HEALTHCARE GOVERNANCE | POLICY BRIEF

MODEL POLICY BRIEF

# Benchmarks Should Be Named for What They Measure

## A Payment Benchmark Transparency and Construct-Separation Standard informed by the Adjudicated Rate Index

**Prepared for:** Federal and state legislators, agencies, independent dispute-resolution entities, health plans, providers, researchers, and professional societies

**Prepared by:** Healthcare Governance

**Related publication:** Benchmark-Outcome Separation in Federal Independent Dispute Resolution (Cureus, 2026; PMID 42306020)

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RECOMMENDED ACTION

**Adopt a Payment Benchmark Transparency and Construct-Separation Standard requiring every public payment metric to identify the construct it measures, its numerator and denominator, cohort, time period, distribution, missingness, and limits—while expressly prohibiting use of the Adjudicated Rate Index as an individual payment formula or substitute for the statutory Qualifying Payment Amount.**

> **A benchmark can be central to a legal process without being empirically interchangeable with the outcome of that process.**

The Adjudicated Rate Index is a descriptive cohort statistic. It does not establish the correct payment, the value of a clinical service, the adequacy of the QPA, or the likely result of an individual dispute.

## Executive Summary

The No Surprises Act protects patients from many unexpected out-of-network bills and creates a federal independent dispute resolution (IDR) process for certain payment disputes between plans and providers. The Qualifying Payment Amount (QPA)—generally rooted in an issuer-calculated median of in-network contracted rates under the statutory methodology—is a central reference in that structure. The out-of-network payment, however, may be an amount agreed to by the parties or an amount selected through IDR. Those are related but distinct constructs. [2–5]

A 2026 peer-reviewed study used CMS federal IDR public-use files from 2023 Q1 through 2025 Q2 to examine disputes involving CPT 13100–13153, a clinically coherent family of complex repair and layered closure codes. For each dispute, the authors divided the selected payment by the reported QPA. The Adjudicated Rate Index (ARI) was defined as the median of those case-level multiples within a specified cohort. [1]

Within that defined domain, the pooled provider/facility-prevailing cohort had a median selected-payment-to-QPA multiple of 28.73×; all analytic cases with available multiple data had a median of 22.41×; plan-prevailing disputes clustered near QPA parity. Median quarter-level ARI exceeded 1.0× in all 10 analyzed quarters. The study concluded only that reported QPA and observed selected payment did not behave as empirically interchangeable descriptive reimbursement measures in this code family and dataset. [1]

THE POLICY LESSON

**Do not replace one oversimplification with another. A reported QPA should not automatically be described as an adjudicated market outcome, and an ARI should not be converted into a mandated payment multiple.**

## Recommended standard

- Require construct labeling: every reported dollar amount or ratio must identify whether it represents QPA, billed charge, plan offer, provider offer, selected payment, agreed payment, allowed amount, Medicare payment, cost, or another measure.
- Require reproducible specifications: numerator, denominator, unit of analysis, cohort, service domain, geography, payer type, prevailing-party status, time period, exclusions, missingness, and data version.
- Require distributional reporting: median, interquartile range, sample size, and relevant subgroup results—not an isolated average or headline multiple.
- Require data-quality disclosure and correction: source fields, validation status, revisions, suppressed cells, and known limitations should travel with public-use data and derivative reports.
- Preserve legal roles: the QPA remains governed by statute and applicable regulation; ARI remains a descriptive research metric unless future law expressly provides otherwise.
- Protect against individual misuse: no ARI result should determine an individual claim, establish payment adequacy, prove market value, or predict an IDR outcome.
- Commission replication across procedures, specialties, regions, payers, years, and alternative data sources before drawing broader conclusions.

# 1. The Payment-Construct Problem

## Different numbers answer different questions

Healthcare payment discussions routinely place unlike measures side by side. A billed charge may reflect a provider's charge structure. A contracted rate reflects a negotiated network relationship. A Medicare amount is an administratively set public-program payment. A QPA is a defined statutory and regulatory construct. A party offer is a litigation or negotiation position. A selected payment is the offer chosen in a specific IDR determination. None should silently inherit the meaning of another.

| Measure | What it represents | What it does not establish by itself |
|---|---|---|
| Billed charge | The amount submitted by a provider or facility under its charge methodology. | Actual collection, negotiated market rate, cost, value, or adjudicated payment. |
| Contracted rate | A negotiated payment term within a defined plan-provider relationship. | A universal market price or a rate available to all providers. |
| QPA | A statutory calculation generally based on a plan or issuer's median contracted rates under the applicable methodology and geographic/specialty rules. | Clinical value, provider cost, billed-charge reasonableness, or the selected IDR payment. |
| Plan or provider offer | A party's proposed out-of-network payment in a specific dispute. | An independently validated fair value or the amount the IDR entity will select. |
| Selected payment | The offer selected by the certified IDR entity for the qualified item or service. | A universal fee schedule, underlying cost, or normative value for other claims. |
| ARI | The median selected-payment-to-reported-QPA multiple within a precisely specified cohort. | An individual payment formula, clinical-value score, legal standard, or forecast. |

## Why construct confusion matters

When a measure is described more broadly than its definition allows, policy analysis can become circular. A QPA may be called "the market rate" without showing whether it tracks the observed outcomes being discussed. A selected payment may be treated as proof of value even though it is one chosen offer in a selected dispute cohort. A multiple may be generalized across unrelated services. Better policy begins with naming the construct and limiting the inference.

### Patient protection and payment analysis are separate

The No Surprises Act's patient protections should remain central. This proposal does not reopen patient balance-billing protections or shift payment disputes back to patients. It addresses the accuracy and transparency of the evidence used by policymakers, agencies, parties, and researchers when evaluating the payment system.

## 2. Federal Structure and Current Data

### QPA and out-of-network rate have defined legal roles

Federal law defines QPA using a methodology tied generally to median contracted rates and inflation adjustments, with alternative methods for new plans, insufficient information, and newly covered services. The statute separately defines the out-of-network rate as an amount determined under applicable state law or an all-payer model, an amount agreed to by the parties, or—when federal IDR applies—the amount of the certified IDR entity's determination. [2]

This distinction is foundational. QPA may inform cost sharing and the IDR process, but the statute does not collapse every out-of-network payment outcome into the QPA itself. Nor does it transform the outcome of one IDR cohort into a generally applicable payment rate.

### CMS public-use files create a transparency opportunity

CMS publishes federal IDR public-use files, supplemental tables, general information, a data dictionary, and a data disclaimer. The files available when this brief was prepared included quarterly data through 2025 Q2, and the documentation had been updated January 21, 2026. [4]

Public-use data make independent analysis possible, but reproducibility depends on stable field definitions, clear correction history, missingness reporting, and careful interpretation. The ARI paper appropriately treated source fields as reported data rather than independently validated ground truth. [1,4]

### The system is large and still evolving

CMS reported that more than five million disputes had entered federal IDR since the portal launched in April 2022. A May 2026 final rule reduced the administrative fee, revised batching and communication processes, required standardized claim codes for certain communications, and established a path toward an IDR Gateway. These operational changes reinforce the need for transparent, versioned data standards as the system evolves. [6]

**CURRENT-LAW CAUTION**

**QPA guidance and IDR rules have also been affected by litigation and subsequent rulemaking. Any bill, regulation, or agency guidance should cite the currently operative provisions and receive contemporaneous legal review.**

# 3. The Adjudicated Rate Index

## Definition

For dispute i, the study calculated a case-level multiple $M_i$ as selected payment divided by reported QPA. For a defined cohort C, ARI was the median of the $M_i$ values in that cohort. The use of a median reduces sensitivity to extreme observations, but it does not eliminate selection effects, data-quality concerns, or the need to report the surrounding distribution.

FORMULA

**Case-level multiple: $M_i$ = Selected Payment$_i$ ÷ Reported QPA$_i$. Cohort ARI: median of all $M_i$ values within a prespecified cohort C.**

## Study domain

- Source: CMS federal IDR public-use files.
- Study period: 2023 Q1 through 2025 Q2.
- Procedural domain: CPT 13100–13153, complex repair and layered closure.
- Analytic views: all cases with available multiple data, provider/facility-prevailing cases, plan-prevailing cases, quarters, and CPT subgroups.
- Purpose: descriptive comparison of reported QPA and observed selected payment within the defined domain.

## Principal findings

| Analytic view | Reported finding | Defensible interpretation |
|---|---|---|
| Provider/facility-prevailing cohort | Median selected-payment-to-QPA multiple: 28.73×. | In that selected cohort, the chosen payment was typically far above the reported QPA; this is not a recommended payment multiple. |
| All analytic cases | Median multiple: 22.41×. | Across included cases with available data, QPA and selected payment were not close descriptive substitutes. |
| Plan-prevailing disputes | Distribution clustered near QPA parity. | The source field behaved consistently with QPA-relative outcomes when selected plan offers approximated QPA. |
| Quarter-level analysis | Median ARI exceeded 1.0× in all 10 quarters. | The observed separation was not confined to one quarter; no causal trend or universal rate was established. |

### What the study did not establish

- That QPA was incorrectly calculated in any individual dispute.
- That the selected payment was clinically or economically correct.
- That 22.41× or 28.73× should be paid in another claim.
- That complex repair results generalize to other CPT families, specialties, regions, payer types, or years.
- That ARI predicts who will prevail or what offer will be selected.
- That observed separation was caused by any single actor, rule, market condition, coding practice, or case characteristic.

## 4. Policy Proposal: Construct-Separation Standard

### Principle one: label the construct

Any statute, regulation, public report, agency dashboard, expert analysis, or policy brief that presents a healthcare payment amount should name the construct in the label—not merely in a footnote. “Rate,” “benchmark,” “market,” and “payment” are too imprecise when used without definition.

### Principle two: disclose the measurement specification

- Numerator and denominator, including currency units and whether amounts include patient cost sharing.
- Unit of analysis: claim line, bundled dispute, item or service, patient episode, provider, plan, or another unit.
- Cohort definition, inclusion and exclusion rules, service codes, specialty, geography, payer or market, and time period.
- Source-system version, extraction date, corrections, missingness, suppression rules, and validation status.
- Distributional statistics, including sample size, median, interquartile range, and other prespecified summaries.
- Prevailing-party, offer-selection, settlement, eligibility, and other process characteristics material to interpretation.
- Plain-language statement of what the measure supports and what it does not support.

### Principle three: preserve construct boundaries

A public body should not describe QPA as the selected payment, adjudicated market outcome, provider cost, or clinical value unless a separate analysis supports that statement. Likewise, it should not describe ARI as a fair-price multiple, a fee schedule, or a replacement for QPA. When related constructs are compared, the report should explain why the comparison is valid and where it is incomplete.

### Principle four: make correction visible

Public-use datasets and agency summaries should carry stable version identifiers, revision dates, change logs, and machine-readable data dictionaries. Corrected values should not silently replace prior releases. Researchers should be able to reproduce an analysis against the cited version.

### Principle five: require domain specificity

Payment relationships should be reported in clinically and administratively coherent domains. Broad pooled results can obscure differences by code family, specialty, geography, plan, time, dispute eligibility, and prevailing party. A domain must be large enough to protect privacy and support stable estimates, but narrow enough to answer the stated question.

## 5. ARI Reporting Specification

When ARI or an analogous benchmark-outcome ratio is reported, the following minimum specification should accompany it.

| Required field | Minimum disclosure |
|---|---|
| Name and version | "Adjudicated Rate Index," version or analysis date, and a link to the written specification. |
| Numerator | Selected payment or other adjudicated amount, with field name, inclusion of cost sharing, and source. |
| Denominator | Reported QPA or other benchmark, with field name, applicable exclusions, and source. |
| Statistic | Median of case-level ratios; identify any weighting, trimming, winsorization, or alternative summary. |
| Cohort | Codes, specialties, geography, payer type, service dates or reporting quarters, eligibility criteria, and exclusions. |
| Process strata | Provider/facility-prevailing, plan-prevailing, mixed or other outcomes, settlements, and ineligible cases as available. |
| Distribution | N, median, P25, P75, minimum/maximum or robust tail summaries, and missing numerator/denominator counts. |
| Limitations | Selection into IDR, offer-selection mechanics, source-field accuracy, coding, bundling, generalizability, and noncausal design. |
| Use boundary | Not a payment formula, legal standard, clinical-value measure, adequacy determination, or individual-outcome predictor. |

### Recommended companion displays

- Distribution of case-level multiples on an appropriate scale rather than only a single summary value.

- Quarter-level medians with interquartile ranges and sample sizes, without implying a trend unless tested.
- Separate prevailing-party strata and an all-case view.
- Code-family or clinically coherent subgroup analyses with suppression for small cells.
- A data-completeness panel showing missing QPA, selected payment, party result, and other key fields.

MANDATORY LEGEND

**ARI summarizes observed selected-payment-to-reported-QPA relationships in a defined cohort. It does not establish the appropriate payment for an individual item or service.**

## 6. Model Legislative and Administrative Framework

The following is concept language for federal or state counsel, agencies, and stakeholders. It is not final statutory text and does not amend the legal weight of any IDR factor.

### Payment Benchmark Transparency and Construct-Separation Act

#### Section 1. Purpose

To improve the accuracy, reproducibility, and public understanding of healthcare payment data by distinguishing statutory benchmarks, party offers, negotiated amounts, adjudicated outcomes, charges, costs, allowed amounts, and clinical-value measures.

#### Section 2. Definitions

- "Payment construct" means a defined type of healthcare financial measure with a stated source, purpose, and unit of analysis.
- "Benchmark-outcome ratio" means a ratio comparing an observed payment outcome to a specified benchmark within a defined unit of analysis.
- "Adjudicated Rate Index" means the median of case-level selected-payment-to-reported-QPA ratios within a prespecified cohort.
- "Public payment report" means an agency report, dashboard, public-use file, data release, or official analysis containing payment amounts or ratios.
- "Construct-separation statement" means a plain-language disclosure of what a measure represents, what it does not represent, and the limits of inference.

#### Section 3. Public reporting requirements

Require covered public payment reports to provide construct labels, specifications, cohort definitions, distributional results, missingness, version history, validation status, and construct-separation statements in both human-readable and machine-readable formats.

#### Section 4. Federal IDR transparency

Direct the responsible Departments to maintain quarterly public-use files and data dictionaries, preserve revision history, publish material field changes before implementation when practicable, and report benchmark-to-outcome relationships in prespecified domains with privacy safeguards.

### Section 5. ARI use boundary

State that publication of ARI or an analogous ratio does not alter the statutory definition or legal role of QPA, create a reimbursement mandate, establish payment adequacy, or determine any individual IDR outcome.

### Section 6. Data-quality program

Authorize audits of source-field completeness and conformance; standardized correction procedures; reconciliation of inconsistent fields; documentation of batching and unit-of-analysis changes; and independent replication using de-identified data where legally permissible.

### Section 7. Research and evaluation

Require a multi-domain validation program across service families, specialties, regions, payers, dispute characteristics, and time periods, including sensitivity analyses and assessment of selection into completed IDR determinations.

### Section 8. Patient safeguard

Provide that no reporting or research requirement changes patient protections, authorizes balance billing, increases patient cost sharing, or makes patients responsible for provider-plan disputes.

### Section 9. Preemption and state use

Clarify that states may adopt analogous labeling and reporting standards for state-regulated payment-dispute systems, consistent with federal law and applicable preemption limits.

### Section 10. Effective date and review

Phase implementation through data-standard development, stakeholder comment, pilot publication, independent evaluation, and scheduled legislative or administrative review.

## 7. Implementation Roadmap

| Phase | Actions | Deliverables |
|---|---|---|
| 0–6 months: define | Convene CMS, Departments, certified IDR entities, plans, providers, patient representatives, statisticians, data stewards, and privacy counsel. | Construct taxonomy, ARI specification, field inventory, legal analysis, and public reporting schema. |
| 6–12 months: standardize | Align data dictionaries, stable identifiers, correction logs, unit-of-analysis rules, and machine-readable metadata. | Versioned schema, reporting guide, data-quality tests, and prototype dashboard. |
| 12–18 months: pilot | Publish selected domain-specific benchmark-outcome panels with explicit limitations and public technical documentation. | Reproducibility review, user testing, burden assessment, and correction workflow. |

| Phase | Actions | Deliverables |
|---|---|---|
| 18–30 months: validate | Replicate across additional procedure families, specialties, payers, regions, and dispute types. | External validation report, sensitivity analyses, and recommendations on appropriate uses. |
| 30+ months: institutionalize | Integrate validated reporting into regular public-use file releases and annual program evaluation. | Quarterly data, annual construct-separation report, change log, and scheduled review. |

### Performance measures

- Percentage of payment fields with complete construct and provenance metadata.
- Time from source correction to public change notice and corrected release.
- Reproducibility of published figures by independent analysts.
- Missingness and internal consistency of QPA, offers, selected payment, prevailing party, and unit-of-analysis fields.
- Number of domains with prespecified, sufficiently powered analyses and stable estimates.
- Evidence of misleading reuse of agency metrics in public reports, with corrective guidance when identified.
- Administrative burden and data-submission error rates for plans, providers, and IDR entities.
- Continued preservation of patient protections and absence of new patient-facing payment obligations.

## 8. Safeguards Against Misuse

**No payment formula.** ARI must not be multiplied by an individual QPA to dictate payment.

**No adequacy conclusion.** An ARI above or below parity does not independently establish that QPA or the selected payment is adequate, excessive, fair, or deficient.

**No individual prediction.** A cohort median does not predict the selected offer, prevailing party, or outcome in a specific dispute.

**No universal generalization.** Results from CPT 13100–13153 should not be applied to unrelated services, specialties, markets, payers, or periods without evidence.

**No causal inference.** A descriptive ratio does not identify why offers diverged, why a party prevailed, or whether policy caused the observed distribution.

**No selective denominator.** The benchmark name, source field, exclusions, and missingness must be reported. Switching denominators changes meaning.

**No hidden mixture.** All-case estimates should not conceal materially different provider/facility-prevailing and plan-prevailing distributions.

**No patient exposure.** Payment analytics must not weaken balance-billing protections or transfer dispute costs to patients.

## 9. Common Objections and Responses

### "QPA already has a statutory definition; no additional framework is needed."

The proposal does not redefine QPA. It requires analysts and public bodies to distinguish QPA from the other payment constructs with which it is compared. Statutory definition makes construct labeling more —not less—important.

### "ARI is merely a ratio and adds no policy value."

A ratio can reveal whether two measures behave as close descriptive comparators within a defined cohort. The value lies in testing an empirical relationship and making divergence visible. Its usefulness depends on domain specificity, transparent methods, distributional reporting, and strict use boundaries.

### "The large multiples prove that QPA is wrong."

They do not. The study did not independently validate QPA calculations or establish a normative payment. The findings show separation between reported QPA and selected payment in one procedural domain; the causes and policy implications require further study.

### "The selected payment is the fair market rate."

Not necessarily. Federal IDR uses a final-offer selection process. The selected amount is an adjudicated outcome for a disputed item or service, not automatically the underlying cost, value, or negotiated market rate for other transactions.

### "Completed IDR disputes represent the entire out-of-network market."

They do not. The data reflect disputes that entered the federal process and reached reportable states, subject to eligibility, filing, settlement, batching, missingness, and selection. Results should be described as IDR-cohort observations.

### "More reporting will burden an already overloaded system."

The reporting proposal builds on data already collected. Its emphasis is standardized metadata, stable definitions, and reproducible publication. A pilot should measure burden and eliminate fields that do not improve interpretation or data quality.

### "Publishing divergence will encourage inflated offers."

The safeguard is domain-specific distributional reporting with explicit non-normative language—not suppression of public data. Policymakers should monitor strategic behavior, but withholding construct definitions can make misunderstanding worse.

# 10. Evidence Boundaries and Research Agenda

## What the published study supports

- ARI can be calculated as the median of case-level selected-payment-to-reported-QPA multiples within a defined cohort.
- In CMS-reported federal IDR disputes involving CPT 13100–13153 during 2023 Q1–2025 Q2, QPA and selected payment did not behave as empirically interchangeable descriptive measures.
- Provider/facility-prevailing and plan-prevailing distributions differed substantially, making stratification important.
- Quarter-level medians remained above QPA parity in all 10 analyzed quarters, although no causal trend was claimed.

## What remains uncertain

- External validity across other procedures, specialties, facility types, regions, payer types, and later reporting periods.
- The accuracy of every issuer-reported QPA, offer, prevailing-party, coding, and selected-payment field.
- How batching, duplicate records, eligibility decisions, settlements, and dispute-selection affect distributions.
- Whether divergence reflects network contracting, case complexity, offer strategy, market structure, coding, data limitations, or other mechanisms.
- Whether alternative weighting, episode construction, or service-level denominators would answer different policy questions.
- How benchmark-outcome relationships affect access, contracting, premiums, utilization, dispute volume, or patient outcomes.

## Priority research program

- Replicate ARI across prespecified clinically coherent code families and specialties.
- Compare results by geography, payer type, provider type, place of service, quarter, and dispute characteristics where fields permit.
- Audit source-field accuracy and assess sensitivity to missingness, exclusions, outliers, and alternative summary statistics.
- Study selection into federal IDR, including ineligible, withdrawn, settled, and completed disputes.
- Compare CMS public-use results with independent claims, all-payer databases, or audited dispute records where lawful.
- Assess whether public construct-separation reporting changes misunderstanding, offer behavior, dispute filing, or administrative burden.
- Develop governance rules for updating the ARI specification without rewriting previously published results.

# 11. Decision Checklist for Policymakers

- Does every payment number state exactly what construct it measures?

- Are numerator, denominator, unit of analysis, cohort, and time period disclosed?
- Are N, median, interquartile range, missingness, and relevant strata reported?
- Is the source-data version and correction history visible?
- Does the analysis separate all cases from materially different prevailing-party groups?
- Is the service domain clinically and administratively coherent?
- Does the report avoid treating QPA, charge, cost, selected payment, and clinical value as interchangeable?
- Is ARI explicitly barred from individual rate setting and outcome prediction?
- Are patient protections preserved?
- Are limitations, selection effects, and noncausal design stated near the findings?
- Is independent replication planned before generalization?
- Will changes be piloted, versioned, evaluated, and corrected publicly?

## 12. Recommended Action

**ADOPT THE PRINCIPLE**

**Benchmarks should be named for what they measure—and never allowed to borrow the meaning of a different payment construct without evidence.**

Congress, federal agencies, state regulators, and professional organizations should adopt a Payment Benchmark Transparency and Construct-Separation Standard. The standard should require reproducible definitions, domain-specific distributions, visible corrections, plain-language use boundaries, and continued public access to federal IDR data.

The first implementation step should be a joint technical process that defines the payment-construct taxonomy, stabilizes the public-use-file specification, pilots ARI reporting in several prespecified service domains, and commissions independent replication. The policy should preserve the QPA's statutory role and the No Surprises Act's patient protections while improving the evidence available to evaluate how administrative benchmarks relate to observed outcomes.

ARI should remain what the published paper says it is: a descriptive cohort-level summary. Its public-policy contribution is not a new mandatory rate. It is a disciplined way to reveal when two measures that appear together in a payment system should not be described as interchangeable.

# References and Source Notes

Federal sources and CMS webpages were checked against materials available July 13, 2026. Federal IDR rules and QPA guidance have been affected by litigation and ongoing rulemaking. Final legislation, regulation, or formal guidance requires current legal review.


1. Klapper AM, Dardano AN, Risin M, Maita K, Denavea ML. Benchmark-Outcome Separation in Federal Independent Dispute Resolution: A Descriptive Analysis of Qualifying Payment Amount and Adjudicated Payment in Complex Repair Claims. Cureus. 2026;18(6):e110912. doi:10.7759/cureus.110912. PMID: 42306020; PMCID: PMC13268617.
2. 42 U.S.C. § 300gg-111, Preventing surprise medical bills, including definitions of qualifying payment amount, recognized amount, out-of-network rate, and the federal IDR process.
3. Centers for Medicare & Medicaid Services. Consolidated Appropriations Act, 2021 and No Surprises Act resources, including QPA methodology and implementation materials.
4. Centers for Medicare & Medicaid Services. Independent dispute resolution reports: Federal IDR public-use files, supplemental tables, data dictionary, disclaimers, and operational reports.
5. Centers for Medicare & Medicaid Services. Plans and issuers requirements and resources, including QPA methodology, audit information, applicability chart, and notices concerning vacated provisions.
6. Centers for Medicare & Medicaid Services. Federal Independent Dispute Resolution Operations Final Rule and fact sheet. May 28, 2026.
7. Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36872 (July 13, 2021), including the QPA methodology and its roles in cost sharing and IDR.
8. Requirements Related to Surprise Billing; Final Rules, 87 Fed. Reg. 52618 (Aug. 26, 2022), addressing federal IDR and QPA information disclosures, subject to later litigation and rulemaking.
9. Centers for Medicare & Medicaid Services. Overview of key No Surprises Act consumer protections and the role of recognized amount and QPA in cost sharing.
10. No Surprises Act, Consolidated Appropriations Act, 2021, Pub. L. 116-260, div. BB, tit. I.


## Document status and use

Healthcare Governance policy brief. Draft 1.0, July 13, 2026. Policy position informed by published research and official federal materials; not itself peer reviewed. Not legal, clinical, actuarial, insurance, investment, or reimbursement advice. Model provisions require counsel review, agency consultation, administrative and fiscal analysis, public comment, and formal drafting.

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