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No Surprise: The No Surprises Act Is Vague and Confusing, and Congress Must Fix It

Doug Badger

KEY TAKEAWAYS

While the No Surprises Act was meant to halt surprise medical bills, it created a flawed system for resolving payment issues between insurers and providers.

This government-mandated dispute-resolution process has sown confusion that each side is trying to turn to its advantage instead of negotiating privately.

Congress should eliminate this process in the act, while retaining provisions that protect consumers from balance bills.

Before the No Surprises Act was implemented in January 2022, consumers often faced surprise medical bills. Patients typically received these bills weeks or months after receiving non-emergency medical care at a network facility or services in a hospital emergency department.[1] These facilities and emergency departments held patients responsible for the difference between the amount that their insurer paid the non-network doctor and the amount that doctor charged, a practice known as balance billing. These bills could range from a few hundred dollars to tens of thousands.[2]

A patient, for example, may have scheduled knee surgery at a network outpatient facility by a network physician, and later receive a large medical bill from a *non*-network anesthesiologist. Or, a patient who sought emergency care for chest pains might later

learn that the doctor who saw him in the emergency department does not participate in his insurance network.

Prices for medical care are generally opaque. Patients do not know how much they will be expected to pay until weeks or months after receiving services.[3] The only control over out-of-pocket payments that consumers can exert in most insurance arrangements is the distinction between in-network and out-of-network services. Insurance plans typically limit cost-sharing for in-network services and protect consumers from balance bills.[4] Consumers know that this protection does not apply outside their insurer's network and that they must pay more for care that they receive from non-network clinicians and at non-network facilities.[5]

Consumers specifically seek non-emergency care from network doctors at network facilities precisely to avoid balance bills. In ascertaining whether a provider or facility participates in their insurer's network, they rely on representations from their insurers and the providers themselves. Before the No Surprises Act, they could face balance bills despite these representations.

They also could be balanced billed for emergency medical care. When medical emergencies arise, consumers do not have the option of seeking out a network provider. Recognizing the exigencies of medical emergencies, Congress had tried to ban balance billing for emergency medical services in the Affordable Care Act (ACA).[6] In one of many instances of the ACA's "inartful drafting,"[7] the law required insurance companies to apply in-network cost-sharing to emergency medical services rendered at non-network facilities but did not bar emergency department physicians and other hospital staff from balance billing patients.

The No Surprises Act prohibited balance billing for emergency medical services, regardless of the hospital or physician's network status. In the case of non-emergency care, the law bars doctors who provide services at network facilities from balance billing patients for those services.

The No Surprises Act barred physicians who provide medical services at network hospitals or emergency services at any hospital from balance billing patients.[8] The new law prohibited insurers and doctors from requiring patients to pay anything more than network cost-sharing.

That left the question of how much the insurer should pay the non-network doctor for such services. So, the No Surprises Act established a novel, convoluted, and ill-conceived arrangement to settle disagreements between insurers and doctors over such payments. The law requires doctors and insurers, who have no contractual relationship with each other, to submit unresolved disputes to binding arbitration.

In essence, Congress has directed the federal bureaucracy to outsource ad hoc medical price-setting to independent-dispute-resolution (IDR) entities.

The legislative text provides these arbiters with no clear guidance on how to resolve disputes. Although it includes a provision requiring arbiters to consider network rates when determining how much an insurer should pay a non-network doctor, it does not explain how arbiters should weigh this rate against other factors.

This lack of clarity helped to break a legislative impasse. The legislation stalled in 2019 and throughout most of 2020, as competing interest groups—doctors and investors who owned physician practices on one side, and insurers, employers, and consumer groups on the other—insisted that lawmakers meet their demands. Each side had sufficient support among Members to block the bill's passage if its demands were not met. The legislation remained stalled for more than a year.

The language that ended the stalemate was confusing enough to generally please both sets of special interest groups. The law's vagueness has sown confusion among arbiters and regulators as judges have sought to ascertain its meaning. Federal agencies have twice issued regulations that attempt to shine clarity through the statutory fog.[9] The courts vacated a critical provision of the first regulation.[10] Federal judges are considering two legal challenges to the second version.[11]

As of January 9, 2023, the Centers for Medicare and Medicaid Services (CMS) had contracted with 13 entities to arbitrate cases.[12] None have experience settling monetary disputes of this nature between non-contracting payers and providers.

Doctors and hospitals have submitted a deluge of unresolved disputes to government-sanctioned arbitration entities that lack clear standards to guide their decision-making.[13] Operating without clear and settled standards and faced with a crush of cases—regulators report that insurers and providers initiated more than 164,000 disputes between April 2022 and December 2022, of which approximately 34,000 had been dismissed or resolved[14]—two of the 13 IDR entities with whom the U.S. Department of Health and Human Services (HHS) had contracted were not accepting new disputes as of January 9, 2023.[15] Federal regulators did not expect this tsunami of disputes. The 2021 interim final rule published in the *Federal Register* estimated that there would be 17,133 disputes annually.[16] Doctors are turning to federal arbiters to replace revenue they once derived from balance billing patients.

Congress has remained on the sidelines as federal agencies iterate regulations and sub-regulatory guidance while defending their existing rules against legal challenges.

This turbulence might prove temporary or long-lasting. In either event, this government foray into price-setting in the commercial market could have unforeseen consequences for hospitals, physicians, insurers, and patients and could invite further government initiatives that regulate the fees that insurers pay to non-contracting physicians.

This *Backgrounder* reviews the current state of play in implementing the binding arbitration system mandated by the No Surprises Act.[17] In addition to chronicling the law's early failures, it offers several reasons behind them. It argues that Congress bears primary responsibility for these failures and the obligation to remedy them. In seeking to appease special interests on both sides of the surprise-billing debate, lawmakers devised a complex and deeply flawed system that each side is seeking to turn to its advantage. Instead of requiring three powerful and well-financed economic actors—insurers, doctors, and hospitals—to negotiate medical fees privately, it imposed a novel and ill-defined system affecting patients, doctors, hospitals, and insurers.[18] This unprecedented government intrusion into negotiations between non-contracting parties could have unforeseen and lasting consequences.

Instead of the complex and poorly defined dispute-resolution process, Congress should amend the No Surprises Act process and adopt, in its place, a truth-in-advertising approach to enforce consumer protections. This approach would protect consumers by holding providers and insurers accountable for representing a facility as being in-network, and it would liberate doctors, insurers, and arbiters from a flawed system for resolving payment disputes that the disputing parties can best resolve themselves.

The Problem

Surprise medical bills became increasingly common in the decade after the enactment of the Affordable Care Act (ACA) in 2010. The ACA purported to protect consumers from being balance billed for emergency care.[19] It required insurance plans to charge only in-network cost-sharing for emergency services, even if provided at a non-network hospital. Nor could non-network hospitals balance bill such patients.

But while the law prevented hospital emergency *departments* from issuing surprise medical bills, it did not bar emergency *physicians* practicing in those departments from issuing such bills. It was not long before investors began to exploit this loophole.

Many hospitals contract with agencies to staff their emergency departments.[20] Emergency physicians affiliated with one investor-owned staffing

firm, EmCare, largely avoided joining insurance networks. A study of emergency department claims paid by one large insurer between 2011 and 2015 found that EmCare raised list prices by 96 percent, on average, and increased out-of-network balance bills by 80 percent at a typical hospital.[21] Its staff physicians billed patients for the difference between their inflated list prices and the amount an insurer paid.

The practice became widespread. A study of claims filed in 2016 with large employer plans found that more than 27 percent of admissions with an emergency room claim included a bill from a non-network provider.[22] Nor were these surprise bills confined to emergency physicians. They also became common among other doctors with hospital-based practices.[23] That same study found that more than 15 percent of outpatient service days that included an anesthesiology claim, and 13.4 percent of those that involved a pathology claim, resulted in a surprise medical bill.[24]

The "Fix"

The purpose of the No Surprises Act is to protect patients from surprise medical bills for emergency care and for non-emergency care at network facilities.

Legislation. The growing practice of surprise medical billing and its perceived unfairness prompted action in several state legislatures before Congress passed the No Surprises Act.[25] California and New York were among the states that enacted laws prohibiting surprise medical bills at emergency departments and in-network facilities. New York required insurers and non-network physicians to submit to binding arbitration and directed arbiters to base their decisions on the amount the doctor charged the patient.[26] California took a different approach, requiring non-network doctors to accept payments tied to in-network reimbursement rates.[27]

While the difference between these two methods may seem technical, they produced vastly different outcomes. A study published in the September 2022 issue of *Health Affairs* found that the New York arbitration approach *in*creased out-of-network payments for nonemergency out-of-network services by 24 percent, while the California surprise billing law *de*creased them by 25 percent.[28]

One weakness of state legislation is that federal pension law, the Employee Retirement Income Security Act (ERISA), places self-funded employer plans under the jurisdiction of the Labor Department rather than state insurance commissioners. An estimated 110 million Americans are covered under such plans.[29]

The political salience of surprise medical bills, coupled with the fact that many plans are subject to federal, rather than state, regulation, captured the attention of Congress in 2019.

Consumer groups and others, including the Kaiser Family Foundation, whose "Bill of the Month" series increased public awareness, helped to goad Congress into action.[30]

Most interest groups conceded that patients should be protected from balance bills for emergency care and non-emergency medical services at network facilities, a position favored by consumer groups. That consensus, however, broke down when it came to determining how much insurers should pay non-network providers in these circumstances. New York and California state laws broadly defined the battle lines. Providers backed New York's binding arbitration, while payers (and consumer groups) favored California's approach, which set benchmark rates based on the amounts that insurers paid network doctors for the same services.

Each side urged Congress to impose the remedy that offered it the better financial outcome. Each group garnered the support of a faction of lawmakers—one that backed arbitration, the others calling for a benchmark based on the median rate that insurers paid to network physicians.[31] These divisions between lawmakers were neither partisan nor ideological. One bipartisan group of Members defended provider interests, while the other sided with insurers. Congress found itself caught between two powerful special interest groups.

Both approaches are deeply flawed. Requiring a *non-contracting physician* to accept an insurer's median network rate as payment in full imposes a rate that is less than what that same insurer pays half the *physicians with whom it has contracted*.[32] The California experience shows that, as expected, this substantially reduces the amount that insurers pay non-network doctors.

The arbitration approach also involves government imposition of contractual obligations on non-contracting parties. It effectively outsources rate-setting to government-certified "experts" who are presumed to be well-informed, impartial, and wise. Instead of setting prices directly, the government would deputize arbitrators to set medical prices on an ad hoc basis. Experience with the New York law shows that this approach results in higher insurance payments to non-network physicians, which directs arbiters to consider billed charges.

Further complicating matters, the Congressional Budget Office (CBO) forecast that imposing the median network rate as the solution to surprise medical bills would slightly reduce health insurance premiums, indirectly saving the government money.[33] Lawmakers hoped to use these savings to offset the cost of extending expiring public health programs.

Congress finally broke the benchmark-versus-arbitration impasse in December 2020. The No Surprises Act blended the two approaches. It requires the federal government to contract with IDR entities to settle disagreements between insurers and non-contracting physicians. If the two parties cannot resolve their disputes, they are to submit their final offers to an IDR. The law directs these entities to choose between the two parties' final offers. IDRs must make a binary choice; they cannot split the difference.

In rendering their decisions, IDRs must consider the median network rate—called the qualifying payment amount (QPA) in the statute—along with a list of "additional circumstances."[34]

The law stipulates that IDRs consider "the qualifying payment amounts... for the applicable year for items or services that are comparable to the qualified IDR item or service and that are furnished in the same geographic region."[35]

Arbiters also must take into account the following "additional circumstances" if one of the parties cites them:

1. The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service...

2. The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided.

3. The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual.

4. The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service.

5. Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous four plan years.[36]

The CBO was satisfied that, since there was a benchmark (that is, the QPA), the median network rate would strongly influence decisions by arbiters. That would redound to the interests of insurance companies, resulting in a 0.5 percent to 1.0 percent reduction in premiums and consequent savings to the

federal government.[37] The bill laid out a method for computing the QPA for 2019, then directed that it be trended forward by the general rate of inflation as measured by the Consumer Price Index (CPI). Since medical prices rise faster than overall inflation, the QPA will almost certainly lag behind increases in medical fees. According to the CBO, insurance premiums will consequently fall by roughly 1 percent, producing federal savings of $196 million over 10 years.[38]

The CBO's analysis of the bill's fiscal effect gave Congress an offset that it could "spend" on extending expiring public health programs while also satisfying lobbyists for the health insurance industry. Lobbyists for providers believed that the QPA was but one among many factors that arbiters would have to consider, giving them leverage to win higher arbitration awards.

Both sides were largely satisfied that the law was vague enough to suit their interests.

Regulation, Round One. It was left to federal regulators to bring coherence to a nebulous statute. With billions of dollars at stake, interest groups shifted their attention from Congress to the federal bureaucracy, each side urging the regulators to adopt its preferred interpretation of a murky and convoluted statute.

Insurers, employers, and consumer groups, whose interests were aligned with those of the insurance industry on this issue, won the opening round. The October 2021 Interim Final Rule required arbiters to "begin with the presumption that the QPA is the appropriate out-of-network rate" for a medical service.[39] The IDR entity "must select the offer closest to the QPA unless [it] determines that credible information submitted by either party clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate, based on the additional factors" specified in the statute.[40]

The Interim Final Rule thus adopted an understanding of the statute that was congenial to the interests of payers and detrimental to those of providers, provoking the first round of litigation.

Litigation, Round One. The Texas Medical Association (TMA) filed suit against the rule, arguing that it improperly required IDR entities to "give outsize weight" to the QPA, which the TMA said was but one among several statutory factors.[41]

A federal judge found in favor of the TMA. In vacating the rule in February 2021, the court held that nothing in the act

> instructs arbiters to weigh any one factor or circumstance more heavily than the others.... Nor does the Act impose a "rebuttable presumption" that the offer closest to the QPA should be chosen—or suggest anywhere that the other factors or information is less important than the QPA.[42]

The HHS lost a second case, *LifeNet, Inc. v. HHS*, which similarly found that the regulation had improperly required a rebuttable presumption for the QPA in cases involving air-ambulance services.[43]

Thus, just months after the No Surprises Act took effect, the courts voided a critical regulatory provision governing the newly established binding arbitration system.

Regulation, Round Two. In response to those court rulings, the Departments of the Treasury, Labor, and HHS published a revised final regulation on August 26, 2022.[44] The departments sought for a second time to instruct arbiters on deciding disputes between insurers and doctors with whom insurers had not contracted. Since the statute never clearly sorted out how heavily to weigh the QPA against other factors and the courts rejected the regulatory effort to establish the QPA as a rebuttable presumption, the agencies faced a formidable challenge.

The revised regulation began by "remov[ing] the provisions that the district court vacated and that adopt standards for making a payment determination that are intended to achieve the statutory aims."[45] Given the lack of clarity of those aims, regulators had to proceed cautiously. The agencies scrapped the "rebuttable presumption" status of the QPA and the requirement that arbiters choose the final offer closest to the QPA.[46] They did, however, stipulate that the IDR must always consider the QPA, even if neither party proposes it.[47] IDR entities also must consider any additional information or circumstances that either party cites.

Second, IDR entities must determine whether additional considerations that a provider might raise—such as patient acuity or the complexity of furnishing a service—are already included in the QPA. In such cases, the IDR entity should *not* consider that additional factor:

> Giving additional weight to information that is already incorporated into the calculation of the QPA would be redundant, possibly resulting in the selection of an offer that does not best represent the value of the…item or service and potentially over time contributing to higher health care costs.[48]

If, however, a factor is not incorporated into the QPA, the IDR entity must "accord that factor appropriate weight."[49] The August 2022 regulation does not offer guidance on what that "appropriate weight" should be. For example, a provider at a neonatal intensive care unit could assert that the QPA did not lend "appropriate weight" to his case mix and scope of services, one of the additional circumstances enumerated in the statute.

This, of course, places additional burdens on the IDR entity. Arbiters must "look behind" the QPA to determine whether it already incorporates other considerations that a provider raises. For example, a provider might argue to the arbiter that the insurer should pay more because of patient acuity. But if the QPA already incorporates patient acuity, then the IDR entity cannot weigh that factor in rendering its decision. That adds yet another layer of complexity—and controversy—to the arbitration process.

Congress created this complexity by ordering the executive branch to prescribe rules for resolving disputes between insurers and providers. The market failure that led Congress to adopt the No Surprises Act was that consumers faced balance billing when they obtained non-emergency care from network doctors at network facilities, and when a medical emergency made seeking out a network facility infeasible. In those circumstances, patients reasonably expected that they would be protected from balance bills. But Congress went further, compelling insurers and providers to resolve their disputes through an arcane and flawed arbitration system rather than letting these powerful economic actors work out their own solutions.

Litigation, Round Two. Although the agencies believe that the new rule is consistent with the statute and in compliance with federal court rulings, the TMA has filed two additional lawsuits against the revised final regulation issued by the Departments of the Treasury, Labor, and HHS.[50] In the first lawsuit, the TMA alleges that the revised regulation continues to overweigh the QPA and that the departments should require arbiters to weigh all factors equally instead. In the second, the TMA argues that the regulation improperly "deflates" the QPA, tilting the playing field to the advantage of insurers over doctors and hospitals. Neither case had been decided at the time of this *Backgrounder*'s publication.

Can the No Surprises Act's Dispute-Resolution Process Work?

Some 10 months after the law took effect and nearly two years after its enactment, the No Surprises Act is mired in a regulatory, legal, and practical morass.

The federal government and IDR entities are overrun with disputes. As of December 5, 2022, the backlog of unresolved disputes stood at 130,000.[51] As of that date, IDR entities had resolved more than 11,000 disputes and dismissed more than 23,000 others as ineligible for the IDR process. During the week of November 21, 2022, alone, 13,304 disputes were submitted, more than half the number that the departments estimated would be submitted over the entire year.[52]

As a result of additional costs imposed by this unanticipated volume of cases, the federal government raised its nonrefundable fee on each disputing party from $50 to $350 per case.[53] This is in addition to the $200–$700 fee that IDRs collect per dispute from each party.[54]

It is, of course, possible that this early turmoil will pass as arbiters and disputing parties become more familiar with the process. That process may at some point become more efficient, even if it further distorts health care markets. Following are some critical questions and considerations:

1. Can the IDR Process Eventually Function More Efficiently and Smoothly? The No Surprises Act attempts to legislate into existence a novel mechanism for resolving disputes between non-contracting parties. While binding arbitration is a widespread practice, contracting parties consent in advance to submit their disputes to that process. Arbitrators rely on contractual terms to determine whether a party is in breach and specify a monetary settlement.

In the case of baseball arbitration, with which the No Surprises Act is often erroneously compared, the collective bargaining agreement between owners and players provides for binding arbitration in certain circumstances. Arbitrators might be asked to decide what a 26-year-old third baseman who batted .286 and hit 35 homers should be paid. In choosing between the offers tabled by the player and ownership, the arbitrator considers the salaries of comparable players and selects the offer most consistent within a rather limited market.

Health care markets are far larger and more complex, and prices are opaque.[55] Hospitals and doctors charge notoriously inflated list prices. Medicare has an established fee schedule. Insurers have prices that they consider usual, customary, and reasonable. The No Surprises Act forbids arbiters from factoring any of those prices into their decisions.

Most doctors contract with insurance companies to accept a predetermined fee schedule, among other terms and conditions. The statute's arbitration system does not affect parties to such agreements.

IDR entities instead arbitrate disputes between doctors and insurers who have no contractual relationships. IDR entities must consider the QPA (generally, the median amount that insurers pay physicians with whom they have contracted for the medical service), but must also consider other factors as well and determine whether some or all these factors are baked into the QPA.

Further complicating matters, the doctor and insurer may disagree over the level of services provided. The QPA is based on the median network rate for each current procedural technology (CPT) code, a product licensed by

the American Medical Association.[56] There are more than 10,000 of these codes, with multiple codes for each service to adjust for different facts and circumstances.[57] For example, there are at least five frequently used CPT codes for professional emergency medical claims (CPT 99281–99285).[58] Each CPT code has its own QPA.

One may consider a dispute over an emergency visit that the physician has coded as 99282. To justify that code, the physician must document that she collected an "expanded problem focused history" and an "expanded problem-focused examination."[59] The insurer, however, believes that the procedure should have been coded as 99281 (a "problem focused history" and a "problem focused examination," omitting the word "expanded").[60] Before the IDR entity can settle on a QPA for the disputed event, it must determine whether to apply the code that the physician chose or the one the insurer asserts is the correct one.

The arbiter may decide to use the QPA for CPT code 99282 because the patient's acuity prompted the doctor to gather an "expanded problem focused history" and perform an "expanded problem focused examination." The arbiter must then decide whether to consider the patient's acuity as an additional factor or whether the QPA for the higher CPT code adequately captures its cost.

There are no entities that routinely adjudicate disputes of this complexity between non-contracting parties. There are Medicare peer review organizations (PROs), private entities that review quality of care and appropriateness of admissions, readmissions, and discharges for Medicare and Medicaid.[61] These groups typically work with providers. Such experience is helpful for arbiters but is not directly on point. The CMS has contracted PROs to serve as IDR entities.[62]

There also are entities known as Qualified Independent Contractors (QICs), which handle appeals of Medicare claims that are denied based on lack of medical necessity. This also is valuable experience, and the CMS has contracted with at least one QIC, but an IDR entity faces a much different and more complex set of tasks.[63]

The CMS also has contracted with a physician adviser service that, among other things, helps providers to appeal claim denials and, in some cases, recommends that a claim be rebilled.[64] That is relevant experience that can benefit a provider dealing with a denied claim from a public or private payer but is far different from the obligations of an IDR entity.

The CMS also has certified entities whose clients include insurers, employer-sponsored plans, and pharmacy benefit managers.[65]

None of this suggests that IDR entities will favor the interests of industries from which they draw their clients, but groups whose expertise is in

reversing claim denials or advising payers on claims disputes and medical necessity determinations will inevitably bring a particular point of view to the arbitration process. This introduces another complication to a process already hampered by vague legislative standards, shifting regulatory and sub-regulatory guidance, and active litigation.

The IDR entities face the additional challenge of weighing quantitative factors against qualitative ones. Arbiters must choose between two numbers: the insurer's final offer and the clinician's final offer. The QPA, whatever its limitations and flaws, is a dollar figure. The other considerations are not quantifiable. What is the marginal dollar value of a hospital's market share? How does an arbiter determine the dollar value associated with a lack of recent "good faith negotiations" between a radiologist and an insurance company over a network contract?

In addition to being qualitative, the statute offers no guidance on the directional effect of each qualitative factor.[66] Should an arbiter pay a doctor who practices in a hospital with market power more or less than the QPA? Should an IDR entity penalize the radiologist or the insurer because the two parties have not engaged in "good faith negotiations" for more than four years?

The endpoint of the IDR process is a dollar figure—the amount that the arbiter will direct the insurer to pay and the provider to accept. Congress has told IDR entities to consider an assortment of quantitative and non-quantitative factors in arriving at that number. This problem is inherent in the statutory scheme and will not resolve itself even if the fog of litigation and shifting regulation eventually lifts.

2. What Might Be the Unintended Consequences of the IDR Process? Should the IDR process emerge from short-term turbulence, its effects on the broader health care system are difficult to predict. As noted, the CBO appears to believe it would pressure non-network physicians in affected specialties to join networks. By joining a network, such physicians would at least be able to negotiate their rates. Those who remain outside the network would be required to accept an arbiter's determination and cannot balance bill their patients. If the QPA—linked to the median network rate, adjusted by the average pace of overall inflation—drives those decisions, then non-contracting doctors will have to accept reimbursement that is less than the amount that half of contracting doctors receive. Insurers will thus gain leverage in negotiating contracts with non-network emergency department physicians, radiologists, anesthesiologists, and others. That would result, the CBO believes, in a slight decrease in health insurance premiums.

If, on the other hand, arbiter awards consistently exceed the QPA, the incentives will reverse. Such awards might induce doctors to remain outside insurance company networks. That would pressure insurers into paying higher rates to network physicians. If that happens, then consumers will face slightly higher insurance premiums.

There also could be second-order effects. Physicians and investors are sophisticated and powerful economic actors who will seek new ways to recover lost revenue from the IDR system and otherwise maximize their payments and return on investment.[67] Administered pricing—the No Surprises Act, in essence, mandates administered pricing, albeit in a convoluted way, since it requires buyers and sellers to accept a price decreed by government-sanctioned authority—incentivizes economic improvisation.

Finally, if the dispute-resolution process proves workable over the longer term, it could become a template for a broader government foray into administered pricing. Congress could, for example, require non-network physicians to submit to binding arbitration with insurers in disputes over fees in all cases, not just in the narrow circumstances addressed in the No Surprises Act. That would greatly limit a non-network clinician's prerogative to set a price for her services without government interference. Such a requirement, especially if anchored to a median network rate, could be sold as a way to reduce health insurance premiums and a backdoor way for the government to establish an administered pricing regime more broadly.

3. Will Congress Amend the Statute to Clarify the Standard for Arbitrating Disputes? The No Surprises Act sought to solve two political problems—one emanating from outside the beltway and the other from inside the beltway. The legislation seems to have successfully addressed the first problem. There is no evidence that non-network doctors and hospitals are balance billing patients in defiance of the law, hence making the law popular with voters.[68]

Had Congress stopped there, it would have achieved its primary policy goal. But lawmakers also confronted an inside-the-beltway challenge: How much should insurers pay non-network doctors? With billions of dollars at stake, dueling special interest groups pressured lawmakers to establish a system for allocating these billions. Insurers wanted a federally mandated system that shifted the cost of eliminating balance billing to providers, while providers wanted the government to push that cost onto insurers. The fuzzy legislative definition of that system mollified the interest groups but fell far short of the clarity that regulators, courts, arbiters, and members of the interest groups themselves require.

Congress as an institution has remained quiet amid the turmoil, although competing groups of lawmakers have occasionally written letters to the agencies to tell them how they think the law should work. These letters offer conflicting explanations of legislative intent, generally favoring the views of one interest group or the other. Absent clarifying amendments to the statute, regulators, judges, and dispute-resolution entities will muddle along, uncertain of how to operationalize the law.

Truth in Advertising: A Better Solution to the Problem of Surprise Medical Bills

The core feature of the No Surprises Act protects consumers who receive emergency medical care and those obtaining non-emergency medical services at in-network facilities from balance billing by non-network doctors. That is an eminently reasonable policy. Finding a network facility during a medical emergency is not feasible. The ACA, as noted, required insurers to charge network cost-sharing for emergency care administered at non-network facilities. Enlarging that requirement to include bills from non-network physicians who provide care in a hospital's emergency department is consistent with existing policy. In effect, it closes a loophole.

For non-emergency care, consumers see doctors who participate in their insurer's network and schedule inpatient and outpatient care at network facilities. They rely on representations from the facility and their insurer that the facility is in-network and reasonably expect that their cost-sharing will be limited, and balance billing prohibited, as stipulated in their insurance policy. Requiring insurers, hospitals, and doctors to also meet those expectations is sound public policy.[69]

Under current law, however, this requirement is enforced through a mandatory arbitration process. Doctors are forbidden to balance bill patients and required to negotiate with insurers over payment. If the parties cannot settle on the amount, they must take the matter to a federal arbiter, who imposes a settlement on the parties.

This system is clearly deeply flawed. Congress should eliminate it. It may be that prohibiting balance billing for emergency services and non-emergency, in-network care is sufficient and that an enforcement mechanism is unnecessary. But since the practice emerged and spread rather rapidly and was woven into the business models of many entities, Congress should consider establishing penalties against those who engage in prohibited balance billing.

Instead of establishing a complex and poorly defined dispute-resolution process to set reimbursement levels on an ad hoc basis, Congress could adopt a truth-in-advertising approach to enforce consumer protections. In cases where a consumer faces a balance bill from a non-network physician at a network hospital or an emergency department, both the insurance company and the hospital should be subject to civil monetary penalties. Hospitals that hold themselves out as network facilities and insurers who tell consumers that a hospital participates in their network create a reasonable expectation that patients will be held responsible only for in-network cost-sharing. The government should hold them accountable for these representations.

Section 1128A of the Social Security Act offers a potential means of enforcing the federal prohibition on surprise medical bills through civil money penalties.[70] Its framework is well-established and applies to a broad range of participants in the health care sector.

Congress could apply the Section 1128A penalties and procedures in the same manner to surprise medical bills as it does in other contexts. A civil money penalty of up to $10,000 per violation could apply to insurers, hospitals, and physicians in cases where a patient is balance billed for emergency services or nonemergent care at a network facility.

The penalty's size and structure require attention, but its chief purpose is to deter insurers, hospitals, and doctors from engaging in the objectionable practice. Faced with the prospect of monetary penalties, insurers, hospitals, and doctors will have all the incentives they need to negotiate mutually agreeable reimbursement levels. All are powerful and interdependent economic actors. Insurers need hospitals in their networks, and hospitals benefit by joining such networks. Hospitals need ancillary physicians, such as anesthesiologists, to be present in operating rooms, and insurers need adequately staffed surgical units for their members. Physicians in specialties that do not generally operate direct-to-consumer practices need privileges at hospitals.

In some markets, hospitals may have the upper hand; in others, a dominant insurer might have the advantage; in still others, a scarcity of specialists in a particular field would empower doctors to leverage higher payments. Once the option of issuing surprise bills is eliminated, the market is the most efficient means to determine who owes what to whom.

Special interest groups have good reason to favor the government over markets. Insurers, hospitals, physician groups, and private-equity firms devote enormous resources to influencing Washington policymakers, creating a more congenial and lucrative regulatory environment without the

competitive messiness of the marketplace. Competing lobbying groups importuned Congress to establish a system that advanced their respective interests. Caught in this crossfire, lawmakers cobbled together profoundly flawed legislation that sought to appease both groups but instead engendered confusion, controversy, and litigation over an IDR process that has so far proved unworkable and may remain so over the longer term.

Conclusion

The No Surprises Act's implementation has so far been a limited success. There is no evidence that consumers are receiving balance bills for emergency care or non-emergency medical services performed at network facilities. The law appears to have achieved its core policy aim.

The same cannot be said of the statute's mandatory arbitration system. Instead of leaving the negotiation of disputed fees to private actors, Congress has subjected non-contracting parties to binding arbitration, established nebulous and conflicting standards to guide federal arbiters, confounded regulators seeking to bring clarity to statutory fog, and prompted lawsuits that already have required one regulatory rewrite—one that further muddied the dispute-resolution standards.

Congress has so far displayed no interest in clarifying its intentions, much less in correcting its error. That error was to create a government solution to a problem that markets are best equipped to solve—determining the amount an insurer owes a non-contracting doctor for medical care provided to one of its members.

Insurers, doctors, and hospitals all are well-positioned to negotiate reimbursement levels and have strong financial incentives to do so. Congress erred in forcing them to resolve their differences through a government-mandated dispute-resolution process.

It is unclear whether this process will benefit doctors or insurance companies. It is also unclear whether time, litigation, and iterative regulation will result in a more smoothly functioning IDR process, and which second-order effects the poorly conceived arbitration system might have on patients, insurers, and providers. These unforeseen effects might include expansion of the arbitration system to all fee disputes between insurers and non-contracting physicians, imposing a more extensive administered pricing mechanism on clinicians.

Congress can set things right by coupling consumer protections against surprise billing with penalties against insurers and providers who provide misleading information to consumers about their cost-sharing exposure.

These penalties will incentivize insurers and providers to privately negotiate reimbursement levels.

Amending the No Surprises Act to eliminate the IDR process in favor of a truth-in-advertising approach would liberate doctors, insurers, and arbiters from confused and conflicting standards for resolving disputes that the disputing parties can best resolve themselves.

Doug Badger is a former Senior Research Fellow in the Center for Health and Welfare Policy at The Heritage Foundation.

Endnotes

1. In this *Backgrounder*, "non-emergency" medical services or care means services for the diagnosis and treatment of a condition in a variety of settings, including a physician's office, a health care clinic, a community health center, and a hospital outpatient department.
2. Kaiser Health News runs an ongoing series titled "Bill of the Month." This series chronicles numerous examples of consumers receiving bills for ambulance rides and other emergency services and for care received at network hospitals. Kaiser Health News, "Bill of the Month," https://khn.org/news/tag/bill-of-the-month/ (accessed October 29, 2022).
3. Medical prices are typically set either by the government (such as for Medicare) or negotiated between providers and insurers. Unlike with other goods and services, the amount that consumers might be willing to pay for a medical service plays no role in determining these prices. As a result, prices for a given medical service can vary considerably within the same geographic location. A 2019 study found that requiring providers of medical imaging services to disclose their prices led to "a shift to lower-cost providers, especially for patients subject to a deductible. Furthermore, the supply-side effects play a significant role in the long run, benefiting all insured individuals. Supply-side effects reduce price dispersion and are especially relevant in concentrated markets." Zach Y. Brown, "Equilibrium Effects of Health Care Price Information," *The Review of Economics and Statistics*, Vol. 101, No. 4 (2019), pp. 699–712, https://direct.mit.edu/rest/article-abstract/101/4/699/58561/Equilibrium-Effects-of-Health-Care-Price?redirectedFrom=fulltext (accessed January 9, 2023). The No Surprises Act includes provisions requiring more price transparency, and the Department of Health and Human Services has promulgated regulations requiring hospitals and insurers to disclose prices. These federal actions, and those of several states, could help to reshape health care markets over the longer term.
4. For example, policies typically set deductibles, co-insurance, or co-pays and establish limits on annual out-of-pocket spending for covered, in-network services. These terms and conditions do not apply to out-of-network medical care.
5. Insurance policies typically set a separate and higher deductible for out-of-network services, require higher co-insurance payments, and do not protect consumers from balance billing. Some policies, notably among HMOs, provide no coverage for out-of-network services.
6. 42 U.S. Code 300gg-19a(b) requires insurers to apply in-network cost-sharing to emergency services rendered at a non-network facility.
7. In one of the cases in which the Supreme Court upheld the ACA's constitutionality, Chief Justice John Roberts wrote that the Court's canon of avoiding surplusage constructions "does not seem a particularly useful guide to a fair construction of the Affordable Care Act, which contains more than a few examples of inartful drafting." *King v. Burwell*, 576 US ____ (2015), https://supreme.justia.com/cases/federal/us/576/14-114/ (accessed January 9, 2023).
8. Public Law No. 116–260, Division BB, December 27, 2020, https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf (accessed January 9, 2023). The law also bars surprise billing for air-ambulance services. This *Backgrounder* does not touch on that aspect of the statute. For a summary of the air-ambulance provisions, see Centers for Medicare and Medicaid Services, "Air Ambulance NPRM–Fact Sheet," September 10, 2021, https://www.cms.gov/newsroom/fact-sheets/air-ambulance-nprm-fact-sheet (accessed January 9 2023).
9. The first interim final rule establishing the IDR process was issued on October 7, 2021. See Office of Personnel Management et al., "Requirements Related to Surprise Billing; Part II," Interim Final Rules with request for comments, *Federal Register*, Vol. 86, No. 192 (October 7, 2021), p. 55980, https://www.govinfo.gov/content/pkg/FR-2021-10-07/pdf/2021-21441.pdf (accessed January 9, 2023). After two adverse court rulings, the federal government issued a revised rule that is itself the subject of ongoing litigation. See U.S. Department of the Treasury, U.S. Department of Labor, and U.S. Department of Health and Human Services, "Requirements Related to Surprise Billing," Final Rules, *Federal Register*, Vol. 87, No. 165 (August 26, 2022), p. 52618, https://www.govinfo.gov/content/pkg/FR-2022-08-26/pdf/2022-18202.pdf (accessed January 9, 2023).
10. *Texas Medical Association v. HHS*, Case No. 6:21-cv-425-JDK, February 23, 2022, https://casetext.com/case/tex-med-assn-v-united-states-dept-of-health-human-servs (accessed January 9, 2023). The government lost a second related case, this one having to do with resolving air-ambulance payment. *LifeNet, Inc. v. HHS*, Case No. 6:22-cv-162-JDK, U.S. District Court for the Eastern District of Texas Tyler Division, July 26, 2022, https://sites-polsinelli.vuturevx.com/112/3606/uploads/22-07-26-lifenet-op-and-order.pdf (accessed January 9, 2023).
11. Amy Lynn Sorrel, "TMA Sues Feds—Again—Over Unfair Arbitration Process Under Federal Surprise Billing Rule," Texas Medical Association, updated October 21, 2022, https://www.texmed.org/Template.aspx?id=60459 (accessed January 9, 2023). The court set a December 20, 2022, hearing date. This line of cases has required the government to rewrite regulations governing the dispute-resolution process, which is the subject of this *Backgrounder*. The No Surprises Act has also inspired other litigation. See, for example, *Dr. Daniel Haller and Long Island Surgical v. HHS et al.,* 21-CV-7208 (AMD) (AYS), August 10, 2022, https://dockets.justia.com/docket/new-york/nyedce/2:2021cv07208/473966 (accessed January 9, 2023).
12. Centers for Medicare and Medicaid Services, "List of Certified Independent Dispute Resolution Agencies," last modified January 9, 2023, https://www.cms.gov/nosurprises/help-resolve-payment-disputes/certified-idre-list (accessed January 12, 2023).
13. On September 7, 2022, the CMS cited a "high volume of disputes" as a reason for "allowing certified Independent Dispute Resolution entities additional time to collect information and evaluate the eligibility of disputes." Centers for Medicare and Medicaid Services, "Payment Disputes Between Providers and Health Plans," notice dated September 7, 2022, https://www.cms.gov/nosurprises/help-resolve-payment-disputes/payment-disputes-between-providers-and-health-plans (accessed January 9, 2023). The CMS subsequently acknowledged that "some disputes are taking longer than expected to process," and offered a trite and formulaic "Thank you for your patience" to disputants. Centers for Medicare and Medicaid Services, "No Surprises Act," https://www.cms.gov/nosurprises (accessed October 29, 2022). The "Thank you for your patience" note has since been removed, and the webpage heading has been changed from "No Surprises Act" to "Ending Surprise Medical Bills"—as of January 9, 2023.

14. Between April 15, 2022, and December 5, 2022, IDR entities had made payment determinations in more than 11,000 cases and found more than 23,000 disputes to be ineligible for the federal IDR process. That left a backlog of 130,000 unresolved disputes. Centers for Medicare and Medicaid Services, "Amendment to the Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act: Change in Administrative Fee," December 23, 2022. "The primary cause of delays in the processing of disputes is the complexity of determining whether disputes are eligible for the federal IDR process," according to the federal government's August 2022 status update. U.S. Department of Labor, "Federal Independent Dispute Resolution Process Status Update," August 19, 2022, https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/federal-independent-dispute-resolution-process-status-update.pdf (accessed January 9, 2023).
15. Centers for Medicare and Medicaid Services, "List of Certified Independent Dispute Resolution Entities."
16. Office of Personnel Management et al., "Requirements Related to Surprise Billing; Part II," Interim Final Rules with request for comments, *Federal Register*, p. 56066.
17. In addition to establishing the IDR process that is the subject of this *Backgrounder*, the act also places other requirements on insurers and providers that are beyond this *Backgrounder*'s scope. For a more complete summary of the law, see Ryan J. Rosso, Noah D. Isserman, and Wen W. Shen, "Surprise Billing in Private Health Insurance: Overview of Federal Consumer Protections and Payment for Out-of-Network Services," Congressional Research Service, July 26, 2021, https://crsreports.congress.gov/product/pdf/R/R46856 (accessed January 9, 2023).
18. This is hardly the first time that Congress has chosen sides in a fight between industry groups. For example, hospitals own roughly half of physician practices, but federal law generally bars physicians from owning hospitals. A February 2022 study by the Primary Care Collaborative found that hospitals own nearly half of medical practices: Primary Care Collaborative, "Hospitals and Corporations Own Nearly Half of U.S. Physician Practices," February 1, 2022, https://www.pcpcc.org/2022/02/07/hospitals-and-corporations-own-nearly-half-us-physician-practices#:~:text=Hospitals%2C%20health%20systems%20and%20corporate,and%20health%20insurers%20(32%25) (accessed January 9, 2023). Section 1877 of the Social Security Act generally prohibits physician-owned hospitals established after 2010 from participating in Medicare. It also restricts pre-existing facilities owned by doctors from expanding capacity. Centers for Medicare and Medicaid Services, "Physician-Owned Hospitals," undated, https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Physician_Owned_Hospitals (accessed October 29, 2022).
19. 42 U.S. Code 300gg(b)(1)(C)(ii).
20. Zack Cooper, Fiona Scott Morton, and Nathan Shekita, "Surprise! Out-of-Network Billing for Emergency Care in the United States," National Bureau of Economic Research *Working Paper* No. 23623, July 2017, https://www.nber.org/system/files/working_papers/w23623/w23623.pdf (accessed January 9, 2023).
21. Benedic N. Ippolito and David Hyman, "Solving Surprise Medical Billing," American Enterprise Institute, March 20, 2019, https://www.aei.org/research-products/report/solving-surprise-medical-billing/ (accessed January 9, 2023), citing ibid. Evidence also exists that this pattern is occurring in other medical specialties whose practices are generally facility-based. See Ambar La Gorgia, Amelia M. Bond, and Robert Tyler Braun, "Association of Physician Management Companies and Private Equity Investment with Commercial Health Care Prices Paid to Anesthesia Practitioners," *JAMA Internal Medicine*, Vol. 182, No. 4 (February 28, 2022), pp. 306–404, https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2789280 (accessed January 9, 2023).
22. Gary Claxton et al., "An Analysis of Out-of-Network Claims in Large Employer Health Plans," Peterson–KFF Health System Tracker, August 13, 2018, https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-health-plans/#item-start (accessed January 9, 2023).
23. A government report summarizing disputes submitted to the IDR process between April 15 and September 30, 2022, found that the vast majority of these disputes concerned emergency medical care. More than 70,000 of the 90,000 disputes that originated during this period arose from care provided at hospital emergency departments. Disputes also were frequent among ancillary providers, especially those practicing in the fields of radiology, anesthesiology, and pathology. "Initial Report on the Independent Dispute Resolution (IDR) Process: April 15 – September 30, 2022," U.S. Departments of the Treasury, Labor, and Health and Human Services, undated, Table 7, p.19 and Table 8, p. 20, https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf (accessed January 17, 2023).
24. Ibid. At least one of these groups, Envision, claims to no longer engage in the practice. It did, however, help to finance a campaign against enactment of the surprise billing ban. Margot Sanger-Katz, Julie Creswell, and Reed Abelson, "Mystery Solved: Private-Equity-Backed Firms Are Behind Ad Blitz on 'Surprise Billing,'" *The New York Times*, September 13, 2019 (updated September 30, 2021), https://www.nytimes.com/2019/09/13/upshot/surprise-billing-laws-ad-spending-doctor-patient-unity.html (accessed January 9, 2023). Over the first months of the IDR process, 81 percent of disputes over medical services involved emergency services. U.S. Departments of the Treasury, Labor, and Health and Human Services, "Initial Report on the Independent Dispute Resolution (IDR) Process: April 15–September 30, 2022," Table 7, p. 19, undated, https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf (accessed January 12, 2023).
25. The No Surprises Act establishes a complex relationship between state laws and the federal statute that is beyond this *Backgrounder*'s scope. For a summary of these interactions, see Jack Hoadley, Madeline O'Brien, and Kevin Lucia, "No Surprises Act: A Federal-State Partnership to Protect Consumers from Surprise Medical Bills," Commonwealth Fund, October 20, 2022, https://www.commonwealthfund.org/publications/fund-reports/2022/oct/no-surprises-act-federal-state-partnership-protect-consumers (accessed January 9, 2023).
26. New York State Department of Financial Services, "Surprise Medical Bills," undated, https://www.dfs.ny.gov/consumers/health_insurance/surprise_medical_bills (accessed October 29, 2022).

27. California Department of Insurance, "Consumer Protection from Surprise Medical Bills," undated, https://www.insurance.ca.gov/01-consumers/110-health/60-resources/NoSupriseBills.cfm (accessed January 9, 2023).
28. Aliza S. Gordon et al., "Surprise Billing Laws: Evidence From New York and California," *Health Affairs*, September 2022, https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01332 (accessed January 9, 2023).
29. Edmund F. Haislmaier, "COVID-19: Effects of the Response on Health Insurance Coverage in 2020," Heritage Foundation *Issue Brief* No. 6079, May 14, 2021, p. 2, https://www.heritage.org/sites/default/files/2021-05/IB6079.pdf.
30. Kaiser Health News, "Bill of the Month."
31. Lawmakers did not divide along partisan or institutional lines. Members of both parties in both the House and Senate aligned with proposals advanced by provider interest groups. They were opposed by a bipartisan and bicameral set of lawmakers who aligned with insurers, employers, and consumer groups.
32. The *mean* network rate is higher than the *median* network rate. Benchmarking payments to non-network physicians to the network median rate thus reduces costs to insurers, resulting in lower premiums.
33. The CBO believed that the inclusion of such a benchmark would slightly reduce health insurance premiums. Employer "contributions" to health insurance is excluded from income and payroll taxes. The CBO assumes that, if premiums are reduced, employers will convert this portion of nontaxable compensation into taxable wages, thus increasing federal revenues.
34. The statute specifically defines the QPA as "the median of the contracted rates recognized by the plan or issuer…under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item[s] or service is furnished," with annual increases based on the consumer price index (42 U.S. Code 300gg-111(a)(3)(E)(i)(I)-(II)). For new services or those for which no median network rate can be computed, the statute provides for alternative methodologies that are beyond this *Backgrounder*'s scope.
35. 42 U.S. Code 300gg-111(c)(5)(C)(i).
36. 42 U.S. Code 300gg-111(c)(5)(C)(ii). In addition, the statute prohibits the IDR from taking into account usual and customary charges, the amount the provider would bill, or payments made under public programs, including Medicare, Medicaid, CHIP, and TRICARE (42 U.S. Code 300gg-111(c)(5)(D)).
37. Congressional Budget Office, "Estimate for Divisions O Through FF, H.R. 133, Consolidated Appropriations Act, 2021, Public Law No. 116-260, Enacted December 27, 2020," January 14, 2021, p. 3. https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf (accessed January 13, 2023).
38. Ibid., p. 5.
39. Office of Personnel Management et al., "Requirements Related to Surprise Billing; Part II," Interim Final Rules with request for comments, *Federal Register*, p. 55984. In assigning a prominent role to the QPA, the rule also was consistent with the CBO's analysis of the statute.
40. Ibid.
41. *Texas Medical Association v. U.S. Department of Health and Human Services*, Memorandum Opinion and Order, U.S. District Court for the Eastern District of Texas, Tyler Division, p. 7. The suit also alleged that HHS had violated the Administrative Procedure Act by failing to seek public notice and comment before finalizing the rule. The plaintiffs prevailed on both grounds.
42. *Texas Medical Association v. U.S. Department of Health and Human Services*, p. 17.
43. *LifeNet, Inc. v. HHS*, Case No. 6:22-cv-162-JDK, U.S. District Court for the Eastern District of Texas Tyler Division, July 26, 2022, https://sites-polsinelli.vuturevx.com/112/3606/uploads/22-07-26-lifenet-op-and-order.pdf (accessed January 13, 2023).
44. U.S. Department of the Treasury, U.S. Department of Labor, and U.S. Department of Health and Human Services, "Requirements Related to Surprise Billing," Final Rules, *Federal Register*, p. 52618.
45. Ibid., p. 52627.
46. Ibid., p. 52628.
47. Ibid., p. 52627.
48. Ibid., p. 52629.
49. Ibid.
50. The first case, which was argued before the U.S. District Court for the Eastern District of Texas, Tyler Division in December 2022, is captioned *Texas Medical Association, et al. v. U.S. Department of Health and Human Services, Department of Labor and the Department of the Treasury,* https://www.texmed.org/uploadedFiles/Current/2016_Advocacy/TMA%20II%20Complaint.pdf (accessed January 13, 2023). The second, filed in November 2022, is captioned *U.S. Texas Medical Association, et al. v. Department of Health and Human Services, Office of Personnel Management, Department of Labor and Department of the Treasury,* https://www.texmed.org/uploadedFiles/Current/2016_Advocacy/TMAs_Third_Lawsuit_Regarding_No_Surprises_Act_Rules.pdf?_zs=LNdEQ1&_zl=hAHw6 (accessed January 13, 2023).
51. Centers for Medicare and Medicaid Services, "Amendment to the Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act."

52. Ibid.
53. Ibid.
54. Ibid. These figures are for single determinations. Higher rates apply to batched determinations.
55. The complexity of health care markets has myriad causes, but one that is often overlooked is the extent to which federal and state governments exert authority over the allocation of medical goods and services. More than 90 million people were enrolled in Medicaid and CHIP in August 2022 and 64.5 million in Medicare. (Some people are enrolled in both Medicare and Medicaid.) Centers for Medicare and Medicaid Services, "CMS Fast Facts," August 2022 version, CMSFastFactsAug2022.pdf (accessed January 11, 2023). Millions more were receiving ACA premium subsidies. In addition, government policies, ranging from regulatory interventions to tax policies, directly affect how Americans spend their money on health care. University of Pennsylvania economist Mark Pauly estimates that "government-affected" spending, as opposed to "market-like" spending, was close to 80 percent in 2016. Federal and state government policies also have contributed to increasing market concentration, which drives up prices. Robert E. Moffitt, "The Truth About Government-Controlled Health Care," The Heritage Foundation, undated, https://www.heritage.org/article/the-truth-about-government-controlled-health-care (accessed December 19, 2022).
56. The American Medical Association collects tens of millions in licensing fees paid by users of its CPT codes. In 2017, the organization reported $317 million in total revenue. The largest source of this revenue—a total of $148 million—is royalties. Royalties is a general term for the fees paid by any doctor, group, practice, hospital, or payer that uses CPT codes. Anne Paddock, "How Revenue Is Spent at the American Medical Association," *Paddock Post*, December 3, 2019, https://paddockpost.com/2019/12/03/how-revenue-is-spent-at-the-american-medical-association-ama/ (accessed January 11, 2023).
57. Sangeeta Dave, "What Are CPT Codes?" AIMS Education, May 13, 2022, https://aimseducation.edu/blog/what-are-cpt-codes#:~:text=There%20are%20over%2010%2C000%20CPT,3%2C500%20codes%20at%20its%20inception (accessed January 11, 2023).
58. There are codes for emergency medical care, but CPT 99281 to CTP 99285 are the most used.
59. Blue Cross and Blue Shield of Minnesota, "Emergency Department Visit Place of Service Restriction," February 23, 2010, https://www.bluecrossmn.com/sites/default/files/DAM/2018-12/P11GA_12944594.pdf (accessed January 11, 2023).
60. Ibid.
61. Plexis Healthcare Systems, "Peer Review Organization," undated, https://www.plexishealth.com/glossary/peer-review-organization-pro/#:~:text=An%20organization%20established%20by%20the,discharges%20for%20Medicare%20and%20Medicaid (accessed October 29, 2022).
62. Centers for Medicare and Medicaid Services, "List of Certified Independent Dispute Resolution Entities." Island Peer Review Organization, according to its website, "works to improve patient care by partnering with healthcare providers across all settings, including hospitals, nursing homes, hospice programs, dialysis centers, physician practices and more." Its activities include "developing health information technologies, data sharing and incentive programs that facilitate cost and quality transparency and promote evidence-based best practices." IPRO, "Our Range of Expertise," https://ipro.org/expertise (accessed January 11, 2023).
63. The CMS has contracted with C2C Innovative Solutions as an IDR entity. Centers for Medicare and Medicaid Services, "List of Certified Independent Dispute Resolution Entities." C2C handles second-level appeals considerations in various regions of the country. C2C Innovative Solutions, https://www.c2cinc.com/ (accessed January 13, 2023).
64. The CMS has certified EdiPhy as an IDR entity. Centers for Medicare and Medicaid Services, "List of Certified Independent Dispute Resolution Entities." EdiPhy says that its brand derives from the word "edify," which it defines as "help[ing] someone understand, to enlighten, to illuminate or to inspire." EDiPhy Adivsors, https://www.ediphy.com/ (accessed January 13, 2023).
65. Such as MCMC, whose clients, according to its website, include "the largest health plans, PBMs [pharmacy benefit managers], disability carriers, TPAs [third-party administrators], UR [utilization review] companies, self-insured employers, Taft–Hartley plans and government organizations." MCMC, "About Us," https://www.mcmcllc.com/about-us (accessed January 13, 2023).
66. Congress could have included quantitative standards in its list of "additional considerations." For example, it might have required the IDR entity to consider how a hospital's prices for a given intervention compared with others in the region. That would, of course, have begged the question of whether arbiters should favor the higher price a facility charged or the lower average price in that market. Congress deftly avoided such policy decisions by slapping together a list of qualitative considerations that passed muster with both cadres of interest groups.
67. A New Jersey hospital system has filed a lawsuit against at least one anesthesiology firm owned by private equity for providing inadequate staffing levels. While there is no direct connection to the No Surprises Act, the case illustrates a possible response to falling reimbursement rates. See Gretchen Morgenson, "This Won't Hurt a Bit: The Anesthesiologist Putting You Under May Work for Private-Equity Firm," NBC News, October 10, 2022, https://www.nbcnews.com/health/health-care/anesthesiologist-putting-may-work-private-equity-firm-rcna51071?utm_campaign=KHN%3A%20First%20Edition&utm_medium=email&_hsmi=229198152&_hsenc=p2ANqtz-_mAAR_PZnA8Velk8FcxHWUahsVPAx7kRpJQsSmkRD2Z6R41C_FT82j6QDFdS1sAO_hulxAKCM56GX-TM3XDN067QPZVw&utm_content=229198152&utm_source=hs_email (accessed January 11, 2023).
68. A February 2020 poll conducted by the Kaiser Family Foundation found that 65 percent of respondents were worried by unexpected medical bills, far more than the percentage of people who expressed concern over prescription drug costs, rent or mortgage, or other financial concerns. Kaiser Family Foundation, "A Polling Surprise? Americans Rank Unexpected Medical Bills at the Top of Family Budget Worries," February 28, 2020, https://www.kff.org/health-costs/press-release/a-polling-surprise-americans-rank-unexpected-medical-bills-at-top-of-family-budget-worries/ (accessed January 11, 2023).

69. For a more complete discussion of this policy option, see Doug Badger and Brian Blase, "A Targeted Approach to Surprise Medical Billing," Galen Institute, December 3, 2019, https://galen.org/2019/a-targeted-approach-to-surprise-medical-billing-2/ (accessed January 11, 2023).
70. 42 U.S. Code 1320a-7a.