

New AHIP/BCBSA Survey Finds Providers are Flooding IDR System with Ineligible Disputes

The No Surprises Act (NSA) protects patients from surprise medical bills for emergency services, air ambulance services or services from out-of-network providers at in-network facilities. To resolve payment disputes, the law created the federal Independent Dispute Resolution (IDR) process, which applies only to “qualified IDR item[s] or service[s].”¹ Under the NSA, qualified items or services that are eligible for IDR include: out-of-network emergency services, out-of-network non-emergency services provided at an in-network facility, and out-of-network air ambulance services. There are also procedural requirements for a qualified item or service to be eligible for payment determination as part of the federal IDR process, including timing requirements, first participation in an open negotiation process, a cooling-off period, rules for batching or bundling multiple claims as a dispute and a lack of applicable state surprise billing law.

New data from AHIP and BCBSA reveal that many claims submitted to the federal IDR process are for ineligible items or services, meaning they do not meet the criteria noted above. Despite the fact that these ineligible claims did not qualify for IDR, many have still resulted in mandatory payment determinations by the arbiter, i.e., the IDR entity (IDRE). Health plans identified that as much as 39% of disputes initiated in 2024 were for ineligible claims that should not have been submitted. Examples include:

- Claims for services payable under Medicare or Medicaid;
- Disputes already resolved through IDR and resubmitted;
- Disputes involving in-network providers; and
- Claims subject to a state surprise billing law.

By funneling ineligible claims into IDR, providers aim to secure binding payment determinations for services often at amounts significantly above market rates.

Under the federal process, IDREs alone are empowered to determine a disputed claim’s IDR eligibility. However, because their fees are refunded when a dispute is ruled ineligible,² IDREs have a financial incentive to proceed—even when the dispute fails to meet all criteria. This structure conflicts with the NSA’s intent that IDREs operate as impartial arbiters.

This study found that IDREs correctly identify fewer than half of ineligible cases. With no avenue for health plans to appeal or even review eligibility or payment determinations, IDREs have largely unchecked authority to mandate payments from health plans beyond the scope of the law—even if the claim should never have been submitted. **These dynamics have created lucrative opportunities for some providers to exploit the IDR process, flooding it with ineligible disputes to secure higher payments that ultimately make health care less affordable for consumers and employers.**

¹ 26 CFR § 54.9816-8T(a)(2)(xi)

² The administrative fee, which is passed through the IDRE to CMS, is not refunded.

Survey Results in Brief

In March-May 2025, AHIP and BCBSA fielded a nationwide survey on surprise billing and IDR using 2024 claims and dispute data. The survey was distributed to over 80 commercial health plans and 25 health plans responded. The responding plans cover 154 million commercial enrollees, or 71% of the total commercial market.

Main Findings:

- In 2024, nearly 20 million health care claims met the criteria for federal surprise billing protections, meaning nearly 20 million surprise bills were prevented in 2024. However, the costs of operating the arbitration program continue to rise sharply.
- Three out of four (76%) claims were paid without further dispute when providers accepted the plan's initial payment.
- Many disputes should never have been submitted to the federal IDR process as they were ineligible under the law. Health plans identified 39% of all disputes as ineligible, including 45% of non-emergency service disputes. Common defects included:
 - Claims for services payable under Medicare or Medicaid;
 - Disputes already resolved through IDR and resubmitted;
 - Disputes involving in-network providers; and
 - Claims subject to state surprise billing laws.

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These findings also suggest IDREs are failing to identify a large volume of ineligible disputes submitted by providers. Because of this, IDREs are considering and issuing payment determinations on ineligible disputes.

Despite the challenges, once arbitration decisions are issued, plans pay nearly three-quarters of arbitration awards within 30 days; 41% were paid in just 15 days. When delays occurred for qualified IDR items or services, they were most often due to provider submission errors (e.g., wrong contact info, missing details) or processing challenges stemming from the very high volume of IDR cases.

Key Takeaways

- The IDR process itself is costly, diverting funds plans could otherwise have spent on patient care or used to lower premiums and patient cost-sharing.
- The vast majority of out-of-network claims covered by the NSA are resolved through prompt payment without dispute or further negotiation.
- IDR is being overused by some providers who submit high volumes of disputes, many of which are ineligible, which adds costs to the health care system.

No Surprises Act Qualified Claims and Resolution Type

In 2024, there were nearly 20 million qualified IDR claims (also known as NSA-eligible claims) across all provider types (Table 1).³ Emergency services accounted for the majority (61%) of qualified IDR claims, followed by non-emergency services (39%). Air ambulance services accounted for less than 1% of all qualified IDR claims, but are the most likely to enter IDR and typically represent high dollar amounts.

Table 1. Total Volume of Qualified IDR Claims

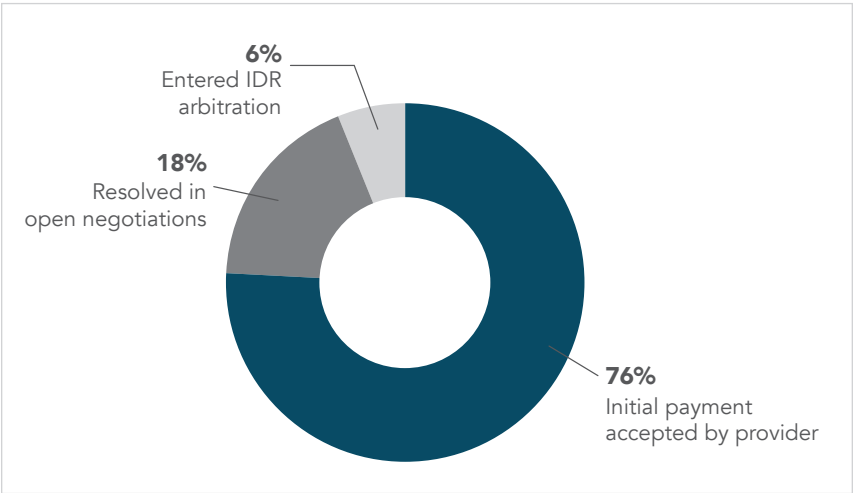
Claims	Emergency Services	Non-Emergency Services	Air Ambulance	All Services
Qualified IDR claims	11,900,000	7,800,000	24,000	19,700,000

For most qualified IDR claims (76%), providers accepted initial payment offers without dispute. About one in four claims (24%) proceeded to open negotiation, a 30-day period established by the NSA for health plans and providers to agree on a payment amount without requiring arbitration. These negotiations often avoided the need for arbitration, with 18% of claims resolved during the open negotiation process. The remaining claims that were still unresolved (approximately 6% of all qualified IDR claims) entered arbitration through the federal IDR process.

Table 2. Qualified IDR Claims by Initial Acceptance Status (N=19.7M)

Claims	Emergency Services	Non-Emergency Services	Air Ambulance	All Services
Initial payment accepted by provider	80%	71%	51%	76%
Resolved in open negotiations	15%	21%	3%	18%
Entered IDR arbitration	5%	8%	45%	6%

Figure 1. Qualified IDR Claims by Initial Acceptance Status - All Services



3 This is a higher estimate compared to the estimate reported in the 2023 survey. The difference stems from the impact of seasonality (2023 survey estimate was extrapolated based on the first 9 month of data) and lag in claims processing, which resulted in an underestimate of NSA-eligible claims.

Eligibility of Disputes Submitted to the IDR Process

An estimated 1.23 million disputes were submitted to the federal IDR process in 2024. There is a stark divide between disputes identified by health plans as ineligible and those deemed ineligible by IDREs. Health plans identified and challenged nearly 40% of disputes as ineligible, often because they were filed after the statutory deadline or lacked required information. However, IDREs deemed only 17% of disputes ineligible.

- IDREs deemed ineligible approximately 15% of emergency, 19% of non-emergency, and 10% of air ambulance service disputes.
- In contrast, the share of disputes identified as ineligible by health plans was more than twice as high (33%, 45%, and 23%, respectively).
- On average, 15% of final payment determinations issued by IDREs were for disputes identified as ineligible by the health plans.⁴

Table 3. IDR Process

Claims	Emergency Services	Non-Emergency Services	Air Ambulance	All Services
Disputes submitted to IDR	625,000	595,000	11,000	1,230,000
Disputes deemed ineligible by the IDRE	15%	19%	10%	17%
Disputes identified as ineligible by the health plan	33%	45%	23%	39%
Ineligible disputes that resulted in final payment determination	15%	16%	7%	15%

The most common reasons health plans deemed disputes ineligible included: claims submitted for dispute outside of the allowed timeframe (29%),⁵ missing key information (13%), subject to a state surprise billing process (8%), or services to which the NSA does not apply (7%).

Other reasons for ineligibility included: incorrectly batched or bundled items or services, failure to initiate an open negotiation process, insufficient information prevented the plan from identifying the claim, no dispute justification had been provided, and claim was reversed or corrected by providers.

Table 4. Share of Disputes Deemed Ineligible by Health Plans, by Reason

Reason Why Health Plan Deemed Disputed Claims Ineligible	Share of Ineligible Disputes (%)
Dispute is outside of the allowed timeframe	29%
Incomplete IDR submission	13%
Dispute should be resolved through a state surprise billing process	8%
Claim is for services not covered by NSA	7%
Dispute is submitted by a provider that is in network/already contracted with the health plan	4%
Patient is covered by an ineligible coverage type (e.g., Medicare, Medicaid, or an Excepted Benefit)	3%
Duplicate IDR submission	2%
Resubmitted IDR disputes where a payment determination was already issued	<1%
Patient is not covered by our health plan	1%
Other	32%

⁴ The percent of health plan-identified ineligible disputes that resulted in a final payment determination in 2024. At the time of the survey, many disputes initiated in 2024 had not reached the payment determination phase.

⁵ Full timeline for IDR process is available from the Centers for Medicare and Medicaid Services (See <https://www.cms.gov/files/document/federal-idr-guidance-disputing-parties-march-2023.pdf>, page 9).

Timeliness of IDR Payments

Despite the overwhelming volume and questions as to eligibility, health plans make appropriate, timely payments to out-of-network providers following payment determinations by IDREs. In 2024, plans paid nearly three out of four claims within 30 days.

For disputes paid more than 30 days after IDR determination, delays most often stemmed from misdirected notices or missing information. In many cases, providers entered incorrect health plan or contact information, preventing plans from being informed about the need for payment (either notice of IDR payment or default judgment). Other delays occurred when IDRE determinations lacked essential information needed to process payment or when the sheer volume of disputes created payment backlogs.

Conclusion

The NSA successfully protected patients from nearly 20 million potential surprise bills in 2024, but the current IDR process is broken—suffering from abuse, inefficiencies, misaligned incentives, and inadequate accountability. The 2024 survey data reveal a significant portion of the already high volume of disputes entering the federal IDR process are ineligible and yet still proceeding, leading to unnecessary administrative costs and abuse of the IDR process.

Survey Implications

- Health plans report that a large share of disputes are IDR-ineligible and result in inappropriate payments.
- Such inefficiencies are straining the system, and some provider groups see an opportunity to extract higher payments.
- Clearer eligibility standards, improved oversight and accountability by regulators, realigned incentives through required fees, stronger screening at the front end and improved IDR operations would reduce waste, fraud and abuse.
- Without reform, the continued growth in IDR volume, especially for ineligible claims, threatens to drive higher premiums and undermine network stability.
- Action from policymakers will enable the NSA to achieve its intended goals: protecting patients while promoting a fair, efficient payment process that sustains accessible, affordable care.

Methodology

In March-May 2025, AHIP and BCBSA fielded a nationwide survey to health plans with enrollment in the commercial market, including both employer-sponsored insurance and the individual market. The survey was distributed to over 80 health insurance plans selling or administering group health plans and Qualified Health Plans. A total of 25 health insurance plans, collectively representing 154 million commercial enrollees, or 71% of the total commercial market, responded to the survey via an online tool.

The survey asked health plans to provide data on qualified IDR claims (also known as NSA-eligible claims) they incurred and paid in 2024. Of these claims, the survey asked for the numbers that were NSA-eligible, that entered open negotiation, that were submitted to IDR or that had initial payment accepted by the provider without a request to IDR.

To arrive at the national estimate of a) NSA-eligible claims, b) claims that entered open negotiation, and c) claims submitted to IDR, the study first calculated NSA-eligible claims per enrollee. It then multiplied the per-enrollee calculations by the 2024 Census estimate of the total number of commercial enrollees (i.e., 216.8 million).