Act FAQs Post-TMA III."
[13] Katie Keith, "The No Surprises Act: A Litigation Status Check," *Forefront Group*, August 26, 2025, https://doi.org/10.1377/forefront.20250825.803087.

As with all federal programs, it is worth noting that IDREs are subject to audit by CMS. To date, CMS has not published findings of systematic non-compliance or bias in IDRE determinations, and no certified entity has had its certification revoked on the basis of improper weighting of statutory factors, or for any other reason. This audit infrastructure provides an important check on IDRE conduct and underscores the need for IDREs to continue operating in ways that are consistent with statute.

III. Qualifying Payment Amounts

a. What the QPA Is and What It Is Not

The QPA is defined by CMS as the median in-network contracted rate as of January 31, 2019, increased for inflation, for a specific service in a specific geographic market, calculated and submitted by the payer. [14] As a result of the prescribed methodology, the QPA reflects the rates that in-network providers have agreed to accept under negotiated contracts. Generally, providers enter those contracts in exchange for patient volume, network membership, and guaranteed payment. [15]

OON providers are not party to the INN contracts that set the QPA and OON emergency physicians have historically charged rates far exceeding their in-network counterparts, averaging 637% of Medicare rates compared to 266% for INN emergency physicians for identical services. [16] This disparity reflects a structural feature of the market rather than aberrant billing; because patients cannot select their emergency physician, OON status carries a less significant volume penalty, giving physicians significant leverage in both OON charges and INN contract negotiations. Interpreting IDR awards that exceed the QPA as inherently anomalous misrepresents the unbalanced nature of this specific market.

This gap is not a product of the NSA or of IDR arbitration. It predates both and is a function of the health care landscape in the United States at large. A payment determination above the QPA therefore does not indicate an excessive result relative to the local or national OON market. It may simply reflect the longstanding gap between INN and OON market pricing. The two have never been equivalent, and the NSA was not designed to make them so. This historical and market context is presented to underscore the notion that the QPA should largely be considered a valid and direct guidepost for INN rates, but treated more cautiously with respect to ONN bills, which are the sole focus of the NSA.

[14] Centers for Medicare & Medicaid Services, "Qualifying Payment Amount Calculation Methodology 45 CFR 149.140," 2021, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAAQualifying-Payment-Amount-Calculation-Methodology.pdf.
[15] Vivian Y. Wu, "Managed Care's Price Bargaining with Hospitals," *Journal of Health Economics* 28, no. 2 (March 2009): 350–60, https://doi.org/10.1016/j.jhealeco.2008.11.001.
[16] Zack Cooper, Fiona Scott Morton, and Nathan Shekita, "Surprise! Out-of-Network Billing for Emergency Care in the United States," *Journal of Political Economy* 128, no. 9 (September 1, 2020): 3626–77, https://doi.org/10.1086/708819.

b. The Rate-Setting Implication of QPA-Anchored Criticism

Published analyses that characterize awards above the QPA, or above Medicare rates, as evidence of program failure implicitly argue that IDR outcomes are acceptable only when they converge on the in-network rate.[17] [18] The logical extension of this position is that out-of-network providers should be paid as though they had signed network contracts, regardless of whether they chose to join the network or whether the network rate on offer was adequate.

Congress considered this approach when designing the NSA and rejected it, opting instead for a process in which both parties submit offers and arbitrators weigh a defined set of factors, with the QPA as one input among several.[19] Evaluating the program by the standard Congress declined to adopt, and treating deviations from that standard as failures, does not constitute a neutral critique of the program's design or implementation. It simply substitutes a policy preference for an empirical finding.

IV. Dispute Volumes

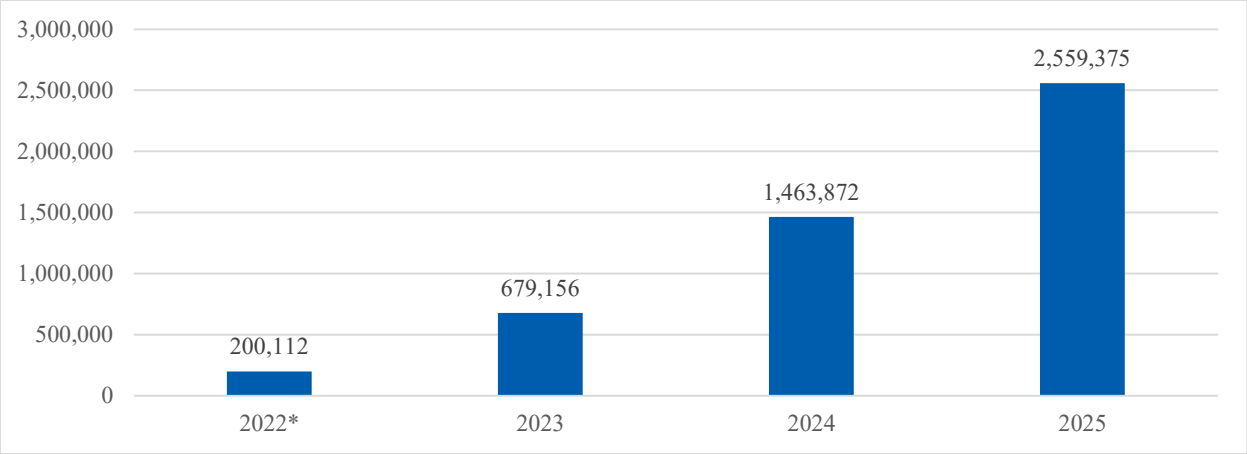
High IDR dispute volume has become a frequently cited indicator of program dysfunction, with critics treating the gap between projections and reality as evidence that providers are gaming the system. That framing inverts the actual problem. The projection was not a reliable baseline and it critically understated the number of patients experiencing surprise bills.

a. Structural Issues with Baseline

CMS projected 17,000 to 22,000 disputes per year at program launch, a figure derived from a 2018 New York State claims extrapolation. What followed bore almost no relationship to that forecast. Approximately 489,000 disputes were filed in the first fifteen months of program operation, annual volume reached 1.46 million by 2024, and cumulative filings through the end of 2025 totaled approximately 4.8 million.[20]

[17] Jack Hoadley and Kennah Watts, "The Substantial Costs of the No Surprises Act Arbitration Process," *Forefront Group*, August 25, 2025, https://doi.org/10.1377/forefront.20250820.13433; Lawson Mansell and Sage Mehta, "New Data Shows No Surprises Act Arbitration Is Growing Healthcare Waste - Niskanen Center," Niskanen Center - Improving Policy, Advancing Moderation, June 18, 2025, https://www.niskanencenter.org/new-data-shows-no-surprises-act-arbitration-is-growing-healthcare-waste/.
[18] Loren Adler, Matthew Fiedler, and Vani Agarwal, "No Surprises Act Arbitration Databook," Brookings, April 20, 2026, https://www.brookings.edu/articles/no-surprises-act-arbitration-databook/.
[19] CHIR Faculty, "Unpacking the No Surprises Act: An Opportunity to Protect Millions | Center on Health Insurance Reforms," Georgetown.edu, 2021, https://chir.georgetown.edu/unpacking-the-no-surprises-act/.
[20] Rosso and Shen, *No Surprises Act (NSA) Independent Dispute Resolution (IDR) Process Data Analysis for 2024*.

Figure 2. Federal IDR Disputes Initiated by Year



*Source: CMS Federal IDR Supplemental Background Reports and bi-monthly IDR updates, available at cms.gov/nosurprises/policies-and-resources/reports. The 2025 total is not published by CMS as a single figure. The number here combines the published H1 2025 total (1,186,812) with the sum of CMS's monthly bi-monthly updates for July through December 2025 (1,372,563). *2022 reflects a partial year (April 15 – December 31).*

The CMS estimate failed to capture the actual expected volume for reasons that had nothing to do with post-NSA behavior. The Government Accountability Office (GAO) documented that in-network claim rates for the four specialties most exposed to NSA regulation – emergency medicine, radiology, anesthesiology, and neonatal and pediatric critical care – had already declined from approximately 98% in 2019 to 90% in 2021, before the first dispute was ever filed (GAO, 2026). That 8% shift in providers moving OON substantially expanded the pool of claims eligible for IDR relative to any pre-2022 estimate, meaning the baseline dispute-eligible population was already larger at program launch than it had been when the projection was constructed. The New York State extrapolation captured none of this.

Alternatively, prior to the enactment of the NSA, surprise billing affected millions of commercially insured Americans each year. While no single source directly quantifies the annual volume of surprise bills in 2021 (the intended baseline year), an estimate can be derived by applying utilization-based rates from peer-reviewed literature to national claims data. According to the Department of Health and Human Services (HHS) Assistant Secretary for Planning and Evaluation (ASPE), drawing on analysis by Pollitz et al. (2020) of large employer plan claims, approximately 18% of emergency department visits and 16% of in-network inpatient hospitalizations for commercially insured patients included at least one OON charge.[21] [22] Applying these rates to 2021 Healthcare Cost and Utilization Project (HCUP) data, which recorded 32.8 million treat-and-release ED visits with commercial insurance as the primary payer and an

[21] U.S. Department of Health and Human Services, "Evaluation of the Impact of the No Surprises Act on Health Care Market Outcomes: Baseline Trends and Framework for Analysis First Annual Report," 2023, https://aspe.hhs.gov/sites/default/files/documents/48b874b63796dc6a68a783cf079ba42a/aspe-no-surprises-act-rtc.pdf.
[22] Karen Pollitz et al., "An Examination of Surprise Medical Bills and Proposals to Protect Consumers from Them," Peterson-Kaiser Health System Tracker, February 10, 2020, https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them-3/.

estimated 10.5 million commercially insured inpatient stays, this yields approximately 5.9 million ED-based and 1.7 million inpatient-based surprise bills, for a combined estimate of roughly 7.5 to 8 million instances annually.

If only one in five of these patients had a claim that qualified for IDR, then the expected volume of claims would be closer to 1.5 million annual claims. Notably, this estimate is conservative: it covers only the two care settings addressed by the NSA's core patient protections and excludes air ambulance services, which were also a significant source of surprise bills prior to the law. Still, these figures underscore the scale of the problem the NSA was designed to address and provide better context for the volume of disputes now flowing through the IDR process than the NY state extrapolation.

b. Concentration of Filings

The concentration of filings among private equity-affiliated providers has attracted particular attention, with those entities initiating between 45-55% of OON emergency and non-emergency disputes per quarter in 2024.[23] Critics treat this as evidence of gaming, but it more directly reflects the market structure of emergency and specialty care delivery. Private equity-affiliated staffing companies dominate the specialties most likely to produce OON encounters, including emergency medicine, radiology, and anesthesiology. This is because those specialties are practiced in hospital and facility settings where staffing contracts, not individual provider network agreements, determine in-network status.[24] The concentration of IDR filings among private equity-affiliated entities is, in substantial part, a function of the concentration of those entities in the specialties most likely to generate IDR-eligible claims.

On the question of network stability, the evidence directly contradicts the prediction that IDR would incentivize providers to remain OON. In-network claim rates rose post-NSA for three of the four most-affected specialties, and payment trend lines largely continued on pre-existing trajectories.[25] Whatever effect the IDR process has had on network participation incentives, the data does not support the claim that it has caused an exodus from commercial insurance networks.

V. Ineligible Claims

Ineligible claim submissions are regularly cited as evidence of systematic abuse committed by high-volume filers, with critics concluding that providers file ineligible claims to impose costs on payers or to drive up settlement values. The operational reality is more complicated. Eligibility determination is a routine part of IDR process, ineligibility rates have been declining as the program matures, and the cost of screening directly falls on IDREs, not on the parties involved in the dispute.

[23] Rosso and Shen, *No Surprises Act (NSA) Independent Dispute Resolution (IDR) Process Data Analysis for 2024*.
[24] Cooper, Scott Morton, and Shekita, "Surprise! Out-of-Network Billing for Emergency Care in the United States," 3626.
[25] Government Accountability Office, "Private Health Insurance: Provider Participation and Payments for Selected Services before and after the No Surprises Act," Gao.gov, 2026, https://www.gao.gov/products/gao-26-107169.

a. Ineligibility Rates

The widely cited claim that 40% of disputes are ineligible relies on a conflation that the data does not support.[26] According to CMS public use data, the actual rate of ineligibility determinations throughout the life of the program (April 15, 2022 – May 31, 2026) is 17%. In the most recent quarter of data available (Q2 2026) that number has dropped to 15.4%.[27] The 40% figure, where it appears in the literature, reflects the rate of filed objections, not the rate at which IDREs sustain those objections and find disputes ineligible. Either party may file eligibility objections to disputes and those objections trigger a formal adjudication by the IDRE.

Eligibility determinations are not subjective. IDREs make these determinations according to strict statutory and regulatory criteria established by Congress and CMS, and may only consider information formally submitted as part of the dispute resolution process. Statute prohibits IDREs from consulting outside information or applying subjective judgment regarding fairness in either eligibility or payment determinations. For example, IDREs cannot make subjective judgments as to whether a service was properly performed on an emergent, planned, or non-emergent basis, but instead must base eligibility determinations solely on whether the dispute satisfies the Federal IDR applicable statutory and procedural requirements. Accordingly, any challenge to an eligibility determination must be substantiated by evidence submitted to the dispute record within a defined timeframe following the eligibility challenge. Under the CMS Final Rule released in May 2026, this window will extend from three to five days beginning in 2027.[28] In practice, IDREs report receiving a high volume of eligibility disputes from payers, but rarely receive accompanying substantiating evidence. In the absence of such evidence, IDREs are required to proceed based solely on the submitted record.

b. Why Disputes Are Found Ineligible

The actual reasons disputes are found ineligible may be largely procedural and jurisdictional, including disputes that fall under state law rather than federal NSA jurisdiction, filings that missed required timing windows, improperly grouped claims, claims involving Medicare or Medicaid which lie outside federal IDR jurisdiction, and submissions where required documentation was not provided within CMS-allowed timeframes. Jurisdiction questions are complex, as the federal-state line under the NSA is not always clear even to experienced practitioners. Similarly, grouping rules for batched disputes are among the most technically demanding aspects of the portal system, and errors in grouping do not carry any inherent implication of bad faith. None of these categories is

[26] AHIP, "New AHIP/BCBSA Survey Shows Nearly 40% of Providers' Surprise Billing Disputes Are Ineligible Under No Surprises Act," press release, October 24, 2025, https://www.ahip.org/news/press-releases/new-ahip-bcbsa-survey-shows-nearly-40-of-providers-surprise-billing-disputes-are-ineligible-under-no-surprises-act.
[27] Centers for Medicare & Medicaid Services, "Independent Dispute Resolution Reports," U.S. Department of Health and Human Services, last modified March 13, 2026, https://www.cms.gov/nosurprises/policies-and-resources/reports.
[28] Centers for Medicare & Medicaid Services, *Federal Independent Dispute Resolution Operations Final Rule* (Washington, DC, 2025), https://www.cms.gov/files/document/federal-independent-dispute-resolution-operations-final-rule.pdf.

straightforwardly evidence of fraud or gaming, and critically, they are addressed in the CMS Final Rule.[29]

The Final Rule directly addresses the procedural and jurisdictional sources of dispute ineligibility that have burdened the Federal IDR process. On the jurisdiction question, the Final Rule addresses the longstanding problem that the existing remittance advice remark code (RARC) N830 was too vague to reliably distinguish between claims subject to state law and those eligible for the Federal IDR process, leaving providers and facilities without meaningful guidance on the correct venue for their dispute. The Final Rule requires plans and issuers to use standardized claim adjustment reason codes (CARCs) and RARCs on remittance advice specifically designed to convey whether a claim is governed by state law, an All-Payer Model Agreement, or the Federal IDR process. This should reduce the likelihood that providers will inadvertently submit state-law claims to the federal system and help IDREs clearly and expeditiously identify these claims.

On batching, the Final Rule sets clearer requirements for how items and services may be grouped into a single dispute, including a 50-line-item limit and more explicit criteria for permissible batching combinations, and commits to releasing additional clarifying guidance with real-world examples to reduce good-faith errors in dispute grouping. On documentation and timing, the Final Rule codifies a 5-business-day window for parties to respond to requests for additional information needed to complete eligibility or payment determinations, with all other timeframes tolled (paused) during that period, addressing the number of disputes that fail on procedural grounds due to incomplete submissions. Taken together, these provisions are designed to reduce ineligible dispute volume not by penalizing filers but by making the rules clearer and the eligibility signals earlier and more reliable.

VI. Decision Rates

A report published by the Congressional Research Service shows that providers won 80% and 85% of disputes in 2023 and 2024, respectively. [30] Median prevailing provider offers in emergency service disputes across 14 states have been documented at 312% of QPA.[31] Median prevailing offers across all dispute types in the first half of 2024 ranged from 383-447% of QPA depending on the data source.[32] When payers prevail, the average payment is approximately 110% of QPA.[33] As previously outlined, whether these figures represent excessive outcomes depends entirely on whether the QPA is the right comparator for these OON claims, and the market reality suggests it is not.

[29] Centers for Medicare & Medicaid Services, *Federal Independent Dispute Resolution Operations Final Rule* (Washington, DC, 2025), https://www.cms.gov/files/document/federal-independent-dispute-resolution-operations-final-rule.pdf.
[30] Rosso and Shen, *No Surprises Act (NSA) Independent Dispute Resolution (IDR) Process Data Analysis for 2024*.
[31] Rosso and Shen, *No Surprises Act (NSA) Independent Dispute Resolution (IDR) Process Data Analysis for 2024*.
[32] CHIR Faculty, "Independent Dispute Resolution Process 2024 Data: High Volume, More Provider Wins | Center on Health Insurance Reforms," Georgetown.edu, 2024, https://chir.georgetown.edu/independent-dispute-resolution-process-2024-data-high-volume-more-provider-wins/.
[33] Hoadley and Watts, "The Substantial Costs of the No Surprises Act Arbitration Process."

Looking beyond the payment amounts themselves, outcomes in the Federal IDR process are influenced not only by the merits of competing offers, but also by party participation and compliance with procedural requirements. Because the process requires parties to submit information within defined timelines and satisfy applicable process obligations, disputes may be resolved without a substantive comparison of the parties' evidence when one party fails to participate fully or satisfy required steps. As a result, a high rate of determinations favoring one side does not necessarily indicate arbitrator preference or systemic bias. Rather, some outcomes reflect procedural defaults, incomplete submissions, or failures to provide information necessary for review. In Q4 2024, 26% of disputes were resolved through a default decision, indicating one side provided incomplete information, and approximately 90% of these defaulted disputes were decided in favor of providers and facilities.[34]

VII. Patient Benefits

a. Surprise Billing Has Been Largely Eliminated for Covered Services

The core promise of the NSA was that patients would no longer receive unexpected, unaffordable bills from OON providers in situations where they could not have anticipated or avoided OON care. The evidence indicates this promise has been kept. Qualitative interviews with 35 provider and insurer representatives conducted by RAND found broad agreement that the NSA has largely eliminated surprise billing for covered services.[35] This finding is notable because it comes from both sides of the IDR dispute. Providers and payers, who disagree sharply about the program's payment outcomes, still agree that the patient protection function is working as intended.[36] [37] Quantitative evidence corroborates the qualitative finding. Published data show measurable reductions in patient out-of-pocket spending for NSA-covered services, with one study documenting an 16.5% decline for affected categories.[38]

b. Provider Networks Have Not Deteriorated

A central prediction of critics who argued that IDR would favor providers was that the program would incentivize providers to abandon their payer networks, preferring OON status and the prospect of favorable arbitration outcomes. This has yet to happen. The GAO documented that in-network claim rates rose post-NSA for three of the four most-affected specialties, and payment

[34] Rosso and Shen, *No Surprises Act (NSA) Independent Dispute Resolution (IDR) Process Data Analysis for 2024*.
[35] Petra Rasmussen et al., "Project Report the Implications of the No Surprises Act on Contract Dynamics, Negotiations, and Finances Perspectives from Key Stakeholders," 2024, https://aspe.hhs.gov/sites/default/files/documents/754f61834289cdd719b542035ee36eba/PRA-1820-9.pdf.
[36] American Medical Association, "AMA, Health Groups Urge Congress to Bolster No Surprises Act," April 2026, https://www.ama-assn.org/press-center/ama-press-releases/ama-health-groups-urge-congress-bolster-no-surprises-act.
[37] Ariel Bayewitz, "Curbing Misuse of the No Surprises Act," Elevance Health, December 19, 2025, https://www.elevancehealth.com/our-approach-to-health/consumer-centered-health-system/curbing-misuse-of-the-no-surprises-act.
[38] Michael Liu et al., "Patient Healthcare Spending after the No Surprises Act: Quasi-Experimental Difference-In-Differences Study," *BMJ* 390 (August 27, 2025): e084803, https://doi.org/10.1136/bmj-2025-084803.

trend lines largely continued on pre-existing trajectories.[39] Whatever effect the IDR process has had on network participation incentives, the data does not support the claim that it has caused an exodus from commercial insurance networks.

This finding matters for the policy debate in three ways. First, it undercuts one of the most commonly cited structural criticisms of the IDR design, namely that arbitration creates perverse incentives for OON status. Second, it suggests that whatever financial advantage providers may derive from favorable IDR outcomes, that advantage is not large enough to outweigh the benefits of network participation. Third, it continues to underscore the patient protection elements of the regulation. Patients benefit when providers they trust stay in network, and any suggestion that has not been the case as a result of the NSA is not supported by the data.

VIII. Conclusion

The NSA has delivered on its core promise. Patients receiving emergency and other covered services from OON providers are no longer subject to the surprise bills that were, before January 2022, a pervasive feature of the American health care experience. Patient out-of-pocket spending has fallen, and participants on both sides of the dispute broadly agree that the law's patient protections from surprise billing is working as intended. The IDR program has nonetheless generated substantial criticism, and this paper has found that while administrative fixes remain important to improving the program over time, many of the criticisms put forth do not match the operational reality of the IDR process.

Dispute volume is high because OON exposure in the affected specialties was always high, and the federal estimate was built on a single-state dataset that bore no relationship to national OON exposure rates at program launch. Ineligible claims are a declining screening outcome, with the widely cited ineligibility rates conflating filed objections with final determinations. Lastly, comparing IDR awards to the INN rate or QPA amount, and concluding the program is failing because awards exceed it, applies a legislative standard Congress declined to adopt.

The No Surprises Act represented a landmark achievement in federal health policy, providing millions of Americans with meaningful protection against a practice that had caused widespread financial harm. Before the law took effect, patients routinely received bills for hundreds or thousands of dollars from OON providers they had no opportunity to select, often in emergency situations where choice was impossible. The NSA has largely eliminated that experience. Dismantling or fundamentally restructuring the program would threaten to withdraw protections that patients have come to rely on, on the basis of criticisms directed at administrative friction, rather than the intent of the underlying law.

[39] Government Accountability Office, "Private Health Insurance: Provider Participation and Payments for Selected Services before and after the No Surprises Act," Gao.gov, 2026, https://www.gao.gov/products/gao-26-107169.