United States Government Accountability Office

Report to Congressional Committees

December 2023

PRIVATE HEALTH INSURANCE

Roll Out of Independent Dispute Resolution Process for Out-of-Network Claims Has Been Challenging

GAO-24-106335

GAO Highlights

Highlights of GAO-24-106335, a report to congressional committees

December 2023

PRIVATE HEALTH INSURANCE

Roll Out of Independent Dispute Resolution Process for Out-of-Network Claims Has Been Challenging

Why GAO Did This Study

About two thirds of individuals in the United States receive their health coverage through private health plans. Balance billing is when insured patients receive a bill from a health care provider for the difference between the amount charged and the payment received from the health insurance issuer. An unexpected balance bill is referred to as a "surprise bill" and may create a financial strain for patients. For individuals with private health insurance, the No Surprises Act prohibits providers from balance billing in certain circumstances and directed the three departments to establish the federal independent dispute resolution process.

The Consolidated Appropriations Act, 2021, includes a provision for GAO to review the federal independent dispute resolution process. This report describes (1) the number and types of disputes submitted between April 2022 and June 2023, and the status of their resolution; (2) selected stakeholders' experiences with the process, and agency actions to address challenges; and (3) how federal agencies oversee the process.

GAO reviewed published reports, relevant federal laws, regulations, and guidance; and interviewed officials from CMS and Labor. GAO also interviewed five selected health care providers or their representatives, which accounted for nearly half of all submitted disputes as of December 2022. In addition, GAO interviewed three issuers, three certified entities that arbitrate the disputes, and 10 stakeholder groups.

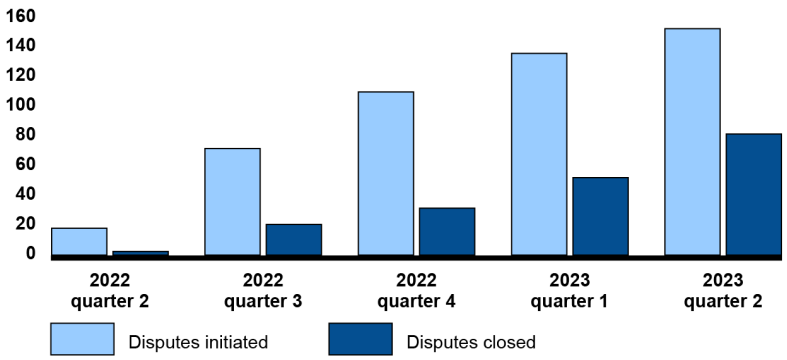
View GAO-24-106335. For more information, contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov.

What GAO Found

The No Surprises Act directed the departments of Health and Human Services (HHS), Labor, and Treasury to establish a federal independent dispute resolution process. The process, which was effective April 2022, is a voluntary forum for health care providers and health insurance issuers to resolve disputes about how much should be paid for out-of-network care. The payment determinations are made by certified dispute resolution entities, which serve as arbiters. The Centers for Medicare & Medicaid Services (CMS)—an agency within HHS—administers the independent dispute resolution process.

The three departments reported that parties submitted nearly 490,000 disputes from April 2022 through June 2023. About 61 percent of these disputes remained unresolved as of June 2023. According to officials from the departments, a primary cause of the large number of unresolved disputes is the complexity of determining whether disputes are eligible for the process.

Number of Out-of-Network Disputes in the Federal Independent Dispute Resolution Process by Calendar Quarter, April 15, 2022—June 30, 2023



Source: Departments of Health and Human Services, Labor, and Treasury; Centers for Medicare & Medicaid Services. | GAO-24-106335

The groups GAO interviewed described a challenging roll out of the independent dispute resolution process, including a higher-than-expected dispute volume. For example, the departments anticipated about 22,000 disputes in 2022, but received nearly 490,000 through June 2023. Four groups told GAO the departments did not account for the experience of states with similar processes when making the estimate. Disputing parties and certified entities also described the broader effects of those challenges, such as backlogs resulting in delays in payment determinations. The departments have taken some actions to address challenges, such as conducting pre-eligibility reviews on submitted disputes.

To address concerns from insurers and providers, CMS and Labor look into complaints; however, stakeholder groups expressed concern with what they describe as a lack of response to submitted complaints. The departments reported limited ability to increase enforcement efforts due to budget constraints. HHS has requested a budget increase for the process, and the departments are revisiting the administrative fee amount, which is intended to cover the costs of the process, and plan to issue updated program rules.

Contents

Abbreviations

CMS	Centers for Medicare & Medicaid Services
DOL	Department of Labor
HHS	Department of Health and Human Services
IDR	independent dispute resolution
QPA	qualifying payment amount

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The majority of Americans receive their health coverage through private health plans, either by purchasing health coverage directly or receiving coverage through their employer. In 2021, about 216.4 million people—or around 66.0 percent of individuals in the United States—had health insurance coverage through private health plans, according to the U.S. Census Bureau.

Balance billing occurs when privately insured patients receive a bill from a health care provider for the difference between the amount charged and the payment from the health insurance issuer for the service.[1] When a balance bill is unexpected, it is referred to as a "surprise bill." Patients may receive a surprise bill from an out-of-network provider for services rendered in situations where patients do not have a choice of provider, such as emergency care and anesthesiology.[2]

Research has shown that the prevalence of out-of-network billing varies by provider specialty and place of service, among other factors. For example, one study found that 13 percent of emergency department claims were billed out-of-network, while 4 percent of physician office visits were billed out-of-network.[3] Another study of large employer claims data found that in 2017, 18 percent of emergency room visits and 16 percent

[1]An issuer is an insurance company, insurance service, or insurance organization that is required to be licensed to engage in the business of insurance in a state.

[2]Issuers have a group of designated providers with whom they have contracts to provide care to patients. Contracted providers accept negotiated payment rates with the issuer as full payment. Providers outside of that network—called out-of-network providers—do not have such contracts and have not agreed to a payment rate with the issuer. Instead, the issuer pays an amount according to what it allows for out-of-network services. Other types of health care providers beyond anesthesiology and emergency care may also send balance bills to patients.

[3]See U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Evaluation of the Impact of the No Surprises Act on Health Care Market Outcomes: Baseline Trends and Framework for Analysis – First Annual Report* (July 2023).

of in-network inpatient admissions resulted in at least one out-of-network charge.[4]

The practice of balance billing may create a financial strain for patients. In one national sample of privately insured patients between 2010 and 2016 the average out-of-network potential financial liability for patients with emergency department visits increased from $220 to $628, and the potential financial liability for inpatient admissions increased from $804 to $2,040 over the same time period.[5] These unexpected costs can cause significant distress for many Americans; 37 percent of respondents in a 2022 survey reported an inability to cover a hypothetical $400 emergency expense using cash or its equivalent.[6]

In December 2020, the Consolidated Appropriations Act, 2021, which included the No Surprises Act, was enacted.[7] For individuals with private health insurance, the No Surprises Act prohibits health care providers from surprise billing for (1) emergency services, (2) non-emergency items or services furnished by out-of-network providers at certain in-network health care facilities, and (3) air ambulance services furnished by out-of-network providers.[8]

The act also directed the departments of Health and Human Services (HHS), Labor (DOL), and Treasury to establish a federal independent dispute resolution (IDR) process. The IDR process provides a forum for out-of-network health care providers, facilities, providers of air ambulance

[4]See K. Pollitz et al., "An Examination of Surprise Medical Bills and Proposals to Protect Consumers from Them," *Peterson-KFF Health System Tracker* (Feb. 10, 2020).

[5]See Eric C. Sun et al., "Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-Network Hospitals," *JAMA internal medicine* 179, no. 11 (2019): 1543-1550.

[6]See Board of Governors of the Federal Reserve System, "Economic Well-Being of U.S. Households in 2022," accessed September 26, 2023, https://www.federalreserve.gov/publications/files/2022-report-economic-well-being-us-households-202305.pdf.

[7]Pub. L. No. 116-260, div. BB, tit. I, 134 Stat. 1182, 2757 (2020) (codified at 42 U.S.C. § 300gg-111).

[8]Examples of emergency services subject to the act—that is, services for which surprise balance billing is banned—may include emergency department services provided by a hospital that is out-of-network or the services of out-of-network emergency department physicians in an emergency room that is part of the patient's network. Examples of non-emergency services provided at facilities that are in-network subject to the act may include an out-of-network anesthesiologist's or radiologist's services provided to a patient during a stay at a hospital that is in the patient's network.

services, and group health plans and health insurance issuers in the group and individual market to resolve certain disputes regarding out-of-network rates without involving the patients.[9] The IDR process began accepting disputes on April 15, 2022. Eligible services include the three types of services, noted above, that are subject to the act. The Centers for Medicare & Medicaid Services (CMS)—an agency within HHS—has been tasked with administering the IDR process. The arbitrators in the IDR process are known as certified IDR entities.

The Consolidated Appropriations Act, 2021, includes a provision for us to review the IDR process established under the No Surprises Act.[10] This report describes

1. the number and types of disputes submitted to the IDR process from April 2022 through June 2023, and the status of their resolution;
2. selected disputing parties' and selected certified IDR entities' experiences with the IDR process, and agency actions to address challenges; and
3. how federal agencies oversee the IDR process.

In addition, we provide information on the private equity ownership of top IDR process initiating parties in appendix I.

To describe the number and types of disputes submitted to the IDR process from April 2022 to June 2023, and the status of submitted disputes, we reviewed published reports and status update documents from HHS, DOL, and Treasury. We also obtained summary data from CMS on disputes submitted to the federal IDR portal through June 2023. We assessed the reliability of the IDR dispute data through a review of CMS's documentation, including guidance and data dictionaries. We also discussed the data limitations in interviews with CMS officials and reviewed a sample of IDR process dispute data. Although CMS is working through a data reconciliation initiative to resolve data issues with the IDR dispute data, we determined the data in the categories that they reported

[9]Unless otherwise specified, "IDR process" refers to the federal IDR process. Out-of-network health care providers, facilities, or air ambulance providers are generally the initiators of an IDR dispute, and group health plans or issuers are generally the non-initiating party in an IDR dispute. For the purposes of this report, disputing parties include both initiating and non-initiating parties. Unless otherwise specified, "health care providers" refers to health care providers, facilities, and air ambulance providers.

[10]Pub. L. No. 116-260, div. BB, tit. I, § 109(d), 134 Stat. at 2681 (2020).

publicly is sufficiently reliable for purposes of describing the number and types of disputes submitted from April 2022 through June 2023.

To describe selected disputing parties' and selected certified IDR entities' experiences with the IDR process, we interviewed representatives from a nongeneralizable selection of five initiating parties (health care providers). These included two health care providers, two practice management companies, and one revenue cycle management company.[11] Together these five initiating parties accounted for 47 percent of dispute submissions involving out-of-network emergency and non-emergency items and services, and 41 percent of disputes involving air ambulance services from April through December 2022. We interviewed representatives from three non-initiating parties (issuers) that together accounted for 43 percent of disputes involving emergency and non-emergency items and services from April through September 2022. We also interviewed three certified IDR entities, which are the third-party arbitrators recognized by HHS, DOL, and Treasury to make the payment determinations in the IDR process. We selected the initiating parties based on criteria including type of disputes submitted (emergency and non-emergency items or services, or air ambulance services), type of organization, and percentage of total disputes submitted. We selected non-initiating parties based on criteria including percentage of disputes received and type of issuer (national or regional). We selected certified IDR entities based on criteria including variation in changes in IDR payment determination fees from 2022 to 2023, and when the entities began accepting disputes.

To gain further understanding of parties' experiences with the IDR process, we interviewed representatives from 10 stakeholder groups, including four groups representing medical providers, two groups representing the insurance industry, one group representing certified IDR entities, one group representing revenue cycle management companies,

[11]Practice management companies perform the administrative services of health care on behalf of providers. These companies may use a staffing model where the providers directly work for the staffing company rather than a group practice or health care facility. Revenue cycle management companies perform billing functions—such as identifying, managing, and collecting patient service revenue—on behalf of providers. In this arrangement, a health care provider or provider group would be a client of a revenue cycle management company.

one group representing employers, and one group representing state insurance regulators.[12]

To describe how federal agencies oversee the IDR process, we reviewed relevant federal laws, regulations, and guidance, as well as interviewed relevant officials from HHS and DOL on their IDR process oversight activities. For example, we reviewed federal IDR process guidance from HHS, DOL, and Treasury for certified IDR entities, and guidance for disputing parties. We also used information from the interviews with the stakeholders described above.

We conducted this performance audit from October 2022 to December 2023 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Independent Dispute Resolution Process

The federal IDR process is a forum for health care providers and health insurance issuers to resolve certain out-of-network payment disputes for private health insurance. In general, initiating parties are providers, and non-initiating parties are issuers.[13] The third-party arbitrator that makes the payment determination in the IDR process is known as a certified IDR entity.[14]

Claims are eligible to be submitted as disputes to the federal IDR process based on the item or service type and the insurance plan type. Eligibility

[12]We interviewed representatives from the American Hospital Association, the American Medical Association, the American College of Emergency Physicians, the Association of Air Medical Services, America's Health Insurance Plans, the Blue Cross Blue Shield Association, the National Association of Independent Review Organizations, Healthcare Business Management Association, the Business Group on Health, and the National Association of Insurance Commissioners.

[13]In some cases, an initiating party could be an issuer rather than a provider, but HHS, DOL, and Treasury reported that health care providers and facilities initiated 99 percent of submitted disputes in calendar year 2022.

[14]Organizations apply to the departments to be certified IDR entities and as part of the application process must demonstrate expertise in arbitration and claims administration, billing and coding, and health care law, among other things.

also depends on compliance with applicable time periods and completion of a 30-business-day open negotiation period prior to submitting a dispute. Specifically, as noted above, the federal IDR process applies to claims for (1) emergency services, (2) non-emergency items or services furnished by out-of-network providers at certain in-network health care facilities, and (3) air ambulance services furnished by out-of-network providers of air ambulance services. Additionally, the federal IDR process generally applies to claims covered by non-federal governmental plans, fully insured and self-insured plans sponsored by private employers, health insurance issuers in the group and individual markets, and plans offered through the Federal Employees Health Benefits program.[15]

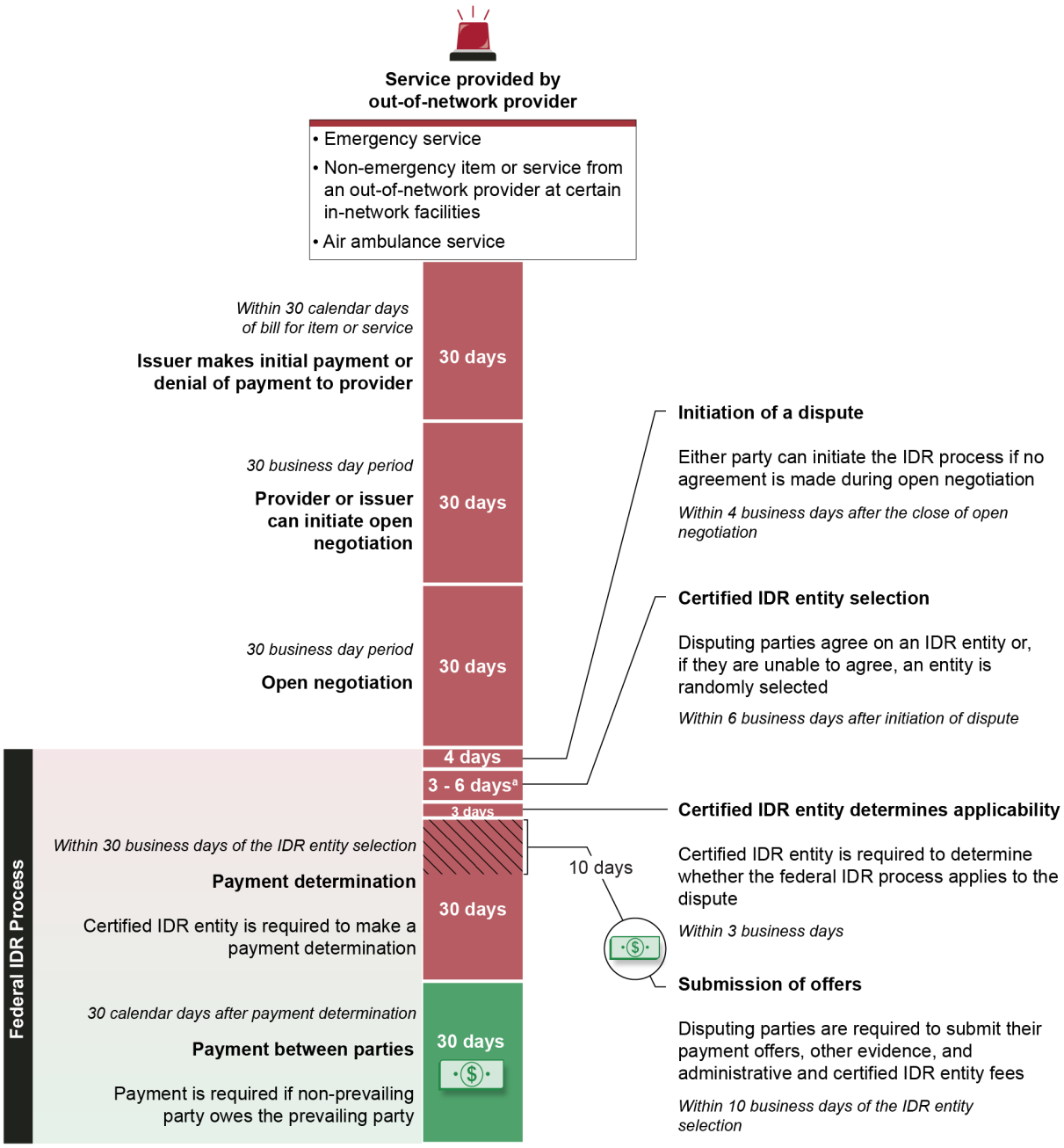
After an out-of-network provider bills for an item or service rendered that is subject to the balanced billing protections of the No Surprises Act, the issuer has 30 calendar days to make an initial payment or deny payment to the provider. The provider, facility, or issuer then has 30 business days to initiate an open negotiation period that lasts 30 business days. If the provider or facility and issuer cannot reach an agreement on an out-of-network rate within this 30-business-day time frame, either party can initiate an IDR process dispute. The initiating party selects a certified IDR entity from a list of certified organizations and both parties must agree on the chosen certified IDR entity. If they are unable to agree on a certified IDR entity within three business days of dispute initiation, the departments randomly select a certified IDR entity within six business days of initiation. CMS developed and maintains an online portal to facilitate the IDR process and parties are to initiate disputes in this portal.

Certified IDR entities are then responsible for determining whether a submitted dispute is eligible for the federal process. Both parties are then responsible for submitting payment offers and additional supporting

[15]The federal IDR process does not apply to items and services payable by Medicare, Medicaid, the Children's Health Insurance Program, or TRICARE. The federal IDR process does not apply in instances where a specified state law or All-Payer Model Agreement under Section 1115A of the Social Security Act provides a method for determining the total out-of-network amount payable under a group health plan, or group or individual health insurance coverage. Specified state laws refer to laws in certain states that provide a method for determining the out-of-network payable amount by a plan for an item or service by an out-of-network provider, facility, or provider of air ambulance services. An All-Payer Model Agreement is a system where a service or treatment generally costs the same for every patient under the same provider, no matter what insurance coverage the patient might hold. In some states, some items or services provided by out-of-network providers, facilities, or providers of air ambulance services may be subject to the federal IDR process, while other items and services are subject to a specified state law or All-Payer Model Agreement.

information, such as the level of training, experience, and quality and outcomes measurements of the provider or facility that furnished the qualified IDR item or service. If the dispute is eligible, using the information submitted by the disputing parties, the certified IDR entity is required to make a determination within 30 business days, and the non-prevailing party is required to make the payment to the prevailing party within 30 calendar days after the determination is made. See figure 1 for a detailed breakdown of the steps involved in the IDR process.

Figure 1: Federal Independent Dispute Resolution (IDR) Process Steps



Source: GAO analysis of Department of Health and Human Services, Department of Labor, and Department of the Treasury documentation (information); GAO (icons). | GAO-24-106335

Notes: If all parties meet all required time periods, the whole IDR process, including open negotiation before a claim is submitted as a dispute, could take up to 5 months and 13 days from the time the bill for services was transmitted. However, this time could be extended due to weekends and holidays in

time periods calculated as business days. After the certified IDR entity is assigned to a dispute, the entity must attest it does not have a conflict of interest with the disputing parties and determine whether the dispute is eligible for the federal IDR process to finalize selection. When the certified IDR entity selection is finalized, the entity is then required to invoice the disputing parties for the administrative fee and certified IDR entity fee; the certified IDR entity fee is only collected if the dispute is eligible for the federal IDR process.

[a]Selection of the certified IDR entity occurs within 3-6 business days of the IDR initiation. Selection will occur within 3 business days—and default to the initiating party's or non-initiating party's preferred selection—if either party fails to respond to the other party's initial choice of certified IDR entity. Selection will occur within 6 business days if the disputing parties do not agree on a certified IDR entity, and in this case the departments of Health and Human Services, Labor, and Treasury will make a random selection of a certified IDR entity.

Certified IDR entities must consider various factors in making a payment determination, including the qualifying payment amount (QPA). In general, the QPA is the median contracted in-network rate for the same or similar service in a geographic area as of January 31, 2019, increased for inflation. The extent to which certified IDR entities are directed to consider various factors, including the QPA, has changed since the program's implementation as a result of court decisions.[16]

When a dispute is submitted to and determined to be eligible by a certified IDR entity for the federal IDR process, both disputing parties are required to pay an administrative fee and an IDR process fee to the certified IDR entity for making the payment determination.[17] The certified IDR entity process fee is refundable to the winning party, but the administrative fee is non-refundable.

[16]See Tex. Med. Ass'n v. U.S. Dep't of Health & Hum. Servs. (TMA I), 587 F. Supp. 3d 528 (E.D. Tex. 2022), appeal dismissed, 2022 WL 15174345 (5th Cir. Oct. 24, 2022); Tex. Med. Ass'n v. U.S. Dep't of Health & Hum. Servs. (TMA II), 2023 WL 1781801 (Feb. 6, 2023), appeal filed, No. 23-40217 (5th Cir. filed Apr. 6, 2023).

[17]In October 2021, the departments issued interim final rules requiring each disputing party to pay an administrative fee to access the federal IDR process. The administrative fee is paid by each party to the certified IDR entity and remitted to the departments. The administrative fee is established annually such that the total administrative fees collected for a year are estimated to be equal to the amount of expenditures estimated to be made by the departments to carry out the IDR process for that year. In addition to the administrative fee, the interim final rules require each party to pay a fee to the certified IDR entity at the time the party submits its offer for the federal IDR process. Upon completion of the IDR process, the non-prevailing party is responsible for the full certified IDR entity fee, which is retained by the certified IDR entity for the IDR services performed. The certified IDR entity is required to refund the certified IDR entity fee paid by the prevailing party.

Federal and State Oversight of the IDR Process

While CMS has been tasked with administering the IDR process, oversight responsibility for the IDR process is shared between federal and state agencies, as is typical under the Public Health Service Act and other applicable laws. HHS, DOL, and Treasury (the departments) share joint oversight responsibilities for certain federal laws applicable to private health coverage.[18] States have primary responsibility for regulating health insurance, and exercise primary enforcement authority over issuers' compliance with state and applicable federal requirements. Which entity or agency has oversight responsibility for IDR process requirements, such as compliance with timelines, depends on the type of coverage, such as group or individual health plans, whether the plan is self-funded or fully insured, and the specific requirement.[19] CMS oversees certified IDR entities in the IDR process.

Employer-sponsored group plans. DOL and Treasury have enforcement authority for IDR process requirements (such as adherence to IDR process timelines) for private employer-sponsored group health plans under the Employee Retirement Income Security Act of 1974, as amended.[20] The plans include those that are fully insured and self-funded. In calendar year 2021, there were about 134 million individuals who were covered by private employer-sponsored group health plans.[21]

HHS has primary authority for IDR process requirements over employer-sponsored plans for state and local governments—known as non-federal

[18]DOL and Treasury generally have primary enforcement authority over private sector employment-based group health plans. Treasury generally has jurisdiction over certain church plans. HHS also has primary enforcement authority over non-federal governmental plans, such as those sponsored by state and local government employers. Additionally, the Office of Personnel Management administers the Federal Employees Health Benefits program, which provides coverage to federal employees, retirees, and family members. The Federal Employees Health Benefits program is the largest employer-sponsored group health plan, covering 8 million federal employees, retirees, and family members.

[19]Group health plans may be self-funded, fully insured, or a mix of the two. Self-funded plans are plans for which the employer pays for employee health care benefits directly, bearing the risk of covering medical benefits generated by beneficiaries. Fully insured plans are plans for which the employer purchases coverage from a state-regulated issuer.

[20]See 29 U.S.C. § 1002 et seq.

[21]See Department of Labor, Employee Benefits Security Administration, *Health Insurance Coverage Bulletin* (Washington, D.C.: Aug. 31, 2023).

governmental plans. In 2017, an estimated 13 million state and local government employees enrolled in these plans.[22]

Individual and fully insured group plans sold by issuers. States have primary responsibility for regulating insurance. Health insurance products sold within a state must meet both federal and state requirements, including IDR process requirements. States generally oversee health insurance sold by issuers (1) in the individual market, where individuals purchase private health insurance plans directly from an issuer or through an exchange; and (2) in the group market, where a plan sponsor (typically an employer) purchases coverage from an issuer. HHS has enforcement authority over issuers in a state if the state notifies the Secretary of Health and Human Services that it does not have the authority or does not intend to enforce certain provisions of the Public Health Service Act, or if the Secretary of Health and Human Services make a determination that the state is failing to substantially enforce certain provisions of the Public Health Service Act. In 2020, the estimated enrollment in these state-regulated markets was 67.1 million enrollees.[23]

States may enforce provisions of the No Surprises Act directly or through a collaborative enforcement agreement with CMS.[24] Prior to the enactment of the No Surprises Act, some states had implemented their own processes and laws regarding the determination of payment amounts to out-of-network providers for services. The No Surprises Act does not supplant these state laws.

[22]This estimate is based on the Agency for Healthcare Research and Quality's 2017 Medical Expenditure Panel Survey. It reflects the number of employees that are enrolled in health coverage through state and local government jobs and does not include dependents.

[23]The estimated enrollment numbers for state-regulated small group and large group markets are from CMS's Medical Loss Ratio data. These estimates are from fully insured plans only and do not include enrollment data for self-funded plans.

[24]In July 2021, CMS sent a written survey to states to provide their assessment of whether the state has authority, and intends to substantially enforce, consumer protections extended or added by the Consolidation Appropriations Act, 2021, which as noted above included the No Surprises Act. CMS also asked state regulators whether each had an All-Payer Model Agreement or specified state law in order to determine whether the federal IDR process would apply in the state. CMS then sent letters to each state insurance regulator clarifying which provisions of the Public Health Service Act the state would enforce directly or through a collaborative enforcement agreement, and which provisions CMS would enforce.

Parties Submitted Nearly 490,000 IDR Disputes from April 2022 through June 2023, Most of Which Remain Unresolved

According to the departments—HHS, DOL, and Treasury—parties submitted nearly 490,000 disputes to the federal IDR process from April 2022 through June 2023, with 38.6 percent of disputes closed as of June 2023. The vast majority of disputes initiated during this time period, about 95 percent, involved out-of-network emergency items or services, or non-emergency items or services provided at an in-network facility, with a small portion initiated for out-of-network air ambulance services (see sidebar).[25]

Federal Independent Dispute Resolution (IDR) Process Reporting Requirements

Under the No Surprises Act, the departments of Health and Human Services, Labor, and Treasury are required to issue a public report quarterly on certain information on the IDR process. The quarterly reports are required to include the number of IDR disputes initiated in that quarter and information about those disputes, such as the geographic area in which an item or service was provided, and the length of time for making a final payment determination, among other things. The departments issued reports in December 2022 and April 2023 that included information on disputes submitted from April 2022 through December 2022. As of September 2023, no additional quarterly updates have been released.

Centers for Medicare & Medicaid Services (CMS) officials told us that limitations in the data reported by certified IDR entities and captured by the IDR portal have prevented the agency from reporting on some of the required elements. According to the officials, as of August 2023, the agency was in the midst of a data reconciliation process with the certified IDR entities to validate the data and plans to report the additional information in a subsequent report.

Source: Pub. L. No. 116-260, div. BB, tit. I, § 103, 134 Stat. 1182, 2804 (2020); Departments of Health and Human Services, Labor, and Treasury status reports on the IDR process; and interviews with CMS officials. | GAO 24 106335

Number of and types of disputes. The departments reported that disputing parties initiated nearly 490,000 disputes from April 2022 through June 2023, the majority of which involved out-of-network emergency or non-emergency items or services. The remaining disputes involved out-of-network air ambulance services.

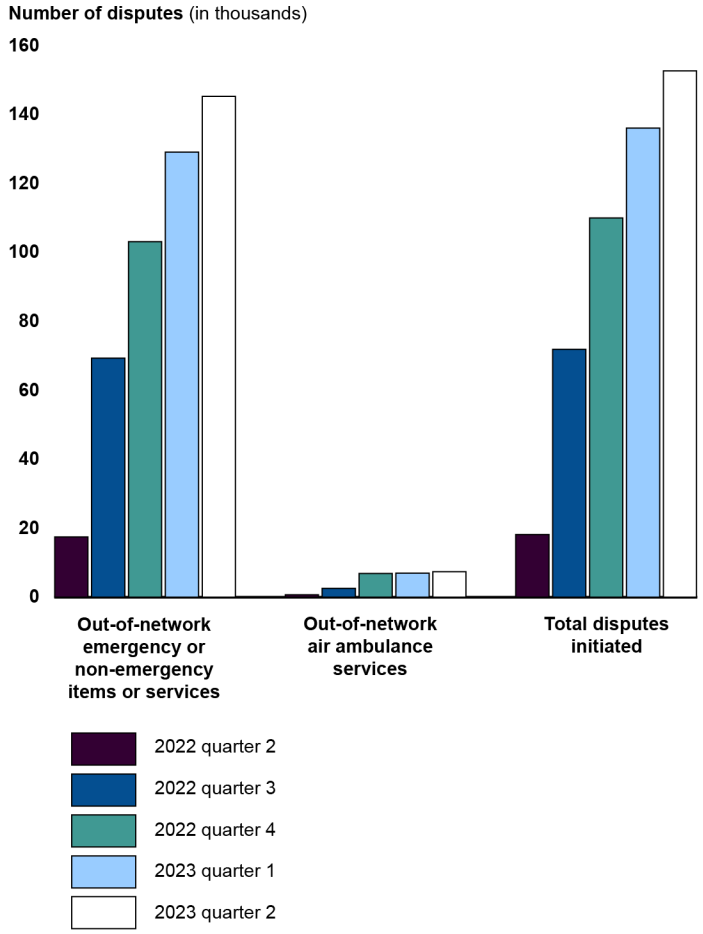
In the October 2021 interim final rules for the IDR process, the departments estimated that the number of disputes initiated in 2022 would be approximately 22,000.[26] Four of the eight disputing parties we interviewed told us that they believed the departments did not take into account available information from states with similar dispute resolution processes, which would have resulted in a higher estimate. For example, Texas reported receiving over 45,000 disputes in 2020—the first year of its state IDR process—and more than 60,000 disputes between January and June 2021.[27] Quarterly dispute submissions in the federal IDR process have exceeded the departments' initial 22,000 dispute estimate number since the third quarter of 2022, and the number of disputes initiated increased for every quarter since April 2022. (See fig. 2.)

[25]For this report, we refer to non-emergency items or services provided at an in-network facility as non-emergency items or services.

[26]See Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980, 56,056 (Oct. 2021).

[27]See Texas Department of Insurance, Senate Bill 1264 2021 mid-year report, July 2021.

Figure 2: Number of and Types of Disputes Initiated in the Federal Independent Dispute Resolution Process by Calendar Quarter, April 15, 2022—June 30, 2023



Source: Departments of Health and Human Services, Labor, and Treasury; Centers for Medicare & Medicaid Services. | GAO-24-106335

Notes: Data begins in quarter two of 2022, because the federal independent dispute resolution (IDR) process portal did not open until April 15, 2022. Services provided beginning January 1, 2022, were eligible for the federal IDR process and parties could initiate these disputes in quarter two of 2022 when the portal opened.

Emergency and non-emergency disputes. The departments reported that over 84 percent of disputes for out-of-network emergency and non-emergency items and services initiated from April 2022 through June 2023 were submitted by health care providers, with the remaining disputes submitted by health care facilities, group health plans, health

insurance issuers, or Federal Employees Health Benefits carriers. (See table 1.)

Table 1: Types of Initiating Parties for Out-of-Network Emergency and Non-Emergency Items or Services, Federal Independent Dispute Resolution Process Disputes, April 15, 2022—June 30, 2023

	Percentage of initiated disputes			
Initiating party type	**2022 quarter 2 and quarter 3**	**2022 quarter 4**	**2023 quarter 1**	**2023 quarter 2**
Health care providers, non-facilities	84	89	89	89
Health care providers, facilities	15	11	12	11
Other	<1	<1	<1	<1

Source: Departments of Health and Human Services, Labor, and Treasury; Centers for Medicare & Medicaid Services. | GAO-24-106335

Notes: Data begins in quarter two of 2022 because the federal independent dispute resolution (IDR) process portal did not open until April 15, 2022. Services provided beginning January 1, 2022, were eligible for the federal IDR process and parties could initiate these disputes in quarter two of 2022 when the portal opened. “Health care providers, non-facilities” includes, for example, medical practices and practice management companies. “Health care providers, facilities” includes ambulatory surgical centers and inpatient hospitals, among others. “Other” represents disputes that were submitted by group health plans, health insurance issuers, or Federal Employee’s Health Benefits carriers. Numbers do not add to 100 percent due to rounding.

The departments reported that while there were more than 500 unique initiating parties for disputes involving out-of-network emergency and non-emergency services or items, the top 10 parties initiated over 70 percent of these disputes as of December 2022. Several of these top initiating parties were large practice management companies, medical practices, or revenue cycle management companies representing hundreds of individual practices, providers, or facilities. For example, the top initiating party accounted for nearly a third of all disputes initiated during calendar year 2022.[28] Furthermore, the departments reported that there were more than 600 unique non-initiating parties for disputes involving out-of-network emergency or non-emergency items and services, with the top non-initiating party representing about one quarter of all of these types of disputes in 2022.[29]

The departments reported that from April 2022 through June 2023, the emergency room was the most common place of service for disputes

[28]The top initiating party for disputes involving out-of-network emergency and non-emergency items and services in 2022 was SCP Health, a large practice management company that represents thousands of clinicians across multiple states.

[29]The top non-initiating party for disputes involving emergency and non-emergency items and services in 2022 was United Healthcare, a large health insurance issuer.

regarding out-of-network emergency and non-emergency items and services, followed by inpatient hospital disputes. (See table 2.)

Table 2: Top Places of Service for Out-of-Network Emergency and Non-Emergency Items or Services for Federal Independent Dispute Resolution Process Disputes, April 15, 2022—June 30, 2023

	Percentage of disputes			
Place of service code	**2022 quarter 2 and quarter 3**	**2022 quarter 4**	**2023 quarter 1**	**2023 quarter 2**
Emergency room – hospital	81	73	78	73
Inpatient hospital	13	16	13	16
On campus – outpatient hospital	9	12	9	11
Other	4	6	4	4

Source: Departments of Health and Human Services, Labor, and Treasury; Centers for Medicare & Medicaid Services. | GAO-24-106335

Notes: Data begins in quarter two of 2022 because the federal independent dispute resolution (IDR) process portal did not open until April 15, 2022. Services provided beginning January 1, 2022, were eligible for the federal IDR process and parties could initiate these disputes in quarter two of 2022 when the portal opened. A place of service code indicates the setting in which a service was provided. “Other” represents all other place of service codes including ambulatory surgical centers, off-campus outpatient hospitals, an office, and independent laboratories. The sum of percent of disputes is greater than 100 percent because some disputes include several different place of service codes.

Additionally, over 75 percent of out-of-network emergency and non-emergency disputes initiated from April 2022 through June 2023 involved emergency services, with the remaining disputes representing ancillary services, such as anesthesia, radiology, and pathology. (See table 3.)

Table 3: Top Types of Services for Out-of-Network Emergency and Non-Emergency Items or Services, Federal Independent Dispute Resolution Process Disputes, April 15, 2022—June 30, 2023

	Approximate percentage of disputes			
Service types	**2022 quarter 2 and quarter 3**	**2022 quarter 4**	**2023 quarter 1**	**2023 quarter 2**
Emergency services	82	75	79	75
Ancillary services	19	22	21	22

Source: Departments of Health and Human Services, Labor, and Treasury; Centers for Medicare & Medicaid Services. | GAO-24-106335

Notes: Data begins in quarter two of 2022 because the federal independent dispute resolution (IDR) process portal did not open until April 15, 2022. Services provided beginning January 1, 2022, were eligible for the federal IDR process and parties could initiate these disputes in quarter two of 2022 when the portal opened. CMS reported that these percentages are approximate. The percent of disputes involving out-of-network emergency services is estimated as the percent of disputes where the initiating party indicated the items and services involved emergency services on the initiation form. The percentage of disputes involving out-of-network ancillary services is estimated as the percent of disputes involving common ancillary services: anesthesiology, radiology, pathology, or neonatology. The sum of percent of disputes may be less than 100 percent because not all ancillary service codes are reflected on this table and there may be other types of services besides emergency and ancillary services. In some cases, the sum of percent of disputes may be greater than 100 percent because it is possible that some common ancillary services are provided during an emergency visit (e.g., an x-ray in an emergency room) and the dispute is counted in both rows.

Air ambulance disputes. Air ambulance services provide emergency transport for critically ill patients and are relatively rare, with few patients requiring such services. As previously shown, about 5 percent of disputes initiated from April 2022 through June 2023 were for out-of-network air ambulance services. The departments reported that most out-of-network air ambulance disputes involved medical transport by helicopter (rotary wing) and the remaining disputes involved medical transport by airplane (fixed wing).[30]

According to the departments, the percentage of disputes initiated for out-of-network air ambulance services that involved rotary wing ranged from 80 to 83 percent by quarter from April 2022 through June 2023. Additionally, according to CMS, the percentage of disputes initiated for air ambulance services that involved fixed wing ranged from 11 to 18 percent by quarter from April 2022 through June 2023. Air ambulance disputes also included services provided in transport, such as oxygen supplies. The top two service codes for out-of-network air ambulance disputes included rotary wing ambulance service and rotary wing air mileage.[31]

The departments reported that more than 60 unique initiating parties submitted disputes for out-of-network air ambulance services during 2022, with the top 10 initiating parties representing over 90 percent of these types of disputes. The top initiating party for out-of-network air ambulance services initiated about 40 percent of all air ambulance disputes in 2022.[32] In addition, the departments reported that there were more than 220 unique non-initiating parties for air ambulance disputes, with the top non-initiating party representing more than 10 percent of all these types of disputes.[33]

[30]There are two types of air ambulances services: medical transport by helicopter or "rotary wing" ambulance, and medical transport by airplane or "fixed wing" ambulance. Rotary wing ambulances are generally used for transports from the scene of the accident or injury to the hospital or for shorter-distance transports between hospitals. Fixed wing aircraft are generally used for longer-distance transports between hospitals. For more information on air ambulances, see GAO, *Air Ambulance: Available Data Show Privately-Insured Patients Are at Financial Risk*, GAO-19-292 (Washington, D.C.: Mar. 20, 2019).

[31]Service codes identify and describe the provided item or service.

[32]The top initiating party for disputes involving air ambulance services in 2022 was Global Medical Response, an air ambulance provider.

[33]The top non-initiating party for disputes involving air ambulance services in 2022 was Zelis, a health care technology company that provides cost management and payment solutions.

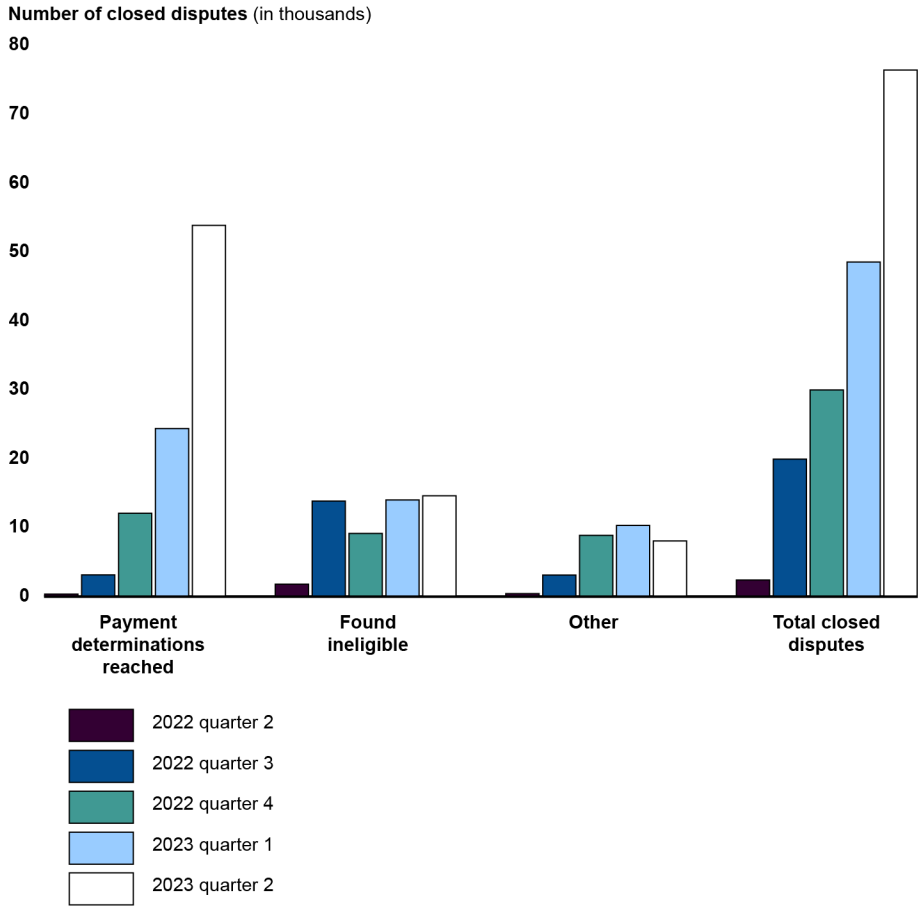
Dispute resolution status. Of the 488,922 disputes initiated from April 2022 through June 2023, 300,065 (61.4 percent) remained unresolved as of June 2023, according to CMS. As a result of a February 2023 court decision, the departments required certified IDR entities to temporarily pause their payment determination decision-making from February 6 through March 17, 2023, further increasing the backlog, according to DOL officials.[34] The departments again paused the IDR process operations twice in August 2023 as a result of court decisions.[35]

- **Out-of-network emergency and non-emergency dispute closures:** Of the 464,409 disputes initiated through the federal IDR portal through June 2023, 176,932 (38.1 percent) were closed by the end of June 2023. Among these closed disputes, certified IDR entities reached a payment determination for about 93,465 (52.8 percent) of them and found about 53,043 (30.0 percent) ineligible for the federal IDR process. The departments reported that the number of payment determinations made by certified IDR entities increased each quarter from April 2022 through June 2023. (See fig. 3.)

[34]See TMA II, 2023 WL 1781801. The pause ended on February 27, 2023, for disputes involving items or services furnished before October 25, 2022. For disputes involving items or services furnished on or after October 25, 2022, the pause ended March 17, 2023.

[35]On August 3, 2023, the departments paused dispute submissions to the federal IDR portal as a result of a court decision vacating the departments' calendar year 2023 administrative fee increase to $350 from $50 per party per dispute. See Tex. Med. Ass'n v. U.S. Dept. of Health & Hum. Servs. (TMA IV), 2023 WL 4977746 (E.D. Tex. Aug. 3, 2023). From August 7, 2023, through August 24, 2023, the departments directed certified IDR entities to process single disputes initiated prior to August 3, 2023. From August 24, 2023, through September 5, 2023, the departments directed certified IDR entities to pause all dispute processing. On August 25, 2023, the departments temporarily suspended all IDR process operations as a result of a court decision vacating provisions of the July 2021 interim final rule and related guidance documents. See Tex. Med. Ass'n v. U.S. Dep't of Health & Hum. Servs. (TMA III), 2023 WL 5489028 (E.D. Tex. Aug. 24, 2023). As of September 5, 2023, the departments directed certified IDR entities to resume processing disputes initiated on or before August 3, 2023, and to process eligibility determinations for single disputes. As of September 21, 2023, the departments directed certified IDR entities to process payment determinations for single disputes and as of October 6, 2023, the federal IDR portal reopened for single, non-air ambulance dispute submissions.

Figure 3: Number of Disputes Closed by Reason and Calendar Quarter for Out-of-Network Emergency and Non-Emergency Items or Services, April 15, 2022—June 30, 2023



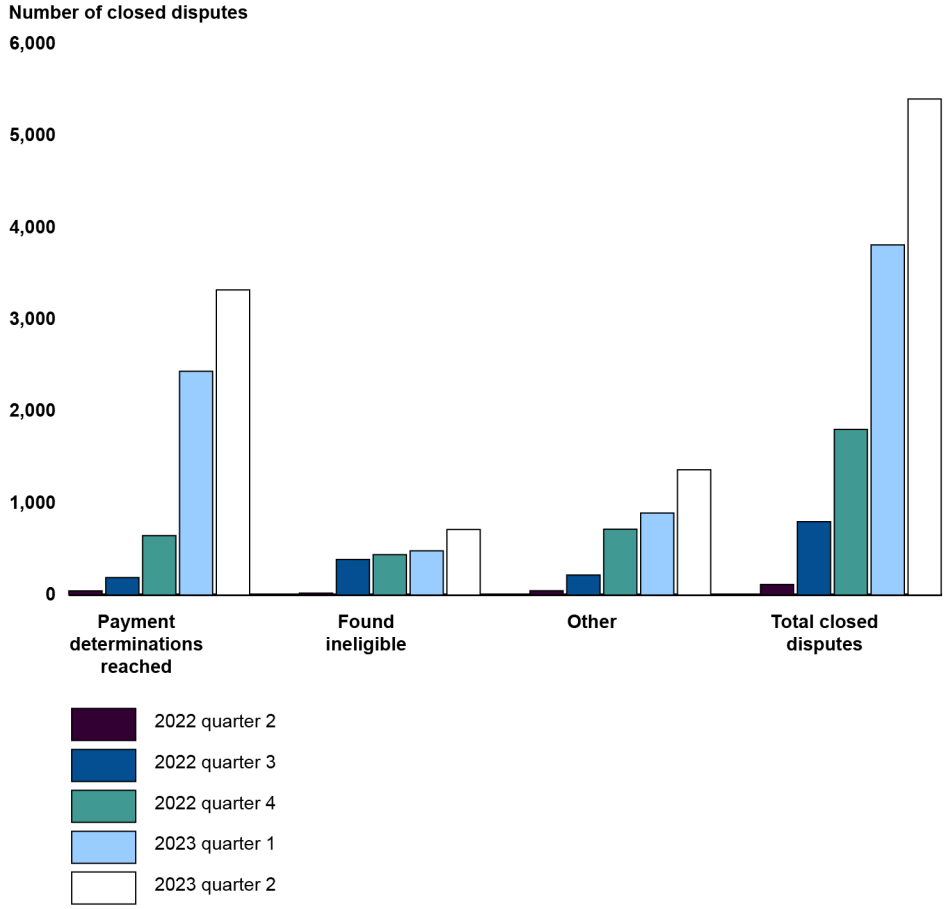
Source: Departments of Health and Human Services, Labor, and Treasury; Centers for Medicare & Medicaid Services. | GAO-24-106335

Notes: Data begins in quarter two of 2022 because the federal independent dispute resolution (IDR) process portal did not open until April 15, 2022. Services provided beginning January 1, 2022, were eligible for the federal IDR process and parties could initiate these disputes in quarter two of 2022 when the portal opened. “Other” represents disputes that were either withdrawn by disputing parties, closed due to outside settlement between the disputing parties, or were closed for other reasons, such as incorrect batching or data entry errors.

- **Out-of-network air ambulance dispute closures:** Of the 24,513 air ambulance disputes initiated through the federal IDR portal as of June 30, 2023, 11,925 (48.6 percent) were closed by June 2023. Of these closed air ambulance disputes, certified IDR entities reached a payment determination for 6,641 (55.7 percent) disputes and found 2,046 (17.2 percent) disputes to be ineligible for the federal IDR

process.[36] Similar to out-of-network emergency and non-emergency items or services, certified IDR entities made over three times more payment determinations for air ambulance disputes during quarter four of 2022 as compared to quarters two and three. (See fig. 4.)

Figure 4: Number of Disputes Closed in the Federal Independent Dispute Resolution Process by Reason and Calendar Quarter for Out-of-Network Air Ambulance Services, April 15, 2022—June 30, 2023



Source: Departments of Health and Human Services, Labor, and Treasury; Centers for Medicare & Medicaid Services. | GAO-24-106335

Notes: Data begins in quarter two of 2022 because the federal independent dispute resolution (IDR) process portal did not open until April 15, 2022. Services provided beginning January 1, 2022, were eligible for the federal IDR process and parties could initiate these disputes in quarter two of 2022

[36]Disputes may be ineligible for the federal IDR process if the item or service is not subject to the federal IDR process, if the type of coverage is not subject to the federal IDR process, or if the item or service is covered under a specified state law or All-Payer Model Agreement.

when the portal opened. “Other” represents disputes that were either withdrawn by disputing parties, closed due to outside settlement between the disputing parties, or were closed for other reasons such as incorrect batching or data entry errors.

CMS officials told us that from January 1 through June 30, 2023, initiating parties (mainly providers) prevailed in about 77 percent of disputes in which a payment determination was reached and non-initiating parties (mainly issuers) prevailed in about 23 percent of such disputes.[37]

Selected initiating and non-initiating parties we spoke with had different opinions on what constituted a “win” in the federal IDR process. For example, one non-initiating party considered it a win that the majority of its claims did not go to the federal IDR process. Specifically, this non-initiating party said that 91 percent of its out-of-network claims eligible for the IDR process did not go through the IDR process. In addition, another non-initiating party noted that an adverse payment determination could require a lower payment amount than what the provider initially billed, which the non-initiating party also took as a win. Further, while CMS officials told us that initiating parties prevailed in the majority of disputes, four of the five initiating parties we spoke with described concerns over access to the federal IDR process, noting that for some providers—such as those with smaller claim amounts—the cost of going through the federal IDR process can be higher than their claim amounts. Specifically, initiating parties said that for those providers with smaller claim amounts, the choice not to file a dispute was associated with the required administrative fee being higher than their claim amount, rather than satisfaction with the issuer’s payment.

[37]Data limitations prevented CMS from providing win rates back to the establishment of the IDR process.

Stakeholders Identified IDR Process Roll-Out Challenges and their Broader Effects, Which the Departments Took Some Actions to Address

The selected disputing parties—both initiating and non-initiating parties—and the selected certified IDR entities we interviewed described a challenging roll out of the federal IDR process. Roll-out challenges included a higher than anticipated dispute volume and difficulty determining dispute eligibility for the federal IDR process. The disputing parties and certified IDR entities also described broader effects associated with those challenges, such as payment determination delays. The departments took some actions to address these roll-out challenges and their effects, but agency officials and some stakeholders we spoke to noted that the federal IDR process is still new and therefore the result of these actions is unknown.[38]

Stakeholders Described IDR Process Roll-Out Challenges, such as High Dispute Volume and Difficulty Determining Dispute Eligibility, Which the Departments Took Some Actions to Address

Disputing parties and certified IDR entities we interviewed described roll-out challenges—including a high dispute volume and difficulty determining dispute eligibility—they experienced with the federal IDR process.

Higher than anticipated dispute volume. Non-initiating parties and certified IDR entities we interviewed described challenges with a higher than anticipated volume of disputes in the first year of the federal IDR process. As noted above, the departments—HHS, DOL, and Treasury—estimated that the number of disputes initiated in calendar year 2022 would be approximately 22,000; however, by the end of 2022, over 200,000 disputes had been initiated.

All three non-initiating parties cited the higher than anticipated dispute volume as a challenge, noting that the federal IDR process was not set up to handle the number of disputes submitted. According to a non-initiating party, billing agencies that represent providers are the primary drivers of the higher than anticipated IDR dispute volume. Another non-initiating party said that initiating parties submit high volumes of disputes, because

[38]In addition to the actions described in this report, on October 27, 2023, the departments issued a proposed rule that addresses some of these challenges. See 88 Fed. Reg. 75,744 (Nov. 3, 2023).

there is no fee or recourse if a submitted dispute is found to be ineligible.[39]

Similarly, representatives from a certified IDR entity told us part of the reason the IDR process dispute volume has been so high is that certain groups see opportunity in arbitration programs and try to send as much volume as they can through the system. Two of three certified IDR entities and one stakeholder group we interviewed told us certified IDR entities had to hire additional staff to process the higher than expected volume of disputes.

However, some initiating parties we spoke to said providers are not submitting a large volume of disputes through the IDR process. For example, representatives from an initiating party said they have taken a conservative approach to dispute submissions. Representatives told us it has submitted only 10 percent of its out-of-network claims to the IDR process. Another initiating party said the claims of providers "flooding" the system are not true, and that while this initiating party has submitted a large portion of the federal IDR process disputes, 94 percent of their claims have been deemed eligible.

Difficulty determining dispute eligibility. As of June 2023, 300,065 (61.4 percent) initiated disputes remain unresolved. The departments reported that the primary cause of the large number of unresolved disputes is the complexity of determining whether disputes are eligible for the federal IDR process. The departments reported several challenges that may be impacting certified IDR entities' ability to determine dispute eligibility.

- **Missing documentation:** The departments reported that in the first 9 months that the IDR process was operational, many disputes were initiated with missing documentation required for the process, including missing or incorrect contact information for the non-initiating party, missing QPAs, or missing proof of open negotiations. The departments noted that incomplete submissions require the certified IDR entities to conduct outreach to disputing parties to obtain the required documentation, which can cause delays in dispute processing.

[39]The administrative fee is due for all initiated disputes regardless of eligibility and is not refundable.

- **Bifurcation in federal and state authority:** The departments reported that in many states, some items or services may be subject to the federal IDR process, while other items and services would be subject to a specified state law outlining a state process or an All-Payer Model Agreement, which the departments refer to as bifurcated states.[40] As of January 2023, CMS reported that there are 21 bifurcated states.[41] According to the departments, disputes submitted in bifurcated states require further review by certified IDR entities to determine eligibility for the federal IDR process. The departments reported that more than two-thirds of disputes submitted to the federal IDR portal during all three quarters of calendar year 2022 involved items or services rendered in bifurcated states, particularly in Florida, Georgia, and Texas.

Three of five initiating parties we interviewed discussed the difficulty in determining which disputes are eligible for the federal IDR process, often because of challenges obtaining necessary information from issuers. One initiating party described challenges determining dispute eligibility without certain information from issuers, such as whether a health plan is self-funded or fully insured, which determines the avenue for dispute resolution. Without this information, the initiating party told us it does not have a reliable way of identifying dispute eligibility.

Four of five initiating parties we interviewed said issuers could provide information on dispute eligibility for the federal IDR process through remittance advice remark codes, which may be used by plans and issuers to communicate information about claims to providers and facilities.[42]

[40]CMS reported that 21 states have specified state laws or All-Payer Model Agreements that protect consumers from surprise billing and provide a method for determining the out-of-network rate in certain circumstances; many of these state laws were in effect at the time the No Surprises Act was passed. Generally, the federal IDR process does not apply in instances where a specified state law or All-Payer Model Agreement provides a method to determine the total amount payable under a group health plan, or group or individual health insurance coverage with respect to the out-of-network items and services furnished by the provider or facility.

[41]For a list of bifurcated states, see Centers for Medicare & Medicaid Services, “Chart for Determining the Applicability for the Federal Independent Dispute Resolution (IDR) Process,” accessed October 11, 2023, https://www.cms.gov/files/document/caa-federal-idr-applicability-chart.pdf.

[42]The departments reported that information about health plan type—whether a plan is fully insured or self-insured—helps initiating parties accurately batch items or services together from the same issuer or from the same self-insured health plan.

CMS encourages, but does not require, issuers to provide remittance advice remark codes to providers as part of the federal IDR process.

Non-initiating parties told us they are providing information on eligibility through other means. For example, one non-initiating party said that its claims have an indicator of whether the claim is eligible for the federal IDR process, including published instructions for next steps if a provider chooses to pursue dispute resolution. With respect to providing claim eligibility information through remittance advice remark codes, representatives said they are hesitant to invest time and money into a systems change that providers may not utilize. Another non-initiating party said that it provides information on where to submit a dispute—such as to the federal IDR process or a state process—on the explanation of benefits.

To mitigate the delays due to incomplete dispute submissions, in June 2022, the departments provided a checklist for issuers identifying the information they must disclose with initial payment or with notice of payment denial. In addition, the departments reported that they continue to publish technical assistance to help disputing parties and certified IDR entities resolve disputes more quickly.[43] Lastly, CMS has updated the IDR portal for both initiating and non-initiating parties to allow for documentation to be collected earlier in the process to ensure complete submissions and speed up dispute processing.

In November 2022, the departments began engaging contractors to assist with pre-eligibility reviews to support certified IDR entities' completion of eligibility determinations. According to CMS officials, the majority of these pre-eligibility reviews are being conducted for disputes initiated prior to November 2022. As of July 2023, CMS officials said they have completed pre-eligibility reviews for a relatively small volume of disputes and are continuing to refine their processes and procedures for pre-eligibility reviews, noting that it is too early to determine the impact of these reviews on certified IDR entities.

Difficulties batching and bundling disputes. Batching and bundling are two methods for submitting disputes that are intended to consolidate multiple claims into fewer disputes. The No Surprises Act instructs the departments to create rules to allow for multiple qualified items or

[43]See Department of Health and Human Services, Department of Labor, Department of the Treasury, *Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities* (Washington, D.C.: August 2022).

services to be submitted as a "batched" dispute when certain conditions are met.[44] In the September 2021 final rule, the departments restricted batching to items that are billed under the same service code, among other requirements.[45] A "bundled" arrangement is when a group health plan or health insurance issuer pays a provider, facility, or provider of air ambulance services a single payment for multiple items or services furnished during an episode of care to a single patient.

The departments reported that in the initial months of the federal IDR process—April to September 2022—many disputes were incorrectly batched. For example, the departments reported that many initiating parties submitted multiple service codes from the same patient encounter as one dispute, rather than separating these different service codes into separate disputes as the September 2021 final rule required. According to the departments, incorrectly batched disputes result in delays to dispute processing.

All five of the initiating parties we spoke to told us that the IDR batching and bundling rules are a challenge, with two noting it contributed to the high volume of disputes, because some of their disputes were not eligible to be grouped together. Therefore, they had to submit a larger number of separate disputes to the process. As an example, air ambulance providers are required to submit two separate IDR disputes for each air ambulance service provided—one for the base rate of the service and one for the mileage rate. This is because the service codes for the base rate and mileage rates are different.

Two of the three certified IDR entities told us that difficulties navigating batching, bundling, and bifurcation in federal and state authority are the main issues with dispute eligibility. For example, one certified IDR entity said that while it may seem to make sense to batch 10 or 100 claims with the exact same service code, similar patients, and similar circumstances, each patient has their own nuances that create complexities with coding. The IDR entity noted that often a dispute may look correctly batched to a

[44]Under the statute, claims can be batched into a single dispute if the items and services are related to the treatment of a similar condition, furnished by the same provider or facility, payment is to be made by the same group health plan or health insurance issuer, and were furnished within the same 30-day period. 42 U.S.C. § 300gg-111(c)(3)(A).

[45]As previously noted, a service code identifies and describes an item or service.

provider, but then a health plan will respond that some portion of the codes are ineligible for the IDR process.

As previously noted, the departments published technical assistance, which included information on determining dispute eligibility, to help disputing parties and certified IDR entities resolve disputes more quickly.[46] However, on August 3, 2023, a federal district court vacated certain batching provisions of the September 2021 interim final rule, including the requirement that items must be billed under the same service code in order to be batched.[47]

Few disputes resolved during open negotiation. Seven of the eight disputing parties we spoke to told us that few disputes are resolved during open negotiation, rendering it a "waiting period" before entering the IDR process rather than a meaningful negotiation opportunity.

- **Volume of claims submitted during open negotiation period:** All of the non-initiating parties we interviewed described a concern with the high volume of claims submitted by providers during the open negotiation period, noting the challenges in processing and responding to a high number of ineligible disputes. Three non-initiating parties said they faced a significant burden to sort through the information they receive from providers to determine which disputes are eligible for the federal IDR process when they receive a large volume. For example, representatives from one non-initiating party said they receive a significant volume of ineligible disputes from providers, with some open negotiation requests containing 15,000 disputed claims—over 85 percent of which are ineligible solely based on dates of service. Another non-initiating party told us that at one point, 60 percent of the disputes it received as part of the open negotiation process from providers were ineligible for the federal IDR process.
- **Lack of engagement during open negotiation:** All five initiating parties and one of three non-initiating parties described the open negotiation period as "not meaningful" or unsuccessful due to a lack of responsiveness from the other party, resulting in the parties entering the IDR process. For example, one initiating party told us that early on

[46]See Department of Health and Human Services, Department of Labor, Department of the Treasury, *Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities* (August 2022).

[47]Tex. Med. Ass'n v. U.S. Dept. of Health & Hum. Servs. (TMA IV), 2023 WL 4977746 (E.D. Tex. Aug. 3, 2023).

in the IDR process, issuers regularly failed to provide information required to initiate the open negotiation period, such as necessary contact information. Another initiating party said it does not receive a response from issuers about 65 percent of the time during the open negotiation period, and that any received responses are often minimal, such as to refer the initiating party back to the original payment offer. In addition, one non-initiating party told us that certain private equity-backed provider groups are often nonresponsive during the open negotiation period, with representatives believing that the party wanted to move toward entering the IDR process rather than engage in a negotiation.[48]

- **Lack of transparency in QPA calculations:** The QPA, which is generally the median in-network rate paid by an issuer for a service in a geographic area, is one of several factors certified IDR entities are to take into consideration when making a payment determination. All five initiating parties we interviewed described concerns with a lack of transparency in the QPA calculations, including two initiating parties who believed that issuers' QPAs had not been adjusted for inflation as required, or seemed artificially low. Two of the three non-initiating parties we spoke to stood by their QPA rates. CMS officials told us they are conducting audits of issuers' QPA calculation methodology, but none of those reports had been released as of July 2023.

Administrative burden. The selected disputing parties and certified IDR entities in our review described concerns with the administrative burden of the IDR process, including challenges using the federal IDR portal. All eight disputing parties we interviewed agreed that navigating the federal IDR process had placed a significant amount of administrative burden on disputing parties.

Five of eight disputing parties and two of three certified IDR entities we spoke with described challenges with the federal IDR portal, noting that the ineffectiveness of the portal contributes to the high administrative burden of the process. Disputing parties said the portal is ineffective because they cannot return to submitted disputes to check their status in the portal, and have to rely on email communication with IDR entities rather than communicating directly through the portal. A non-initiating party told us there are few validation mechanisms within the federal IDR portal to ensure that information is entered correctly, also causing the parties to communicate primarily by email. Representatives from this non-

[48]For more information on the private equity ownership of initiating parties, see appendix I.

initiating party noted that added pre-fill options would help to alleviate this administrative burden. One certified IDR entity we interviewed said the federal IDR portal is not as effective as it could be, because the portal does not screen out ineligible disputes, which would be helpful as the manual screening is time-consuming.

CMS officials told us they have made improvements to the federal IDR portal since it was released and continue to improve the functionality. For example, officials told us that they started collecting claim numbers as a mandatory data element, because officials learned from issuers that the claim number was particularly helpful. Officials noted this has reduced certified IDR entities' and issuers' time and effort to collect information on their own. Moreover, officials said they enabled automated screening features to help reduce the number of ineligible disputes that are submitted. Representatives from one certified IDR entity found a validation tool that the departments added to the federal IDR portal helpful, noting that it automatically calculates the open negotiation and dispute submission timeline requirements, and precludes initiating parties from creating a dispute if requirements are not met.

Stakeholders Described Broader Effects Associated with the Roll-Out Challenges, such as Payment Determination Delays, Which the Departments have Taken Some Actions to Address

The selected disputing parties and certified IDR entities in our review told us roll-out challenges associated with the federal IDR process have broader effects, such as delays in payment determinations.

Payment Determination Delays

All of the selected initiating parties described significant delays in payment determinations. As previously noted, only 38.6 percent of disputes submitted since April 2022 were closed as of June 2023.[49] Data from the departments were not available on the percentage of unresolved disputes that are delayed, but all five initiating parties told us that many disputes have taken longer than the required time frames. For example, one initiating party told us in May 2023 that only 14 percent of its disputes

[49]As the federal IDR process can take up to one month and 13 days from the time a dispute is initiated through the IDR portal, it is expected that not all disputes initiated from April 2022 would be closed by the end of the calendar year; however, this time could be extended due to weekends and holidays in time periods calculated as business days.

have reached payment determinations; the remaining 86 percent were unresolved. Representatives from this initiating party noted that most of its outstanding disputes are very late. Some disputes were approaching a year old without resolution.

All five selected initiating parties described payment determination delays, which may have contributed to significant dispute reimbursement delays, drawing out IDR process timelines.[50] For example, one initiating party told us that only 9 percent of its disputes have been resolved, with only 3 percent of disputes both resolved and paid. Representatives said that completion of the actual IDR process—from submission of the dispute to receiving payment after a determination in their favor—takes an average of 150 days. They further added that the minimum wait for a payment determination and payment tends to be between 50 and 100 days, and their longest wait was about 268 days. Another initiating party told us that their payment determination wait time averages about 90 days.

Two of the three certified IDR entities we interviewed described having payment determination delays as a result of their backlogs. For example, one certified IDR entity told us in April 2023 that it has about 12,000 disputes in backlog. Representatives from this certified IDR entity estimated that it takes about 100 days from the time a dispute is initiated for them to determine dispute eligibility and make a payment determination, as opposed to the 43 business days specified for the process. Mostly the delays are due to challenges making eligibility decisions and missing documentation. Another certified IDR entity we interviewed said it had about 3,000 disputes in backlog, noting that most are from the first few months of IDR process implementation.

In December 2022, the departments acknowledged a significant backlog of disputes pending eligibility determinations and that the backlog continued to grow, adding to the number of disputes delayed. As previously noted, to address this issue, in November 2022 the departments engaged contractors to help conduct pre-eligibility reviews, which include outreach and technical assistance in support of the certified

[50]The whole IDR process timeline, including open negotiation before a claim is submitted as a dispute, could take up to 5 months and 13 days if all timelines are met; however, this time could be extended due to weekends and holidays in time periods calculated as business days. In September 2022, the departments implemented flexibilities to allow additional time for certified IDR entities to collect information to evaluate dispute eligibility. These flexibilities contributed to the lengthened IDR process timelines.

IDR entities' eligibility determinations. CMS officials told us that they have not determined if these pre-eligibility reviews will help shorten delays.

Temporary pauses in IDR decision-making as a result of court decisions have also contributed to delays. As a result of a February 2023 court decision, the departments required certified IDR entities to temporarily pause their payment determination decision-making from February 6 through March 17, 2023.[51] The departments paused the IDR process operations twice in August 2023 as a result of court decisions.[52]

Payments Following Payment Determinations

Initiating parties expressed concerns over not receiving timely payments after a payment determination in their favor. CMS and DOL also reported this issue as the biggest reason for complaints during the audit period. For example, the five initiating parties told us that issuers have regularly failed to pay determination awards upon losing an IDR process dispute within the 30 days required under the No Surprises Act. One initiating party said that the majority of the payment determinations it has won through the IDR process remain unpaid past the 30-day statutory deadline. Another initiating party stated it had over $5 million in outstanding IDR payments that remain unpaid past the 30-day deadline.

Two of the three selected non-initiating parties we interviewed described challenges making timely payments after a determination. Representatives from one non-initiating party told us they have had several instances in which they were not notified of a dispute—either because the provider entered incorrect issuer contact information or failed

[51]See TMA II, 2023 WL 1781801. The pause ended on February 27, 2023, for disputes involving items or services furnished before October 25, 2022. For disputes involving items or services furnished on or after October 25, 2022, the pause ended March 17, 2023.

[52]On August 3, 2023, the departments paused dispute submissions to the federal IDR portal as a result of a court decision vacating the departments' calendar year 2023 administrative fee increase to $350 from $50 per party per dispute. See TMA IV, 2023 WL 4977746. From August 7, 2023, through August 24, 2023, the departments directed certified IDR entities to process single disputes initiated prior to August 3, 2023. From August 24, 2023, through September 5, 2023, the departments directed certified IDR entities to pause all dispute processing. On August 25, 2023, the departments temporarily suspended all IDR process operations as a result of a court decision vacating provisions of the July 2021 interim final rule and related guidance documents. See TMA III, 2023 WL 5489028. As of September 5, 2023, the departments directed certified IDR entities to resume processing disputes initiated on or before August 3, 2023, and to process eligibility determinations for single disputes. As of September 21, 2023, the departments directed certified IDR entities to process payment determinations for single disputes and as of October 6, 2023, the federal IDR portal reopened for single, non-air ambulance dispute submissions.

to include a claim number in the IDR portal. As a result, the non-initiating party lost the dispute by default and did not know about the dispute or its determination until the provider asked for the payment.

Another non-initiating party said it is difficult for them to properly identify claims when some dispute determinations are sent from a certified IDR entity without an indicated dollar amount or are sent in a lump sum across many different disputes without allocation instructions. For example, according to one non-initiating party, across multiple different disputes, the issuer owes one provider a given dollar amount; however, for proper accounting, the issuer needs to know how much was attributed to each claim.

IDR Process Administrative Fees

The departments reported that the rising volume of disputes leading to increased costs was a factor in their December 2022 decision to increase the IDR process administrative fee from $50 per dispute in calendar year 2022 to $350 per dispute for 2023.[53] All five initiating parties we interviewed cited this fee increase as a challenge, noting that it could limit access to the IDR process for certain providers. One initiating party told us that demand for the IDR process may decline as some provider groups—such as radiology, anesthesiology, and emergency physicians—will not be able to overcome the $350 fee. For example, certain services tend to have claim amounts less than $350, meaning that even if the provider won an IDR dispute they would lose money on the claim due to the $350 fee. On August 3, 2023, a federal district court vacated the departments' $350 administrative fee for 2023.[54]

In-Network Contracting

Disputing parties we interviewed told us the implementation of the IDR process has not resulted in or encouraged in-network contracting as the parties believe the No Surprises Act intended.

[53]Under the No Surprises Act, the administrative fee is designed to recoup ongoing costs of the federal IDR process such that the amount of total fees paid is estimated to be equal to the departments' estimated expenditures. In addition to the increased administrative fee, several certified IDR entities increased their payment determination fees in 2023. For example, two of the three certified IDR entities we interviewed described the complexity in making payment determinations and the volume of ineligible disputes as reasons for their fee increases.

[54]See TMA IV, 2023 WL 4977746. As a result of the court decision, the administrative fee reverted back to $50 per party per dispute for disputes initiated on or after August 3, 2023. In September 2023, the departments issued a proposed rule regarding the calculation of IDR fees and proposing to set the administrative fee at $150 for 2024. 88 Fed. Reg. 65,888 (Sept. 26, 2023).

Seven of the eight disputing parties we interviewed described a failure of the IDR process to encourage in-network contracting, though the different sides had different explanations for the reasons. For example, one initiating party said the reason the law has not encouraged in-network contracting is that issuers are making "take-it-or-leave-it" rate offers below market benchmarks, with the understanding that if the providers want higher rates they will be forced to go through the federal IDR process. Another non-initiating party we interviewed said some providers are seeking what the issuers consider to be exorbitant payment rates. Two stakeholder groups we interviewed said that as the federal IDR process has not yet stabilized to set acceptable payment rates for services, it will take time for contracting to change.

Certified IDR Entity Decision-Making

Both disputing parties and the certified IDR entities we interviewed described concerns over certified IDR entity decision-making in the federal IDR process.

Lack of uniformity and potential biases in decision-making. All eight of the disputing parties we interviewed discussed challenges with a lack of uniformity or potential biases in certified IDR entity decision-making. Disputing parties told us there is a high degree of variability between certified IDR entities and a lack of consistency in decision-making. For example, one non-initiating party said it has seen cases where a single certified IDR entity will make a determination in favor of the provider in one dispute and the issuer in another dispute when the provider, service, and QPA are the same. Another non-initiating party said it would be beneficial to receive more information from certified IDR entities on their decision-making rationale, which could help both parties make more rational decisions with respect to whether to enter the federal IDR process. This party acknowledged that this may be difficult to do with the high volume of disputes.

Three of the five initiating parties we interviewed also described concerns over potential biases in certified IDR entity decision-making. For example, one initiating party said that some certified IDR entities appear to have a bias in favor of issuers, as more weight was given to the QPA early on in the IDR process. Subsequent litigation changed the extent to which certified IDR entities may consider various factors, including the QPA, when making payment determinations. Representatives from another initiating party told us they have experienced a 100 percent loss rate with a single certified IDR entity—in contrast to this initiating party's overall IDR process win rate of 90 percent.

Lack of legal protections for decision-making. While the No Surprises Act generally limits judicial review of payment determinations, two of three certified IDR entities we spoke to discussed concerns related to a lack of "hold harmless" protections, or immunity from litigation.[55] Representatives from one certified IDR entity said they are not "held harmless," or exempt from litigation, for IDR process payment decisions.[56] Representatives noted that a provider dissatisfied with a payment determination outcome can include the certified IDR entity as a co-defendant in a lawsuit, even if that provider is primarily suing a health plan.[57] Another certified IDR entity noted that not having this type of immunity compromises the integrity of the process.

CMS officials told us they provide guidance to certified IDR entities, coordinate through regular meetings, and provide technical assistance.[58] In addition, on September 7, 2022, the departments implemented flexibilities to allow additional time for certified IDR entities to collect information to evaluate dispute eligibility.

[55]42 U.S.C. § 300gg–111(c)(5)(E)(i)(II).

[56]Representatives told us these types of protections are typical for federal external reviews, and protections are based on National Association of Insurance Commissioners model laws. In general, these protections hold independent review organizations responsible for final and binding determinations in health care, while providing immunity to the review organization with exceptions for bad faith reviews.

[57]However, in November 2023, a federal district court held that while the No Surprises Act creates a limited right to judicial review of IDR decisions, it does not create a cause of action to sue a certified IDR entity itself. See Med-Trans Corp. v. Cap. Health Plan, Inc., et al., 2023 WL 7188935 (M.D. Fla. Nov. 1, 2023).

[58]See Department of Health and Human Services, Department of Labor, The Department of the Treasury, *Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities* (Washington, D.C.: August 2022).

Federal Agency Oversight of the IDR Process is Driven by Response to Submitted Complaints; Stakeholders Expressed Concerns with Oversight

CMS and DOL Oversight Generally Consists of Responding to Submitted Complaints

CMS and DOL oversee the IDR process through complaint reviews and market conduct examinations.

CMS Oversight

CMS oversight of compliance with the IDR process is focused on certified IDR entities, non-federal governmental plans, and issuers and providers in states where the agency has enforcement authority with respect to the IDR provisions. The agency conducts oversight through investigations of complaints and market conduct examinations, including audits of issuers' QPAs.

Complaint reviews. CMS manages a No Surprises help desk that receives and triages complaints related to the No Surprises Act, including those concerning the federal IDR process. The help desk may receive complaints about providers, issuers, or certified IDR entities. Officials said that when a complaint is received, the help desk reviews the complaint to determine whether CMS, another federal agency, or a state insurance regulator has jurisdiction over the complaint. CMS then refers the complaint to the appropriate entity if it is not under its jurisdiction or directs the complainant to submit the complaint to the relevant state department of insurance.

CMS officials told us that when they receive a complaint related to the IDR process that is within the agency's jurisdiction, they work to establish the factual accuracy of the complaint and may reach out to the complainant to obtain additional documentation or clarification. If CMS

determines that a party is non-compliant with the IDR process regulations, the agency could require corrective actions or issue a civil monetary penalty against the party, according to CMS officials. For instance, in the case of failure to make a payment following an adverse payment determination, the agency would require the issuer to pay the provider the determined award amount. According to CMS officials, as of May 2023, the agency had not issued any civil monetary penalties. Agency officials told us that they usually try to use enforcement mechanisms, such as corrective action plans, before moving to civil monetary penalties in cases of new programs.

Officials said that complaints against issuers and plans are usually due to a failure to make a payment within 30 calendar days after an IDR payment determination has been made, as noted above. They also said that complaints against IDR entities are generally regarding challenges to eligibility decisions, challenges to final payment determinations, and failure to respond to or adhere to deadlines.

CMS officials told us that as of May 2023, the agency had received 281 complaints against certified IDR entities and 115 complaints against issuers or providers within the agency's jurisdiction.[59] CMS officials told us that 186 of the 281 complaints against certified IDR entities have been closed, and 46 of the 115 complaints against plans and issuers have been closed. The outstanding complaints remain under investigation. CMS officials said that in April 2023, the agency had closed 40 complaints that were made against a plan or issuer under CMS's jurisdiction. Of those 40 closed complaints, CMS determined that the issuer had not made a required payment in 30 cases and CMS made the issuer pay the providers in these instances.

Market conduct examinations. CMS officials told us that they may also conduct market conduct examinations to examine a broader set of requirements for a particular party under CMS's enforcement authority that may result from an IDR process complaint investigation. CMS's market conduct examinations are in depth reviews of plans' and issuers' compliance with state and federal health insurance laws and regulations. According to officials, CMS only conducts market conduct examinations

[59]Officials said that the number of total complaints regarding the IDR process is higher, because these figures do not include the number of complaints that other federal agencies or state regulators have received. For example, CMS officials told us the departments received 3,400 complaints regarding late payment issues and 3,200 of those complaints were referred to the Department of Labor.

of issuers' lines of business for which the agency has jurisdiction and for requirements over which CMS has authority. Issuers can have several different lines of business. For example, CMS can conduct market conduct examinations on fully insured individual and group market health insurance coverage in a state in which CMS has authority over an issuer. The market conduct examination on an issuer would not include an issuer's other lines of business for which CMS does not have authority, such as plans under DOL's enforcement authority including self-funded employer-sponsored plans. In addition, CMS can conduct market conduct examinations for non-federal governmental plans because the agency has jurisdiction over those types of plans.

CMS officials told us they are conducting QPA audits as part of their market conduct examinations. QPA audits are intended to determine whether issuers and plans are in compliance with QPA calculation methodology. Officials said these audits are based on complaints, information from other agencies, and any other relevant information. They said the audits include an in-depth investigation of information such as an issuer's data pertaining to the QPA calculation, required disclosures, internal documents, and a narrative of an issuer's QPA methodology. According to CMS officials, the agency has initiated 23 QPA audits—all of which were initiated through complaints and are ongoing as of July 2023. CMS plans to publicly release the audit reports once they are completed.

DOL Oversight

DOL officials told us the department oversees compliance with the IDR process through reviews of complaints received for employer-sponsored group plans under its jurisdiction.

Complaint reviews. According to DOL officials, when the department receives a complaint, a benefits advisor reviews the complaint and may reach out to the group health plan or provider for additional information. The benefits advisor asks the group health plan to make a payment to a provider or to explain why the plan does not think it owes a payment. When warranted by the evidence, the benefits advisor works with the group health plan to get voluntary compliance, which may, for example, result in a payment to a provider that had not been paid according to the IDR time frames.

DOL officials told us they could not report the exact number of complaints the department received related to the IDR process, because the department's tracking system does not track IDR process complaints specifically. Rather, it includes all types of complaints related to the No

Surprises Act.[60] The officials said that as of August 2023, DOL had received 12,585 complaints related to the No Surprises Act; 11,485 of those complaints had been closed.[61]

Stakeholders Expressed Concern with IDR Process Complaint Response

Representatives from the selected initiating parties and stakeholder groups we interviewed expressed concern with the lack of response to submitted complaints.

All five initiating parties and four stakeholder groups we interviewed told us they receive little to no response when submitting complaints to CMS regarding the IDR process. For example, one initiating party said that its only course of action when encountering problems with the IDR process is to submit complaints to the No Surprises help desk. However, the party was requesting help so often as a result of the issues it was experiencing that CMS discouraged it from continuing to contact the help desk. The party said it also lessened the number of complaints it submits because it had not seen a resolution on any submitted complaints.

Furthermore, one initiating party and two stakeholder groups said that it is not always clear which entity should receive their complaint. For example, one stakeholder group said a member submitted a complaint to CMS regarding a lack of payment after a payment determination was made on a dispute. The group waited months for a response and then CMS directed the complainant to their state department of insurance for assistance. However, the state department of insurance did not have any information on enforcement of the IDR process.

CMS officials told us that the biggest challenge the agency has faced in responding to complaints is the high complaint volume, which they said they underestimated. The officials also said that some complaints are about numerous disputes. The officials said that because the IDR process is new there have been many inquiries to manage and they can be complex and time-consuming to sort through and address. Three stakeholder groups we interviewed noted that the IDR process is new and will take time to settle. For example, one stakeholder group told us that over time they expect enforcement authority to be better understood by all

[60]For example, DOL officials told us that they received complaints regarding group health plans not making a payment or denial of payment within 30 calendar days of a claim submission.

[61]DOL officials told us that, as of September 2023, benefits advisors closed 484 complaints related to the No Surprises Act resulting in over $6 million in payments made by plans.

stakeholders as has happened with other insurance market reforms in the past.

CMS officials told us that they coordinate with other federal agencies to ensure consistency in interpreting and enforcing provisions of the No Surprises Act. For example, CMS, DOL, Treasury, and the Office of Personnel Management hold weekly coordination meetings to discuss the IDR process implementation and enforcement, according to CMS and DOL officials.[62]

CMS and DOL reported limited ability to increase their enforcement efforts due to budget constraints. CMS officials told us that without a budget increase for the IDR process they do not anticipate a change in their ability to conduct audit and enforcement activities. DOL officials also said they have a fixed budget for oversight that includes much more than just the IDR process, such as mental health parity investigations and other issues with a greater direct relationship to consumers. HHS requested an increase in funding for the implementation of the No Surprises Act in its fiscal year 2024 budget request. The departments are also revisiting the administrative fee for the IDR process, which is intended to cover the cost of the process, in response to recent litigation.[63] Further, CMS officials told us they plan to issue updated IDR process rules.[64]

Agency Comments

We provided a draft of this report the HHS, DOL, and Treasury. All three departments provided technical comments, which we incorporated as appropriate.

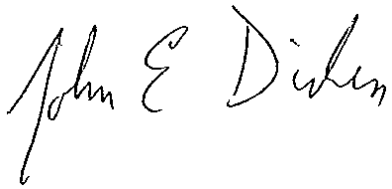
We are sending copies of this report to the Secretaries of Health and Human Services, Labor, and Treasury and other interested parties. In addition, the report will be available at no charge on GAO's website at http://www.gao.gov.

[62]The Office of Personnel Management has jurisdiction over federal employee health plans, which may have disputes go through the IDR process.

[63]The departments issued a proposed rule on September 26, 2023, related to the calculation of the administrative fee.

[64]In addition to the actions described in this report, on October 27, 2023, the departments issued a proposed rule that addresses some of these challenges. See 88 Fed. Reg. 75,744 (Nov. 3, 2023).

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at DickenJ@gao.gov. Contact points for our Office of Congressional Relations and Office of Public Affairs can be found on the last page of this report. Other major contributors to this report are listed in appendix II.



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Appendix I: Private Equity Ownership of Initiating Parties in the Federal Independent Dispute Resolution Process

Private equity is a type of private fund that generally pools money from institutional and individual investors and invests in companies that are often not publicly traded. Research has shown that private equity investment in health care has increased in recent years.[1] For example, private equity firms have invested in physician staffing companies that contract with hospitals for outsourced physicians in a variety of specialties, including those that are known for surprise billing, such as anesthesiologists and emergency physicians.[2]

To examine the ownership of initiating parties participating in the federal independent dispute resolution (IDR) process, we obtained from the Centers for Medicare & Medicaid Services (CMS) a list of the top 10 parties submitting disputes for emergency and non-emergency items and services for April 2022 through December 2022, and a list of the top 10 parties submitting disputes for air ambulance services for April 2022 through December 2022. We then identified each initiating party in the Standard and Poor's Capital IQ database. Standard and Poor's Capital IQ is a web-based platform that provides comprehensive financial data on public and private companies. We assessed the reliability of the data through a review of Standard and Poor's Capital IQ documentation, interviews with Standard and Poor's Capital IQ representatives, and comparison to third party analyses. We determined that the data were sufficiently reliable for the purposes of our report.

We reviewed each party's ownership and investors listed for any private equity firms. We classified any current private equity ownership or investment as evidence of private equity ownership for the purposes of this report. For any parties we could not identify in the database, we conducted additional web searches to identify any evidence of private equity ownership or investment.

[1]See Zhu, Jane M., Lynn M. Hua, and Daniel Polsky, "Private Equity Acquisitions of Physician Medical Groups across Specialties, 2013-2016," *JAMA* 323, no. 7 (2020): 663-665.

[2]See Adler, Loren, Conrad Milhaupt, and Samuel Valdez, "Measuring Private Equity Penetration and Consolidation in Emergency Medicine and Anesthesiology," *Health Affairs Scholar 1*, no. 1 (2023). See also Zack Cooper et al., "Out-Of-Network Billing and Negotiated Payments for Hospital-Based Physicians," *Health Affairs 39*, no. 1 (2020): 24-32; and Garmon, Christopher, and Benjamin Chartock, "One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills," *Health Affairs 36*, no. 1 (2017): 177-181.

CMS identified that the top 10 initiating parties were responsible for submitting 67 percent of disputes involving out-of-network emergency and non-emergency services as of December 31, 2022.

The top initiating parties that submitted disputes for out-of-network emergency and non-emergency items and services in the IDR process included physician groups, practice management companies, and revenue cycle management companies. A physician group is a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among its members. Practice management companies perform the administrative services of health care on behalf of providers. These companies may use a staffing model where the providers directly work for the staffing company rather than a group practice or health care facility. Revenue cycle management companies perform billing functions—such as identifying, managing, and collecting patient service revenue—on behalf of providers. In this arrangement, a health care provider or provider group would be a client of a revenue cycle management company.

We found that six of the top 10 initiating parties submitting emergency and non-emergency disputes were owned, in least in part, by private equity firms. These parties accounted for 46 percent of all out-of-network emergency and non-emergency disputes submitted in calendar year 2022. (See fig. 5.)

Figure 5: Private Equity Ownership of Top Federal Independent Dispute Resolution Process Initiating Parties for Disputes Involving Emergency and Non-Emergency Items and Services in 2022

Practice management company	Number and percent of disputes submitted in 2022	Evidence of some private equity ownership
SCP Health	59,234 (30%)	Yes
Team Health	11,826 (6%)	Yes
Envision Health	5,850 (3%)	Yes

Revenue cycle management company	Number and percent of disputes submitted in 2022	Evidence of some private equity ownership
R1 RCM	24,430 (12%)	No
Logix Health	7,083 (4%)	No
Round Table Physicians Group	6,699 (3%)	No

Physician group	Number and percent of disputes submitted in 2022	Evidence of some private equity ownership
Singleton Associates, P.A.	6,048 (3%)	Yes
Sonoran Radiology	4,693 (2%)	Yes
Providence Anesthesiology Associates, PA	4,433 (2%)	No
SpecialtyCare	4,203 (2%)	Yes

Source: GAO review of Centers for Medicare & Medicaid Services data, Standard & Poor's Capital IQ database, and additional web searches (data); GAO (icons). | GAO-24-106335

CMS found that the top 10 initiating parties were responsible for submitting 93 percent of disputes involving air ambulance services as of December 31, 2022. The top initiating parties that submitted air ambulance disputes in the IDR process included air ambulance providers, revenue cycle management companies, and health systems.

We found that five of the top 10 initiating parties submitting air ambulance disputes were owned, at least in part, by private equity firms. These private equity-owned initiating parties accounted for 66 percent of all air ambulance disputes submitted in calendar year 2022. (See fig. 6.)

Figure 6: Private Equity Ownership of Top Federal Independent Dispute Resolution Process Initiating Parties for Disputes Involved Air Ambulance Services in 2022

Air ambulance provider	Number and percent of disputes submitted in 2022	Evidence of some private equity ownership
Global Medical Response, LLC	4,188 (41%)	Yes
Air Methods	1,946 (19%)	Yes
PHI Air Medical, LLC	1,741 (17%)	No
Life Flight Network	390 (4%)	No
Apollo MedFlight	369 (4%)	Yes
Critical Care Services, Inc.	115 (1%)	Yes

Revenue cycle management company	Number and percent of disputes submitted in 2022	Evidence of some private equity ownership
Health Services Integration	257 (3%)	No
Quick Med Claims	130 (1%)	Yes

Health system	Number and percent of disputes submitted in 2022	Evidence of some private equity ownership
Intermountain Healthcare	191 (2%)	No
UPMC	142 (1%)	No

Source: GAO review of Centers for Medicare & Medicaid Services data and Standard & Poor's Capital IQ database (data); anatolir/adobe.stock.com (helicopter); GAO (icons). | GAO-24-106335

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7114 or DickenJ@gao.gov

Staff Acknowledgments

In addition to the contact named above, Lori Achman (Assistant Director), Alison Granger (Analyst-in-Charge), and Elaina Stephenson made key contributions to this report. Deborah Healy, Suhna Lee, Stephanie Lola, Drew Long, Roxanna Sun, and Emily Wilson Schwark also made important contributions.

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