MODEL POLICY BRIEF

Benchmarks Should Be Named for What They Measure

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

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

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RECOMMENDED ACTION

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

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

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

Executive Summary

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

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

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

THE POLICY LESSON

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

Recommended standard

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

1. The Payment-Construct Problem

Different numbers answer different questions

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

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

Why construct confusion matters

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

Patient protection and payment analysis are separate

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

2. Federal Structure and Current Data

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

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

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

CMS public-use files create a transparency opportunity

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

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

The system is large and still evolving

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

CURRENT-LAW CAUTION

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

3. The Adjudicated Rate Index

Definition

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

FORMULA

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

Study domain

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

Principal findings

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

What the study did not establish

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

4. Policy Proposal: Construct-Separation Standard

Principle one: label the construct

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

Principle two: disclose the measurement specification

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

Principle three: preserve construct boundaries

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

Principle four: make correction visible

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

Principle five: require domain specificity

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

5. ARI Reporting Specification

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

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

Recommended companion displays

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

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

MANDATORY LEGEND

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

6. Model Legislative and Administrative Framework

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

Payment Benchmark Transparency and Construct-Separation Act

Section 1. Purpose

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

Section 2. Definitions

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

Section 3. Public reporting requirements

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

Section 4. Federal IDR transparency

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

Section 5. ARI use boundary

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

Section 6. Data-quality program

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

Section 7. Research and evaluation

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

Section 8. Patient safeguard

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

Section 9. Preemption and state use

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

Section 10. Effective date and review

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

7. Implementation Roadmap

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

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

Performance measures

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

8. Safeguards Against Misuse

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

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

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

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

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

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

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

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

9. Common Objections and Responses

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

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

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

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

"The large multiples prove that QPA is wrong."

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

"The selected payment is the fair market rate."

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

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

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

"More reporting will burden an already overloaded system."

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

"Publishing divergence will encourage inflated offers."

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

10. Evidence Boundaries and Research Agenda

What the published study supports

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

What remains uncertain

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

Priority research program

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

11. Decision Checklist for Policymakers

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

12. Recommended Action

ADOPT THE PRINCIPLE

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

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

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

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

References and Source Notes

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

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

Document status and use

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

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Name Benchmarks for What They Measure

Adjudicated Rate Index | Payment-benchmark transparency and construct separation

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

THE ISSUE

In brief. Healthcare-payment debates often place unlike dollar constructs side by side: billed charge, contracted rate, Medicare payment, Qualifying Payment Amount (QPA), party offer, agreed amount, and selected IDR payment. They may be related, but they arise from different methods and answer different questions. Calling each one a “rate” or “market value” creates false equivalence.

WHY IT MATTERS

- The No Surprises Act gives QPA a defined legal role; an out-of-network payment can arise through agreement or IDR.
- Policy analysis becomes unstable when one construct silently borrows the meaning of another.
- Public-use data are valuable only when cohort, version, missingness, selection, and distribution are visible.

POLICY DIRECTION

- Label every payment construct explicitly and disclose numerator, denominator, unit, cohort, geography, period, exclusions, and data version.
- Report distributions, sample size, subgroup results, correction history, and known missingness—not only a headline multiple.
- Preserve the statutory role of QPA and prohibit use of ARI as an individual payment formula or substitute benchmark.
- Replicate across procedures, specialties, regions, payers, years, and data sources before generalizing.

WHAT THE ARTICLE OR FRAMEWORK CONTRIBUTES

Contribution. ARI is the cohort median of case-level selected-payment-to-reported-QPA multiples. In CMS federal IDR data for complex repair codes (2023 Q1–2025 Q2), the median was 22.41× among analytic cases and 28.73× in provider/facility-prevailing cases; plan-prevailing disputes clustered near QPA parity. The study supports descriptive separation within that domain.

EVIDENTIARY BOUNDARY

Do not overread it. ARI does not prove that QPA was wrong, that a selected payment was correct, that either multiple should be paid elsewhere, or that the findings generalize beyond the studied code family and dataset. It does not predict an individual IDR outcome.

BOTTOM LINE **Before comparing healthcare-payment numbers, require each measure to identify exactly what it is—and what it cannot establish.**

Source foundation: Benchmark-Outcome Separation in Federal Independent Dispute Resolution (Cureus, 2026) | PMID 42306020 | doi:10.7759/cureus.110912

Follow the Cuts

Aligning Healthcare Cost Policy With Economic Control

Prepared for members of Congress, legislative staff, regulators, and physician organizations

> **Core principle.** Economic attribution should precede economic regulation. Before assigning blame or imposing another payment cut, Congress should identify who set the price, who constructed the benchmark, who adjudicated the claim, who owned the entity that was paid, and who retained the revenue.

Executive Summary

Federal healthcare policy often treats the physician as the principal cost driver because the physician is visible: the physician orders the test, performs the procedure, prescribes the drug, and signs the claim. Visibility, however, is not economic control. Physicians frequently do not set the product price, the facility charge, the insurance premium, the network benchmark, the claims-payment rule, or the final destination of the revenue.

The **Scrutiny–Control Inversion** names the resulting policy error: economic scrutiny and cost containment are directed toward the actor most visible at the point of care rather than toward the actors exercising the greatest control over price formation, payment methodology, market access, claims adjudication, ownership, and revenue capture.

What the record shows	Source
Medicare physician fee updates rose ~14% (2000–2023) while practice-cost inflation (MEI) rose ~52%; through 2024, ~14% vs. ~56%.	MedPAC, June 2025 Report to Congress; 2026 update
The conversion factor fell from $38.26 (2001) to $33.40 (2026)—below its 2001 nominal level, and roughly 47% of its 2001 purchasing power after inflation.	CMS final rules; AMA conversion-factor history
Medicare Advantage payments ran an estimated $84B (2025) and $76B (2026) above traditional-Medicare equivalence—approaching the ~$92B paid annually under the entire physician fee schedule.	MedPAC, March 2025 and March 2026 reports
U.S. prescription-drug prices were 278% of prices in 33 peer countries; brand-originator gross prices were 422%.	RAND, 2024 (2022 data)
13% of audited Medicare Advantage prior-authorization denials and 18% of payment denials met the governing Medicare rules; Marketplace insurers denied 20% of in-network claims, and fewer than 1% were appealed.	HHS OIG, 2022; KFF, 2025
In the same rule cycle, CMS titled its physician rule around cutting “spending waste” while framing a 5.06% Medicare Advantage payment increase through access, affordability, and stability.	CMS newsroom, 2025–2026

Why this matters. If Congress attributes healthcare costs to the wrong economic actor, the consequences compound: physician shortages may worsen as real reimbursement falls; independent practices may disappear into hospital, private-equity, and insurer ownership; market concentration may increase; patients may pay more despite repeated physician payment cuts; and future legislation may miss the true drivers of spending entirely. Twenty-five years of physician unit-price compression have coincided with rising total costs—evidence that cutting the most visible price is not the same as containing the cost.

The Legislative Problem

Congressional cost debates routinely collapse distinct economic functions into a single label. The physician who initiates care is treated as though the physician also determined the price, controlled payment, and retained the revenue. Three recurrent errors follow.

Error	What Congress often sees	What must also be measured
Clinical initiation treated as economic causation	The physician ordered or performed the service.	Who set the drug, device, facility, or benchmark price attached to the episode?
"Provider spending" treated as physician income	The expenditure is coded as clinical or physician spending.	Who owned the practice—hospital, private equity, or the insurer itself—and retained the payment?
Outlier treated as profession-wide pattern	A dramatic charge, award, or denial appears in a report.	The denominator, payment distribution, ownership, and concentration among repeat corporate entities.

Evidence From the Three Ledgers

Ledger I — Who receives the cuts?

Physician payment is governed by a broad, annual, automatic, and inflation-insensitive architecture: budget neutrality, sub-inflation statutory updates, sequestration, recurring valuation changes, and—beginning in 2026—a recurring −2.5% "efficiency adjustment." Congressional relief is temporary and must be reenacted; the reduced baseline persists when it lapses. The major corporate-sector restrictions examined in the underlying analysis were more often selective, phased, suspended, repealed, or offset by payment growth: the medical-device excise tax and the health-insurer fee were both repealed, and Medicare drug negotiation—real and expanding—began only in 2026 with 10 products.

Ledger II — Who controls and captures the money?

Economic control lies in price setting, benchmark construction, prior authorization, claims editing, out-of-network repricing, payment timing, ownership, and retained revenue. A physician may decide that care is clinically necessary while manufacturers set product prices, insurers construct benchmarks and adjudicate payment, hospitals set facility economics, and vertically integrated corporations pay—and retain—revenue within their own walls. Payment recorded as "physician spending" is increasingly captured by insurer-, hospital-, and private-equity-owned entities.

Claims adjudication is price formation. The physician may complete a necessary service, but the insurer can still determine whether it was authorized, how it is coded, whether it is repriced, what documentation is accepted, whether a denial is reversed, and when payment occurs. The realized price of care is set at adjudication, not at the fee schedule.

Ledger III — Who receives the blame?

Official language can amplify the inversion. In matched CMS communications from the same policy period, physician payment was linked to waste, efficiency, and overvaluation; insurer payment was linked to access, stability, affordability, and sustainability; and pharmaceutical restraint was paired, in the headline itself, with innovation and certainty.

What the Evidence Does — and Does Not — Establish

Established or strongly supported	Not established
Long-standing real compression of Medicare physician unit prices. Substantial payer control over claims adjudication and realized payment. Large international product-price dispersion for identical products. Matched official-language asymmetry in the communications examined.	A coordinated campaign against physicians. That lobbying expenditures purchased specific votes. That every insurer denial or repricing decision is improper. That physician utilization and billing never contribute to spending.

This candor is deliberate: the framework classifies its own claims so that policy built on it rests only on what the record supports.

> **What this brief does not argue.** This brief does not argue that physicians never contribute to healthcare spending; that insurers, manufacturers, or device makers should be free of regulation; or that every denial or repricing decision is improper. It argues one thing: economic responsibility should be assigned according to measurable economic control. That is a governance principle, not a position for or against regulation.

Recommended Congressional Actions

1. Require economic attribution before cost containment. Every major healthcare cost proposal should identify who created the clinical need, who selected the service, who set the unit price, who constructed the benchmark, who adjudicated payment, who owned the receiving entity, and who retained the revenue.

2. Separate physicians from corporate medical entities. Federal reports should distinguish independent practices, hospital-owned groups, insurer-owned medical groups, private-equity-backed staffing organizations, management-services organizations, and revenue-cycle or arbitration firms. The single term “provider” is economically inadequate.

3. Require denominator and ownership disclosure. Reports describing outliers should disclose the number of entities involved, total eligible claims, distributional data, actual payment rather than billed charges, ownership, and concentration among repeat organizations.

4. Require benchmark provenance. Any benchmark used in legislation, regulation, or public reporting should be labeled as government-administered, insurer-calculated, contract-derived, charge-based, cost-based, survey-based, or adjudicated. An insurer-derived qualifying payment amount should not be presented as an independent market price.

5. Apply parallel economic language across sectors. If above-benchmark physician payments are called waste or overpayment, modeled insurer payments above fee-for-service equivalence should be described in comparable economic terms, with equivalent methodological caveats.

6. Create claims-management transparency and appeal accountability. Require reporting of denial, downcoding, repricing, reversal, appeal, and payment-delay rates; disclosure of automated and third-party repricing systems; and disclosure of compensation arrangements tied to claimed savings. Audit whether insurer-affiliated and independent practices are treated differently.

7. Index physician payment to practice-cost inflation. An administered national fee schedule that predictably trails practice-cost growth produces an automatic real cut. Permanent inflation-sensitive updates would force any intended real reduction to be made explicitly.

8. Evaluate international net-price comparison for globally marketed products. Direct a study of verified net prices for identical drugs and device models across comparable high-income countries—adjusting for rebates, volume, taxes, distribution, bundled services, and launch behavior—before any federal reference framework is designed.

Questions for Congressional Hearings

1. Who controls the benchmark used in this proposal, and can an independent auditor reproduce it?

2. What percentage of the total episode cost is professional physician payment?

3. Is the entity described as a "provider" an independent physician, a hospital, a private-equity-backed group, or an insurer-owned practice?

4. What are the denial, downcoding, repricing, reversal, and payment-delay rates for this payer or program?

5. Does the proposed cost control operate automatically each year, and is it indexed to input-cost inflation?

6. What restrictions on insurers, manufacturers, or device makers were delayed, narrowed, suspended, repealed, or offset during the same period?

7. Are outlier claims reported with denominators, medians, distributions, ownership, and concentration among repeat entities?

8. Who retains the revenue after the claim is paid?

Model Legislative Principles

> **Suggested statutory finding.** Congress finds that clinical initiation, price formation, claims adjudication, ownership, and revenue retention are distinct economic functions. Federal cost-containment policy should identify and measure the entity controlling each function before assigning responsibility or modifying payment.

> **Suggested reporting requirement.** Any federal report characterizing a healthcare sector as a cost driver should disclose benchmark provenance, ownership of the paid entity, actual payment distributions, professional payment as a share of total episode spending, and the economic actor capable of changing the price or retained revenue.

Implementation Path

1. Direct GAO or MedPAC to complete a dual-coded federal cost-containment census across physicians, insurers, pharmaceutical manufacturers, and device makers (2001–present).

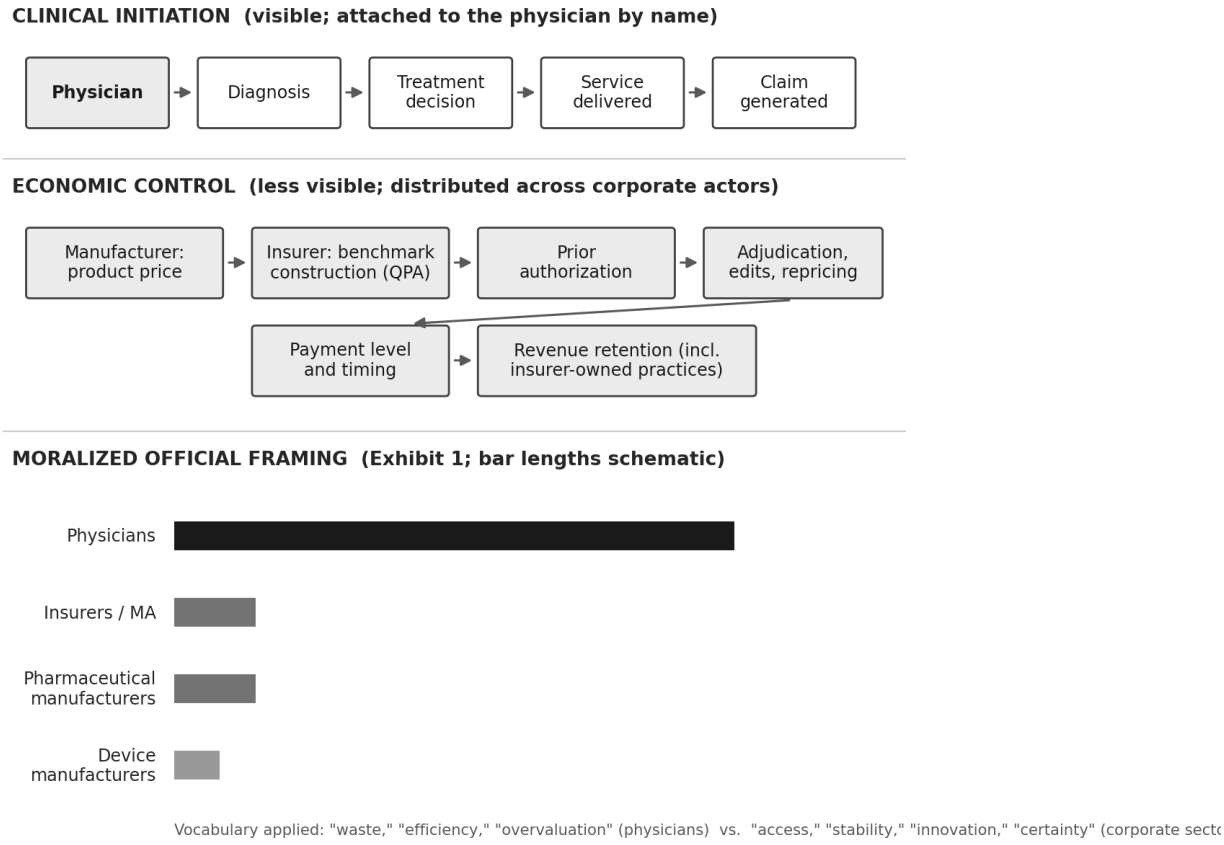
2. Require CMS to publish standardized claims-denial, downcoding, repricing, appeal, reversal, and payment-timing datasets.

3. Commission an international matched-product net-price audit for drugs and devices.

4. Require ownership-specific reporting for insurer-, hospital-, and private-equity-owned medical groups.

5. Apply the Scrutiny–Control framework prospectively to pending legislation and report whether the containment burden follows measurable economic control.

The Framework at a Glance



Upper panel: the visible clinical pathway. Middle panel: the less visible chain of economic control. Lower panel: the asymmetry of moralized official framing (bar lengths schematic). Adapted from the source manuscript, Figure 3.

Selected Evidence

1. MedPAC: Report to the Congress: Medicare and the Health Care Delivery System, Ch. 1 (physician fee schedule updates). June 2025; physician-adequacy update, 2026.
2. CMS: CY 2026 Physician Fee Schedule final rule (CMS-1832-F); CY 2026 Medicare Advantage and Part D Rate Announcement.
3. MedPAC: Report to the Congress: Medicare Payment Policy. March 2025; March 2026 update (Medicare Advantage payment estimates).
4. Mulcahy AW, Schwam D, Lovejoy SL: International Prescription Drug Price Comparisons: Estimates Using 2022 Data. RAND; 2024.
5. Arnold DR, Fulton BD: UnitedHealthcare pays Optum providers more than non-Optum providers. Health Aff. 2025;44:1395-1403.
6. HHS Office of Inspector General: Medicare Advantage prior-authorization denial audit (OEI-09-18-00260). 2022.
7. Lo J, Long M, Wallace R, Salaga M, Pestaina K: Claims Denials and Appeals in ACA Marketplace Plans in 2023. KFF; 2025.
8. Duffy EL, et al.: No Surprises Act independent dispute resolution outcomes for emergency services. Health Aff Sch. 2024;2:qxae132.
9. Wouters OJ: Lobbying expenditures and campaign contributions by the pharmaceutical and health product industry, 1999–2018. JAMA Intern Med. 2020;180:688-697.

Prepared from: Klapper AM. Follow the Cuts: The Scrutiny–Control Inversion in American Healthcare, 2001–2026 (manuscript submitted for publication). This brief is for legislative education; views expressed are those of the author.

FOLLOW THE CUTS

One-Page Congressional Brief: Align Healthcare Cost Policy With Economic Control

THE PROBLEM. Congress attributes cost to the physician who orders or delivers care—even when manufacturers set product prices, insurers construct benchmarks and adjudicate claims, hospitals set facility economics, and corporations own the practice and retain the revenue. Visibility is not economic control.

WHAT THE EVIDENCE SHOWS	THE CORRECTION
• Physician fee updates rose ~14% while practice-cost inflation rose ~52–56% (MedPAC). • The 2026 conversion factor ($33.40) sits below its 2001 nominal value ($38.26). • Modeled MA excess payments—$84B (2025), $76B (2026)—approach the entire ~$92B physician fee schedule. • U.S. drug prices: 278% of 33 peer countries; brand-originator gross prices 422% (RAND). • 13% of audited MA prior-authorization denials met Medicare rules (OIG); Marketplace insurers denied 20% of in-network claims, <1% appealed (KFF). • CMS framed physician policy as "waste/efficiency" but insurer and drug policy as "access/stability/innovation"—in the same rule cycle.	• Require economic attribution before imposing cost containment. • Separate independent physicians from hospitals, private equity, and insurer-owned groups. • Require denominator, ownership, and actual-payment disclosure when citing outliers. • Label benchmark provenance; an insurer-calculated QPA is not an independent market price. • Publish denial, downcoding, repricing, reversal, appeal, and payment-delay data. • Index physician payment to practice-cost inflation. • Evaluate verified international net prices for identical drugs and devices.

THE FRAMEWORK: THE SCRUTINY–CONTROL INVERSION

Economic scrutiny and cost containment are directed toward the actor most visible at the point of care rather than toward the actors controlling price formation, payment methodology, market access, claims adjudication, ownership, and revenue capture.

Before Congress cuts payment, ask: Who set the price? Who built the benchmark? Who adjudicated the claim? Who owned the recipient? Who kept the money?

Clinical initiation is not economic control. | Visibility is not economic control.

Source framework: Klapper AM. Follow the Cuts: The Scrutiny–Control Inversion in American Healthcare, 2001–2026 (manuscript submitted for publication). Key sources: MedPAC 2025–2026; CMS CY2026 rules; RAND 2024; HHS OIG 2022; KFF 2025. Prepared for legislative education; views are those of the author.

Visibility Is Not Control

Construct integrity and operative accountability in reimbursement, access, and cost policy

A number can be precise and still answer the wrong question. Visibility identifies where a problem appears; it does not establish who controlled it.

THE ISSUE

In brief. A physician fee, facility payment, Medicare rate, commercial contracted rate, QPA, billed charge, adjudicated payment, and total episode expenditure all use dollars, but they are different constructs. Policy also tends to blame the actor visible to the patient even when authority, data, staffing, network design, financial exposure, and bedside risk are distributed across physicians, payers, hospitals, owners, administrators, regulators, and statutes.

WHY IT MATTERS

- Construct drift can turn exact arithmetic into an unsupported policy inference.
- Directory enrollment does not prove appointment, emergency-call, transfer, complex-case, after-hours, or continuity capacity.
- A lower index payment is not automatically a lower episode or system expenditure.

POLICY DIRECTION

- Require a Construct and Control Statement for material public reimbursement, network, access, savings, and adjudication analyses.
- Identify source, construction, intended purpose, context fit, interpretive boundary, denominator, and uncertainty.
- Map authority, visibility, financial exposure, data control, bedside risk, and visible accountability for the disputed variable.
- Measure functional specialist availability and separate index savings from downstream episode and system effects.

WHAT THE ARTICLE OR FRAMEWORK CONTRIBUTES

Contribution. The article offers a five-filter construct-separation test, a six-question variable-attribution test, and a functional specialist-availability framework. Together they create a disciplined sequence: identify the visible measure, classify it, test its boundary, map operative control, and state whether the inference is supported or needs more evidence.

EVIDENTIARY BOUNDARY

Do not overread it. The framework is conceptual and hypothesis-generating. It does not set reimbursement, validate charges, invalidate Medicare or QPA methodology, prove access harm, establish savings, or assign legal liability. Reliability and policy impact still require testing.

BOTTOM LINE **Public policy should not assign value, savings, access, or accountability until it has defined the construct and mapped operative control.**

Source foundation: Visibility Is Not Control (prepublication technical report dated July 7, 2026; final citation and DOI to be confirmed)

MODEL POLICY BRIEF

Visibility Is Not Control

A construct-integrity and operative-accountability standard for reimbursement, access, and cost-containment policy

Prepared for: Congress, HHS and CMS, state legislatures and insurance regulators, Medicaid agencies, IDR entities, hospitals, health plans, specialty societies, researchers, and public oversight bodies

Prepared by: Healthcare Governance

Related technical report: Visibility Is Not Control: Construct Separation and Variable Attribution in Surgical Reimbursement Policy, by Andrew M. Klapper, Anthony N. Dardano, Michael Risin, Karla Maita, and Monali Mahedia

Source status: Prepublication PDF dated July 7, 2026; final journal citation and DOI to be confirmed

Version: Draft 1.0

Date: July 13, 2026

Status: Policy position informed by a conceptual technical report, official data, regulation, and published research; not itself a peer-reviewed publication, payment standard, or legal opinion

RECOMMENDED ACTION

Require a Construct and Control Statement before a public body relies on a reimbursement figure, network measure, adjudicated outcome, or savings estimate to claim value, adequacy, fairness, or accountability. The statement should identify what the measure is, how it was built, what it omits, and who controlled the operative variables.

> **A number can be precise and still answer the wrong question. Visibility identifies where a problem appears; it does not establish who controlled it.**

This proposal does not set reimbursement, validate billed charges, invalidate Medicare or QPA methodology, prove access harm, or assign legal liability. It creates a measurement discipline that should precede those judgments.

Executive Summary

Healthcare reimbursement policy frequently compares figures that share a dollar sign but do not share a construct. A physician professional fee, facility payment, Medicare Physician Fee Schedule rate, commercial contracted rate, qualifying payment amount, billed charge, adjudicated payment, and total episode expenditure are related economic objects, but they differ in provenance, construction, purpose, and interpretive boundary. Treating one as a proxy for another creates construct drift: the arithmetic may remain exact while the inference becomes unstable. [1-5]

A second error is attribution drift. Patients and policymakers often see a physician, a bill, or an unavailable specialist. The controlling variables may instead be distributed among a physician, payer, hospital, corporate owner, regulator, claims administrator, or statutory framework. Physicians also control clinically important variables, including treatment selection, documentation, code assignment, timing, and case acceptance. Accountability should follow operative control, not visibility or organizational preference. [1]

The supplied technical report proposes three operational tools: a five-filter construct-separation test, a six-question variable-attribution test, and a functional specialist-availability framework that distinguishes directory enrollment from actual appointment, emergency, transfer, complex-case, after-hours, and continuity capacity. The paper is conceptual and hypothesis-generating; it does not provide a validated causal or payment model. [1]

Recommended policy

Congress, HHS/CMS, state legislatures, regulators, Medicaid agencies, and public oversight bodies should adopt a modular Construct Integrity and Variable Attribution Standard for significant reimbursement, access, network, and cost-containment analyses. At minimum, the standard should require:

- Construct identity: name the economic or access object being cited rather than using a generic label such as price, rate, cost, market value, access, or savings.
- Source and construction: disclose who generated the measure, the data source, time period, population, geography, exclusions, calculation method, and selection process.
- Purpose and boundary: state what the measure was designed to administer or describe and what cannot validly be inferred from it.
- Denominator discipline: separate physician professional reimbursement, facility revenue, insurer administration, pharmaceuticals, intermediaries, corporate overhead, and downstream episode spending before assigning responsibility for cost growth or savings.
- Context fit: identify whether urgency, complexity, site, case mix, geography, and clinically material variables are represented.
- Control mapping: identify authority, visibility, financial exposure, data control, bedside risk, and visible accountability for each disputed variable.
- Functional access: supplement directory counts with operational measures when policy claims concern real specialist availability.
- Outcome scope: treat adjudicated payments and completed disputes as selected observations unless generalizability is established.
- Savings validation: distinguish a reduction in an index payment from a reduction in total episode or system expenditure.

- Uncertainty and symmetry: disclose missing data, alternative interpretations, and apply the same standard to provider, payer, hospital, corporate, and governmental claims.

CORE POLICY JUDGMENT

Before government acts on a number, it should establish that the number measures the question being asked and that accountability is assigned to the actor or structure that controlled the operative variable.

1. The Policy Problem

Same unit does not mean same construct

Dollar-denominated figures are easy to compare because they share a unit. That convenience can obscure differences in source, method, purpose, and boundary. Medicare rates administer a federal benefit under statutory and budgetary rules. QPA is generally an issuer-calculated median contracted-rate benchmark under the No Surprises Act framework. A billed charge is a provider request. An adjudicated payment is an outcome of a specified dispute process. Total episode expenditure aggregates downstream utilization. None automatically establishes the others. [1,4-7]

Visible figure	What it can describe	Unsupported substitution to avoid
Physician professional fee	Professional work, judgment, liability exposure, availability, follow-up, and practice infrastructure.	Total encounter spending, facility overhead, or physician take-home income.
Facility payment	Site infrastructure, nursing, equipment, space, and facility overhead.	Physician professional work unless separately enumerated.
MPFS rate	Medicare payment under a federal administrative fee schedule.	Universal commercial market value or complete case-specific complexity.
QPA	A statutory and regulatory contracted-rate benchmark used in No Surprises Act administration.	Independent fair value, total episode cost, or proof of functional access.
Billed charge	The provider's stated requested amount.	Reasonable payment or clinical value without independent support.
Adjudicated payment	A case-specific result produced by a defined dispute process.	Universal entitlement, price standard, or prediction for another dispute.

Visible figure	What it can describe	Unsupported substitution to avoid
Total episode expenditure	Aggregate downstream spending across a care trajectory.	Professional-fee adequacy unless the components are decomposed.

Visibility does not establish control

The actor closest to the patient often absorbs visible accountability. The physician appears on the bill and at the bedside; the hospital receives the transfer; the insurer appears on an explanation of benefits. Yet network architecture, benchmark construction, authorization rules, staffing, ownership structure, claims timing, coding, documentation, treatment selection, and adjudication rules may be controlled by different parties. Accurate policy should map variables before assigning blame or credit.

Directory presence is not functional access

A directory listing can establish contractual presence. It does not establish that a specialist accepts new patients, participates in emergency call, takes complex transfers, manages salvage cases, offers after-hours coverage, or maintains post-operative continuity. A count is not a capability. Network-adequacy claims should therefore specify which access construct is being measured. [1,8-10]

A lower index payment is not automatically a system saving

Reducing one visible fee may reduce spending at that line item. It does not establish lower total expenditure if the policy changes site of service, consolidation, availability, transfer burden, delay, reoperation, or downstream utilization. Any savings claim should identify its time horizon and cost components rather than extrapolate from the most visible transaction. [1,11-13]

2. The Visibility-Control Framework

Five-filter construct-separation test

Filter	Required question	Minimum disclosure
1. Source and provenance	Who generated the number, and from what data?	Originator, dataset, dates, population, geography, exclusions, and version.
2. Construction method	How was it calculated, selected, negotiated, or adjudicated?	Formula or process, weighting, inflation, sampling, exclusions, and validation.
3. Intended purpose	What was it designed to measure or administer?	Statutory, contractual, operational, descriptive, or research purpose.

Filter	Required question	Minimum disclosure
4. Context fit	Does it reflect the urgency, complexity, market, and care environment at issue?	Documented variables represented, omitted, or proxied.
5. Interpretive boundary	What should not be inferred from it?	Explicit nonclaims and conditions requiring additional evidence.

Six-question variable-attribution test

Question	Analytic function
Who had authority?	Identify who could approve, deny, delay, contract, benchmark, process, staff, or restrict the service.
Who had visibility?	Identify who the patient or policymaker saw, whether or not that party controlled the outcome.
Who had financial exposure?	Identify who bore direct or shifted consequences of delay, denial, underpayment, complication, or utilization.
Who controlled the data?	Identify who held claims, contracted-rate, denial, authorization, staffing, directory, or adjudication data.
Who carried bedside risk?	Identify who bore immediate clinical, ethical, reputational, liability, or professional risk when care was needed.
Who absorbed visible accountability?	Identify who became the face of the dispute and test whether that visibility tracked operative control.

Five-stage inference sequence

1. Identify the visible dollar figure, access claim, or savings assertion.
2. Name and classify the construct using the five filters.
3. Test its boundary and determine whether the policy question requires additional constructs.
4. Map operative control using the six attribution questions.
5. Classify the inference as supported, unsupported, or requiring additional evidence.

VALIDITY GATE

No policy inference should pass merely because the number is official, precise, familiar, or visible. It must fit the question and remain within its interpretive boundary.

Functional specialist availability

Dimension	Operational question	Directory-only failure
Appointment access	Can a new patient obtain timely evaluation?	Listed clinician is closed to new patients or has extended waits.
Emergency call	Is the specialist available for urgent after-hours intervention?	Network enrollment exists without call participation.
Complex or revision cases	Will the specialist accept high-acuity, revision, or salvage cases?	Listed practice limits care to lower-acuity elective cases.
Transfer acceptance	Are transfers accepted from hospitals or emergency departments?	Nominal capacity does not accept transfer workload.
After-hours coverage	Is capability available outside routine business hours?	Patients are redirected without specialty response.
Vulnerable-population capability	Does the network have pediatric, geriatric, or salvage expertise?	General specialty listing is treated as subspecialty capacity.
Continuity	Does responsibility persist through recovery and complications?	Care fragments across employment or corporate structures.

3. Current Policy Environment

Existing federal and state systems already recognize that purpose, methodology, and access matter. The proposed standard does not replace those systems. It supplies a common disclosure and inference discipline across them.

Policy domain	Existing construct	Boundary requiring explicit treatment
National expenditure reporting	CMS National Health Expenditure Accounts classify spending by service and payer.	The physician-and-clinical-services category is broader than physician professional fees; gross spending is not take-home income. [2,3]

Policy domain	Existing construct	Boundary requiring explicit treatment
Medicare payment	MPFS uses relative value units, a conversion factor, geographic adjustment, statutory updates, and budgetary rules.	Administrative payment adequacy and updates do not automatically establish commercial value or case-specific complexity. [11]
No Surprises Act	QPA is a legally important benchmark in cost sharing and federal dispute administration.	Legal relevance should not be recast as proof of independent market value, access, or total episode cost. [4-7]
Federal IDR	Certified entities resolve eligible out-of-network disputes; CMS publishes aggregate process and outcome data.	Completed disputes are selected observations produced by statutory, evidentiary, timing, and eligibility processes. [5-7,14]
Medicare Advantage networks	Plans must maintain sufficient provider networks under 42 CFR 422.116 and CMS review.	Time-distance and enrollment measures should not be described as complete proof of high-acuity functional availability. [8,15]
Marketplace networks	CMS uses network reviews and appointment-wait-time standards for QHPs in federally facilitated exchanges.	Primary and behavioral health access measures do not necessarily establish complex procedural, emergency-call, transfer, or salvage capacity. [9]
Consolidation oversight	GAO reports increasing physician consolidation and mixed evidence on access and quality.	Ownership, site of service, price, access, and quality are related but distinct variables requiring separate measurement. [12]

The gap is not absence of data; it is absence of a common inference standard

Agencies and researchers collect large volumes of expenditure, claims, directory, network, dispute, ownership, and utilization data. The recurring problem is that public analysis may shift from one construct to another without stating the transition. A uniform Construct and Control Statement would make that transition visible and reviewable.

4. Proposed Construct Integrity and Variable Attribution Standard

When the standard should apply

The standard should apply proportionately when a federal or state public body uses a monetary, access, network, or outcome measure to support a material policy judgment, including:

- legislation, rulemaking, payment policy, budget estimates, and fiscal notes;
- public network-adequacy certification and access reporting;
- government-funded rate, charge, cost, and savings studies;
- aggregate federal or state dispute-resolution reporting and evaluation;
- public claims about sector responsibility for expenditure growth;
- public performance dashboards, directories, or market-adequacy reports;
- audits, oversight hearings, and enforcement analyses that assign accountability; and
- demonstration projects that claim system savings, value, or access improvement.

Routine claim adjudication, private contracting, individual clinical decisions, and emergency care should not be delayed by the standard. Agencies may establish tiered requirements so low-impact analyses receive a concise disclosure while major rules and statutory proposals receive full analysis.

Required Construct and Control Statement

Required element	Question answered	Public output
Construct declaration	What exactly is being measured?	Named object and definition; no generic cost or rate label.
Provenance	Where did it come from?	Source, owner, dates, population, geography, version, and exclusions.
Construction	How was it produced?	Formula, negotiation, selection, adjudication, sampling, weighting, and validation.
Purpose	What was it designed to administer or describe?	Statutory, contractual, operational, descriptive, or research role.
Boundary	What does it not establish?	Explicit nonclaims and required supplemental evidence.
Denominator map	Which spending components are included or excluded?	Decomposed professional, facility, administrative, pharmaceutical, intermediary, and downstream categories where relevant.

Required element	Question answered	Public output
Context fit	Does it represent the circumstances at issue?	Urgency, complexity, case mix, site, geography, time, and missing variables.
Control map	Who controlled each operative variable?	Authority, visibility, exposure, data, bedside risk, and shared control.
Outcome scope	How far may the result be generalized?	Selection, completion, missingness, comparator, and external-validity statement.
Uncertainty	What remains unknown?	Confidence interval or qualitative uncertainty, data limitations, alternatives, and unresolved questions.

Network claims: add functional availability

When a public body claims network adequacy or specialist access, directory enrollment should be supplemented with the operational dimensions relevant to the population and service. Measures may include appointment availability, call-panel participation, urgent response, transfer acceptance, complex and revision case acceptance, after-hours coverage, vulnerable-population capability, continuity, and complaint or failed-access data. Metrics should be risk-adjusted, geographically appropriate, and validated to avoid imposing unsupported universal thresholds.

Savings claims: require decomposition and time horizon

A policy that lowers one payment line should describe which parties and cost components are affected, the time horizon, likely substitution or site-of-service effects, downstream utilization, administrative burden, and access measures. A projected index saving should be labeled as such until episode or system savings are measured.

IDR and adjudicated outcomes: classify before interpreting

Federal and state IDR reporting should distinguish statutory benchmark, offer, selected payment, prevailing party, eligibility, completion, timing, fee, code family, geography, and missingness. Aggregate outcomes may be valuable descriptive evidence but should not be presented as a universal payment standard, floor, ceiling, or settlement instruction. The ARI study provides a concrete example of why benchmark and outcome should remain separate constructs. [14]

Denominator discipline: no sector blame by category label alone

Before attributing cost growth to physicians, hospitals, payers, pharmaceuticals, corporate entities, or administrators, the analysis should state exactly which numerator and denominator are used. CMS reported $1.1097 trillion in physician and clinical services spending in 2024, approximately 21 percent of national health expenditures, but the category includes more than physician professional fees. A

narrower Census/FRED physician-office revenue series is also gross establishment revenue, not take-home compensation. [1-3]

5. Model Legislative and Regulatory Framework

The following is modular concept language, not final statutory text. Federal and state counsel should adapt jurisdiction, preemption, confidentiality, administrative-law, budget, and delegation provisions.

Section 1. Short title

The Construct Integrity and Operative Accountability Act or regulation.

Section 2. Purpose

Improve the validity and transparency of public reimbursement, network, access, and cost-containment analysis by requiring construct separation, variable attribution, functional-access measurement when applicable, and explicit evidence boundaries before material policy inference.

Section 3. Definitions

- Construct means a defined economic, administrative, access, clinical, or outcome measure with a specified source, construction method, purpose, and interpretive boundary.
- Construct drift means an inference that substitutes one construct for another without demonstrating fit.
- Operative variable means a factor materially capable of producing, preventing, delaying, modifying, or measuring the outcome at issue.
- Variable attribution means identification of the actor or structure with authority or control over an operative variable.
- Visibility means patient-facing or public-facing presence and does not, by itself, establish control.
- Functional specialist availability means operational capacity to provide the relevant service, not directory enrollment alone.
- Index saving means a reduction in a specified transaction or payment line that has not yet been shown to reduce total episode or system expenditure.

Section 4. Covered analyses

Apply the standard to material public analyses, proposed rules, fiscal estimates, network certifications, publicly funded studies, aggregate dispute reports, and official savings or accountability claims. Authorize de minimis, emergency, national-security, and privileged-enforcement exceptions with written justification.

Section 5. Construct and Control Statement

Require the responsible agency or public contractor to publish the ten elements in Section 4 of this brief in plain language and technical form. The statement should accompany, not replace, the underlying analysis.

Section 6. Functional availability supplement

When access or network adequacy is material, require measures appropriate to the specialty, acuity, geography, population, and care setting. Do not treat a directory count as conclusive proof of emergency, transfer, complex-case, or continuity capacity.

Section 7. Savings and expenditure claims

Require cost decomposition, affected-party analysis, time horizon, administrative cost, utilization and site-of-service effects, and access monitoring. Label unvalidated reductions as index savings or projected savings rather than realized system savings.

Section 8. Aggregate dispute reporting

Require outcome reports to identify selection, eligibility, completion, benchmark, offer, payment, code, geography, missingness, fees, and timing where law and privacy permit. Prohibit presentation of selected completed outcomes as a universal price standard absent separate authority and validation.

Section 9. Data access and confidentiality

Authorize secure, minimum-necessary data linkage and independent analysis while protecting patient identity, trade secrets, privilege, and confidential negotiated terms. Permit aggregation, suppression, controlled research access, audit, and due process. Do not require public release of identifiable contract or patient data.

Section 10. Symmetry and conflicts

Require the same construct, boundary, denominator, and attribution rules for provider, payer, hospital, government, and corporate claims. Require analysts and contractors to disclose funding, data control, material relationships, and methodological conflicts.

Section 11. Review and correction

Provide public methods, comment, correction, version history, and appeal or reconsideration when a published control map or construct statement materially misstates a party's role or data. Corrections should identify whether the change affects the policy inference.

Section 12. Pilot and evaluation

Phase the standard through selected payment, network, and cost-containment programs; publish burden and utility findings; refine templates; and require independent review before expansion. Sunset or revise requirements that do not improve interpretability or decision quality.

6. Implementation Roadmap

Phase	Actions	Deliverables
0-6 months: design	Convene federal and state agencies, patients, clinicians, plans, hospitals, employers, IDR entities, economists, actuaries, methodologists, and privacy counsel.	Construct taxonomy, control-map template, burden tiers, legal analysis, and pilot protocol.
6-12 months: inventory	Review existing rules, fiscal notes, expenditure categories, network reports, IDR data, and public dashboards for construct and attribution gaps.	Crosswalk of current measures, duplicative fields, data owners, and priority pilots.
12-24 months: pilot	Apply the standard to one payment rule, one network review, one IDR report, and one system-savings claim.	Public Construct and Control Statements, functional-access module, and burden/utility results.
24-36 months: refine	Test inter-reviewer agreement, public comprehension, data feasibility, cost, and correction procedures.	Revised templates, technical guidance, training, and minimum data set.
36+ months: scale and evaluate	Extend proportionately; publish annual evaluation and independent audit; revise or sunset weak components.	Versioned standard, compliance report, research files, and legislative recommendations.

Performance measures

- Percentage of covered analyses with complete construct, boundary, denominator, and control disclosures.
- Inter-reviewer agreement in classifying constructs and operative variables.
- Correction rate and number of material inferences changed after review.
- Analyst, agency, stakeholder, and public comprehension of what a cited measure does and does not establish.
- Administrative burden by analysis tier, agency, data source, and stakeholder type.
- Share of network reports using functional measures relevant to specialty, acuity, and geography.
- Share of savings claims reporting index, episode, and system effects separately.
- Completeness, timeliness, and interpretability of aggregate IDR and payment-policy data.
- Evidence of unintended effects, including disclosure overload, delayed rulemaking, gaming, or proprietary-data exposure.

7. Audience-Specific Use

Audience	Construct error to prevent	Minimum application
Congress and legislatures	Treating a visible line-item reduction as system savings or a sector category as proof of responsibility.	Require construct, denominator, control, and time-horizon statements in bills and fiscal notes.
CMS and HHS	Treating administrative rates or dispute outcomes as economically complete.	Publish source, purpose, boundary, selection, and access implications with major payment analyses.
State regulators	Treating directory enrollment as functional specialist availability.	Measure appointment, call, transfer, complex-case, after-hours, vulnerable-population, and continuity capacity where relevant.
Hospitals and health systems	Conflating professional payment with downstream institutional exposure.	Separate fee, facility, readmission, reoperation, length-of-stay, transfer, and post-acute components.
Health plans	Presenting benchmark or initial payment as self-validating fair value.	Disclose methodology, purpose, boundary, network design, and claims-process variables.
Physicians and specialty societies	Presenting charge, code, or clinical complexity as self-validating payment adequacy.	Document source support, case fit, alternatives, limits, and physician-controlled variables.
IDR entities and researchers	Substituting one dollar construct for another or generalizing selected outcomes.	Classify benchmark, offer, payment, selection, missingness, timing, and external-validity limits.
Cost-containment analysts	Measuring savings only at the index fee.	Report episode expenditure, downstream use, administrative cost, access, and site-of-service migration.

8. Safeguards Against Misuse

No price setting. The standard does not select a reimbursement amount, fair value, ceiling, floor, or payment entitlement.

No benchmark invalidation. An administrative benchmark may be legally controlling or operationally useful within its domain.

No charge validation. A provider request remains a construct requiring independent support; visibility-control analysis does not make it reasonable.

No causal shortcut. An association among payment, consolidation, access, or utilization does not establish causation without appropriate design.

No automatic liability. Control mapping is an analytic step, not a legal duty, fault finding, bad-faith determination, or damages allocation.

No directional bias. The framework must capture physician-, payer-, hospital-, corporate-, administrative-, regulatory-, and shared-control variables.

No directory erasure. Directory enrollment remains useful; it is simply not a complete measure of every form of access.

No outcome overgeneralization. Adjudicated payments are observed dispute outcomes, not universal price standards or settlement instructions.

No proprietary-data publication mandate. Public transparency should use aggregation, suppression, secure access, and legal protections.

No emergency delay. Measurement, verification, or reporting must never condition urgent evaluation, stabilization, transfer, or treatment.

No rigid one-size-fits-all metric. Functional availability and context-fit measures must reflect specialty, acuity, population, geography, and data feasibility.

No jurisdictional overreach. State provisions must respect ERISA, federal program rules, trade-secret law, and other preemption or confidentiality limits.

9. Common Objections and Responses

Responses to recurring critiques

"This is physician-fee advocacy."

That concern is valid if the framework is applied directionally. The proposed standard is symmetric and can support a lower payment when a billed charge, clinical-complexity claim, or provider-side denominator is unsupported. It also identifies physician-controlled documentation, coding, treatment, timing, and case-acceptance variables.

"QPA and Medicare rates are legally important; extra caveats weaken them."

Legal relevance is not disputed. The standard asks whether the cited measure is being used for the purpose the law assigned to it. Identifying a benchmark's domain strengthens rather than weakens valid use and prevents unsupported extrapolation.

"Agencies already explain methodology."

Many do, but disclosures vary by program and often separate method from policy inference. A short, standardized Construct and Control Statement would make source, purpose, boundary, denominator, and operative control comparable across programs.

"Control is shared and impossible to assign."

Shared control is an acceptable finding. The objective is not to force a single culprit; it is to avoid attaching accountability automatically to the most visible actor. The statement can identify joint authority, constrained discretion, and uncertainty.

"Network standards already measure adequacy."

Existing time-distance, enrollment, appointment, and directory rules are important. The proposal adds operational dimensions only when the policy question concerns emergency, complex, transfer, after-hours, vulnerable-population, or continuity capacity not captured by the existing measure.

"More disclosure will slow policy and increase burden."

A tiered standard can reuse existing data and remain brief for low-impact work. Major payment, access, or savings policies already require analysis; classification at the beginning may reduce later disputes over what the evidence actually establishes.

"Contracted rates and payer data are proprietary."

The standard does not require public release of identifiable negotiated terms. Agencies can disclose methodology, construct, boundary, and aggregate findings while using secure, protected data for audit and validation.

"Coding and modifiers already capture complexity."

They capture many clinically relevant features, but the empirical question is whether the specific benchmark and dataset incorporated the materially documented variables in the case. Code equivalence should not be presumed to establish full clinical equivalence.

"Adjudicated outcomes are the best available evidence."

They can be highly informative. Their meaning still depends on eligibility, selection, completion, evidence, statutory factors, geography, code family, and process. Classification improves use without dismissing the data.

"The framework is not validated."

Correct. Initial adoption should be a pilot disclosure and analytic standard, not a dispositive legal test. Inter-reviewer agreement, burden, comprehension, and decision impact should be evaluated before expansion.

10. Evidence Boundaries and Research Agenda

What current evidence supports

- Common reimbursement figures have distinct legal, economic, and administrative constructions. [1,4-7,11]
- CMS national expenditure categories are broader than physician professional fees and should not be interpreted as physician take-home income. [1-3]
- QPA and federal IDR outcomes are distinct constructs; the ARI complex-repair study demonstrates descriptive separation within one defined cohort while expressly limiting generalization. [14]

- CMS network standards already use multiple dimensions, including time-distance and appointment-wait measures in defined programs, supporting the principle that enrollment alone is not the only access construct. [8-10,15]
- Physician consolidation has increased, while available evidence on access and quality effects remains limited or mixed, reinforcing the need to separate ownership, price, quality, and access constructs. [12]
- Payment-adequacy assessment uses multiple indicators rather than one dollar figure, as reflected in MedPAC's recurring statutory analysis. [11]

What has not yet been established

- That the Visibility-Control framework produces reproducible classifications across independent reviewers.
- That professional-fee compression causes specialist-access limitations in a particular market or specialty.
- That any specific billed charge, contracted rate, QPA, MPFS rate, or adjudicated payment is appropriate or inappropriate.
- That directory participation overstates functional access in every network or service line.
- That a reduction in an index payment increases total episode expenditure or causes site-of-service migration.
- That public Construct and Control Statements improve policy outcomes enough to justify their administrative burden.
- That one functional-availability metric can be validly applied across specialties, populations, and geographies.

Priority research questions

- Can independent reviewers reliably apply the five filters and six attribution questions?
- Which disclosures most improve understanding among legislators, regulators, patients, clinicians, plans, and adjudicators?
- How often do public analyses substitute MPFS, QPA, charge, contracted rate, adjudicated payment, and total episode expenditure?
- How do payment constructs compare within matched specialty, geography, code, acuity, and time cohorts?
- Which functional-availability measures best predict completed access for emergency, transfer, revision, and complex cases?
- What relationships exist among professional payment, practice consolidation, site-of-service migration, call participation, and specialist availability?
- When do lower index payments produce episode savings, cost transfer, administrative burden, delay, or downstream utilization?
- What privacy-preserving data linkage is feasible for claims, network, staffing, transfer, ownership, and outcome data?
- What tiered disclosure design offers the best balance of rigor, speed, burden, and public comprehension?

11. Decision Checklist for Policymakers

- Is every cited price, rate, cost, payment, savings, access, and adequacy measure explicitly defined?
- Are source, dates, population, geography, construction method, exclusions, and version disclosed?
- Is the measure being used for its intended statutory, administrative, contractual, or descriptive purpose?
- Does the analysis state what the measure cannot establish?
- Are physician professional, facility, administrative, pharmaceutical, intermediary, and downstream components separated where relevant?
- Does the benchmark fit urgency, complexity, site, case mix, geography, and time?
- Are authority, visibility, financial exposure, data control, bedside risk, and shared control mapped?
- If access is claimed, is functional capacity measured beyond directory presence?
- If savings are claimed, are index, episode, and system effects separated and time horizons stated?
- If adjudicated outcomes are cited, are selection, completion, benchmark, code, geography, missingness, and process identified?
- Are uncertainty, missing data, alternative explanations, and external-validity limits explicit?
- Is the framework applied symmetrically to provider, payer, hospital, corporate, regulator, and government claims?
- Are confidentiality, proprietary data, preemption, due process, and correction mechanisms addressed?
- Will the policy be piloted, independently evaluated, revised, and sunset if burden exceeds value?

12. Recommended Action

ADOPT THE PRINCIPLE

Public policy should not assign value, savings, access, or accountability until it has identified the construct, defined its boundary, and mapped operative control.

Congress and state legislatures should authorize a phased Construct Integrity and Variable Attribution Standard. HHS/CMS, state insurance and Medicaid agencies, and other responsible bodies should develop a shared taxonomy, tiered templates, functional-availability modules, and pilot protocols with balanced stakeholder participation.

The first pilots should address four high-yield settings: a major payment rule, a network-adequacy review, an aggregate IDR report, and a public cost-savings claim. Each pilot should publish a plain-language Construct and Control Statement, technical appendix, burden estimate, correction pathway, and independent evaluation.

The standard should remain an analytic disclosure discipline, not a price, liability, benchmark-override, or care-delay mechanism. Its purpose is to ensure that governing evidence measures the question asked and assigns accountability to operative control rather than visibility.

References and Source Notes

The supplied technical report was reviewed in full. Its PDF is dated July 7, 2026 and displays an incomplete Cureus citation and DOI; the final publication status, DOI, and formatted citation should be updated when confirmed. Government sources were checked against materials available July 13, 2026. Final legislation requires federal and state counsel review, agency consultation, administrative-burden analysis, privacy review, public comment, and formal drafting.

1. Klapper AM, Dardano AN, Risin M, Maita K, Mahedia M. Visibility Is Not Control: Construct Separation and Variable Attribution in Surgical Reimbursement Policy. Supplied prepublication technical report, July 7, 2026; final citation and DOI to be confirmed.
2. Centers for Medicare & Medicaid Services. National Health Expenditure Fact Sheet.
3. Federal Reserve Bank of St. Louis. Total Revenue for NAICS 6211: Offices of Physicians - Taxable Establishments (REV6211TMSA), sourced from the U.S. Census Bureau.
4. Centers for Medicare & Medicaid Services. Plans and issuers requirements and resources, including No Surprises Act QPA methodology.
5. Centers for Medicare & Medicaid Services. About Independent Dispute Resolution.
6. Centers for Medicare & Medicaid Services. Independent dispute resolution reports.
7. Centers for Medicare & Medicaid Services. Overview of No Surprises Act rules and fact sheets.
8. Centers for Medicare & Medicaid Services. Medicare Advantage Network Adequacy.
9. Centers for Medicare & Medicaid Services. 2025 Payment Notice webinar materials, including Marketplace network and appointment-wait-time standards.
10. Centers for Medicare & Medicaid Services. CCIIO examinations, audits, and reviews of issuers, including network adequacy and appointment wait time resources.
11. Medicare Payment Advisory Commission. March 2026 Report to the Congress: Medicare Payment Policy.
12. U.S. Government Accountability Office. Health Care Consolidation: Published Estimates of the Extent and Effects of Physician Consolidation. GAO-25-107450, September 2025.
13. Klapper AM, Dardano AN, Risin M, Maita K. Cost-Trajectory Framework for Total Episode Expenditure in Complex Wound Reconstruction: The CASCADE Model. Cureus. 2026;18:e108363.
14. Klapper AM, Dardano AN, Risin M, Maita K, Denavea ML. Benchmark-Outcome Separation in Federal Independent Dispute Resolution: A Descriptive Analysis of Qualifying Payment Amount and Adjudicated Payment in Complex Repair Claims. Cureus. 2026;18:e110912.
15. Electronic Code of Federal Regulations. 42 CFR 422.116, network adequacy standards.

Document status and use

Healthcare Governance policy brief. Draft 1.0, July 13, 2026. Policy position informed by a supplied conceptual technical report, official sources, and published research; not itself peer reviewed. Not legal, actuarial, clinical, investment, reimbursement, or regulatory-compliance advice. Model provisions require jurisdiction-specific counsel review, administrative and fiscal analysis, stakeholder consultation, data-feasibility testing, public comment, and formal legislative or regulatory drafting.

Suggested website classification: Policy analysis | Draft | Reimbursement constructs | Variable attribution | Network adequacy | Functional availability | No Surprises Act | Independent dispute resolution | Cost containment | Public accountability

HEALTHCARE GOVERNANCE | POLICY BRIEF

MODEL POLICY BRIEF

Value Should Be Measured Across the Entire Episode of Care

A transparent policy framework for durable reconstruction, downstream burden, and expected total episode expenditure

Prepared for: Legislators, agencies, public and private payers, hospitals, professional societies, and healthcare organizations

Prepared by: Healthcare Governance

Version: Draft 1.0

Date: July 13, 2026

Status: Policy position informed by published research; not itself a peer-reviewed publication

RECOMMENDED ACTION

Adopt an Episode-of-Care Value Analysis Standard for decisions in which an index treatment may materially change the probability or burden of success, complications, reoperations, readmissions, post-acute care, prolonged recovery, or other downstream consequences.

The relevant economic question is not only what the index procedure costs. It is what care trajectory the decision is expected to create or prevent.

This brief does not recommend that a jurisdiction mandate CASCADE, establish a payment rate, or direct a particular treatment. CASCADE is presented as one published conceptual framework that illustrates how a transparent, probability-weighted episode analysis can be structured.

Executive Summary

Healthcare decisions are often evaluated one service at a time even when the clinical and economic consequences unfold across an entire episode. In complex wound reconstruction, an apparently lower-cost index strategy may be followed by wound failure, infection, reoperation, prolonged hospitalization, post-acute care, outpatient wound management, readmission, and delayed recovery. A more resource-intensive index reconstruction may—or may not—reduce the probability of that downstream trajectory.

The policy problem is not that every decision should favor the more expensive procedure. It is that an index-only comparison can exclude the very consequences the decision is expected to influence. When downstream events are material, policymakers, payers, hospitals, and reviewers need a transparent method for defining the episode, comparing strategies, estimating probabilities and costs, and testing uncertainty.

CASCADE—Cost Analysis of Surgical Complications and Downstream Expenditure—is a broader episode-trajectory project and calculator architecture. The full implementation model compares alternative strategies using index cost, success and failure probabilities, success-pathway cost, failure-pathway cost, additional procedures, post-acute and outpatient utilization, recovery-time burden, and expected total episode cost. For publication, that architecture was deliberately reduced to a bounded three-input threshold relationship focused on incremental reconstruction cost, absolute failure-risk reduction, and expected failure-trajectory cost.

The resulting 2026 peer-reviewed, PubMed-indexed article presents CASCADE as a conceptual framework for complex wound reconstruction. It expressly states that the published model is literature-derived, not a primary data analysis or statistically validated predictive model, and requires validation against institutional or claims-based data. [1]

Federal healthcare policy already recognizes episode-based analysis. CMS defines an episode as services and supplies used to treat a condition over a defined period; its TEAM model holds selected hospitals accountable for quality and Medicare spending from surgery through 30 days after discharge for specified procedures. CMS also maintains episode-based cost measures through an iterative process with expert and public input. [2-4]

Recommendation

Adopt a jurisdiction-appropriate Episode-of-Care Value Analysis Standard through legislation, administrative guidance, payer policy, institutional governance, professional guidance, or demonstration programs. The standard should:

- Apply only when an index decision can reasonably be expected to affect material downstream clinical or resource consequences.
- Define the patient population, comparator strategies, episode boundaries, time horizon, perspective, outcomes, and cost construct before analysis.
- Require transparent probabilities, data sources, calculations, assumptions, exclusions, uncertainty ranges, and sensitivity analysis.
- Separate charges, costs, allowed amounts, and payments rather than treating them as interchangeable.
- Pair economic analysis with quality, safety, patient-centered outcomes, clinical appropriateness, and access safeguards.

- Protect patients and clinicians from sole-source automated denials, unsupported adverse inferences, and incentives to avoid high-risk patients.
- Pilot and validate any operational model before using it for payment, coverage, performance assessment, or utilization management.

Core policy judgment

When two clinical strategies place different downstream trajectories at risk, an index-only cost comparison evaluates a different economic unit from total episode value. That distinction should be made explicit before the analysis influences care, payment, or institutional policy.

1. The Policy Problem

Patients experience trajectories—not isolated line items

A clinical episode may include the index operation, routine follow-up, complications, emergency care, readmission, repeat procedures, rehabilitation, home health, skilled nursing, outpatient wound care, pharmaceuticals, and time away from work or normal function. The precise components depend on the policy question and the perspective of the analysis.

An index-only comparison can be appropriate when downstream consequences are negligible, equivalent, or outside the decision's causal reach. It becomes incomplete when the selected strategy is expected to change the probability or severity of later events.

The recurring failure pattern

Lowest immediate cost is treated as lowest total cost. The initial procedural expenditure is visible and attributable; later costs may be fragmented across admissions, providers, facilities, and payment systems.

Complications are separated from the decision that placed them at risk. Failure may be coded and paid in a later encounter even when the probability of that failure was affected by the index strategy.

Different economic constructs are blended. Charges, internal costs, standardized payments, allowed amounts, and reimbursement are distinct measures and may answer different questions.

Average estimates are applied without risk stratification. An expected-value model can mislead if the patient population, wound environment, clinical severity, or comparator strategy differs from the data used.

Precision obscures uncertainty. A single dollar estimate can appear authoritative even when probabilities, downstream pathways, and cost ranges are uncertain.

Why the issue is timely

CMS currently uses and tests episode-based approaches in multiple settings. TEAM began in 2026 for selected hospitals and five surgical episode categories, with episodes extending from surgery through 30 days after discharge. CMS reports 33 episode-based cost measures in the 2026 MIPS cost performance category. These programs do not validate CASCADE or require its use; they show that federal policy

already treats the episode—not only the isolated service—as a legitimate unit for cost and quality analysis. [2-4]

2. The CASCADE Framework

The full project model

The full CASCADE project treats each treatment option as a strategy with its own episode trajectory. It does not begin by assuming that definitive reconstruction is preferred. It calculates—or displays separately when monetization would be inappropriate—the expected consequences of each strategy across success and failure branches.

FULL STRATEGY-LEVEL ARCHITECTURE

Expected total episode cost for strategy s = index treatment cost + probability-weighted success-pathway cost + probability-weighted failure-state costs + expected additional-procedure, readmission, post-acute, outpatient, and recovery-related costs attributable to that strategy.

A generalized implementation expression is:

$$E[TEC \mid s] = C_{index,s} + P_s \times C_{success,s} + \Sigma_k(P_{k,s} \times C_{failure,k,s}) + C_{recovery,s} + C_{institutional,s}$$

In this expression, s is the strategy; Cindex is index treatment cost; Ps is the probability of successful trajectory completion; Csuccess is the downstream cost of the success pathway; k identifies distinct failure states; Pk and Cfailure,k are the probability and cost of each failure trajectory; Crecovery represents measurable recovery-time and disability burden when an appropriate valuation method is available; and Cinstitutional represents attributable system effects such as readmission exposure or disrupted resource use. Shared baseline costs may be displayed but cancel when they are identical across comparators.

The calculator architecture should also report clinically important burdens that are not credibly monetized—such as days to recovery, number of additional procedures, days hospitalized, readmission risk, functional limitation, and caregiver burden—as separate outputs. They should not be forced into a dollar total merely to create a more dramatic result.

Strategy comparison

For two strategies, CASCADE compares their expected total episode costs and their burden profiles:

$$\Delta ETEC = E[TEC \mid \text{strategy 2}] - E[TEC \mid \text{strategy 1}]$$

A negative ΔETEC favors strategy 2 on expected episode expenditure; a positive ΔETEC favors strategy 1. A near-zero difference, overlapping uncertainty ranges, or conflicting clinical and economic outcomes should be reported as indeterminate and resolved through clinical judgment, patient preference, and the governing decision standard—not through false numerical precision.

The simplified published model

The paper minimized the broader architecture to isolate the central economic relationship between the incremental cost of definitive reconstruction and the probability-weighted failure expenditure it may avoid. In simplified form:

PUBLISHED DECISION RULE

Definitive reconstruction is economically favored in the published model when $\Delta C < \Delta P \times C$, where ΔC is incremental reconstruction cost, ΔP is the absolute reduction in failure probability, and C is expected failure-trajectory cost conditional on failure. [1]

The published model compares two strategies: routine closure and definitive reconstruction. A baseline episode cost common to both strategies cancels from the comparison. The publication uses a Clinical Risk Score to place cases into risk tiers and a Failure Cost Tier to bound downstream cost ranges. [1]

What the model contributes

- A defined economic unit: expected total episode expenditure conditional on the selected strategy.
- A strategy-level calculator architecture that can represent success, multiple failure states, additional procedures, recovery time, and downstream utilization.
- A visible relationship between incremental treatment cost, failure-risk reduction, and downstream trajectory cost.
- A bidirectional comparison: the model can favor either strategy depending on the inputs.
- A structure for sensitivity analysis rather than reliance on one deterministic estimate.
- A documentation pathway connecting clinical risk, expected failure trajectory, reconstructive mechanism, and anticipated prevented events.

What the publication does not establish

- It is not a primary data analysis, claims-based economic study, or statistically validated predictive model.
- Its Clinical Risk Score is nonvalidated and its point assignments are expert-informed and literature-supported rather than statistically derived.
- Its illustrative cost ranges are not observed case-level measurements.
- It does not prove that a specific reconstruction will prevent failure in an individual patient.
- It does not define reimbursement, coverage, medical necessity, or a universal treatment standard.
- It requires future validation using institutional cost accounting, claims, complication data, and other observed datasets.

STATUS

Published conceptual framework. Peer reviewed and indexed in PubMed. Not yet externally validated or calibrated for mandatory payment, coverage, or treatment decisions.

Full-model outputs

Output domain	Required content
Index treatment	Index facility, operative, supply, implant, anesthesia, and other included costs, with the chosen cost construct stated.
Success pathway	Probability of success; routine follow-up; recovery time; function; and residual resource use.
Failure pathways	Probability and cost of each clinically coherent failure state rather than one undifferentiated average when data support stratification.
Additional procedures	Expected number and type of washouts, revisions, salvage operations, or definitive reconstructions.
Care settings	Hospital days, ICU, readmission, emergency care, skilled nursing, home health, rehabilitation, and outpatient wound care.
Recovery burden	Time to healing, time away from work or normal activity, disability, caregiver burden, and patient-reported outcomes—monetized only when methodologically supportable.
Institutional consequences	Readmission exposure, bundled-payment overrun, OR displacement, and quality effects when causally and economically attributable.
Expected total and difference	Strategy-specific expected total episode cost, incremental difference, uncertainty range, and threshold at which the preferred strategy changes.

3. Proposed Episode-of-Care Value Analysis Standard

Trigger for use

The standard should be used when a decision-maker proposes to compare treatment strategies and there is a reasonable clinical basis to believe that the index choice may materially affect complications, revisions, readmissions, post-acute care, recovery, disability, or another downstream consequence. It should not be imposed when the episode framework adds no meaningful information.

Required disclosure schedule

Required element	Minimum disclosure
1. Decision question	State the coverage, payment, clinical, procurement, or governance question the analysis is intended to inform.
2. Comparators	Define each strategy, including what is and is not included in the index treatment.
3. Population and setting	Identify the clinical population, risk profile, facility setting, geography, and exclusions.
4. Episode boundaries	State the start event, end event or time horizon, downstream settings, and included services.
5. Perspective	Identify whether the analysis reflects payer, provider, patient, employer, public, or societal consequences.
6. Outcomes	Define success, failure, complications, reoperation, readmission, recovery, function, and other material outcomes.
7. Probabilities	Disclose each probability, source, population fit, and method of risk adjustment or stratification.
8. Resource and cost inputs	Identify the cost construct, source year, inflation method, units, and included downstream resources.
9. Calculation pathway	Provide formulas, workpapers, treatment of shared costs, and protections against double counting.
10. Uncertainty	Report plausible ranges, sensitivity analysis, threshold analysis, and variables that most influence the result.
11. Quality and patient burden	Report safety, function, recovery time, disability, patient preference, and access implications where material.
12. Limitations and conflicts	Disclose missing data, generalizability limits, funding, financial interests, model version, and validation status.

Minimum interpretation rule

No episode-value estimate should be presented as a single self-proving number. Results should include the comparator-specific total, the incremental difference, the principal assumptions, and a sensitivity or threshold analysis showing when the conclusion changes.

4. Safeguards

Clinical appropriateness comes first

An economic model should not override individualized clinical judgment, informed consent, shared decision-making, emergency care obligations, or a patient's right to medically necessary care. A favorable expected-value result does not establish that a procedure is appropriate for a particular patient; an unfavorable result does not prove that it is unnecessary.

No sole-source automated decision

A CASCADE output or other episode-value estimate should not be the sole basis for denying, reducing, delaying, or recouping payment for care. Material adverse decisions should include qualified human review, disclosure of the inputs used, and a meaningful reconsideration or appeal pathway.

Risk adjustment and equity

Episode approaches can create incentives to avoid clinically complex patients if risk is inadequately measured. Any operational program should assess whether results vary by clinical severity, disability, socioeconomic conditions, rurality, safety-net status, or other factors that affect access and outcomes. Risk adjustment must be transparent and periodically evaluated for unintended consequences.

Data and construct integrity

- Do not substitute billed charges for actual costs or standardized payments without explaining the choice.
- Do not combine facility, professional, post-acute, and patient costs without identifying the perspective and source of each input.
- Do not count the same service in both baseline and failure trajectories.
- Do not treat association as a patient-specific causal prediction.
- Do not select an episode window merely because it produces a preferred result.
- Do not conceal unfavorable sensitivity scenarios or missing data.

Versioning and validation

Every operational model should display its version, revision date, data vintage, intended use, validation status, and change history. Material changes to risk tiers, probabilities, cost ranges, or outcome definitions should be prospectively documented rather than silently applied to prior cases.

5. Implementation Pathways

Pathway	Practical first step
State Medicaid or public employee demonstration	Pilot episode-value disclosure for a narrowly defined procedure or high-risk cohort; preserve benefit and appeal protections.
Hospital governance	Require service-line committees to document total episode consequences when comparing reconstructive strategies, staffing, or supply decisions.
Payer coverage or payment pilot	Use transparent inputs and quality safeguards; prohibit calculator-only denials and publish validation results.
Workers' compensation or administrative review	Require episode boundaries, cost construct, clinical fit, uncertainty, and reviewer qualifications when total episode value is disputed.
Professional-society guidance	Publish minimum reporting standards for episode-based clinical and economic analyses.
Research collaborative	Validate probabilities, failure trajectories, cost inputs, and patient-centered outcomes using observed multi-institutional data.

Phased approach

- Phase 1 — disclosure: standardize the required elements without tying results to payment or coverage.
- Phase 2 — retrospective validation: compare modeled estimates with observed clinical trajectories, payments, costs, and outcomes.
- Phase 3 — prospective pilot: test usability, inter-reviewer consistency, access effects, and unintended incentives.
- Phase 4 — limited implementation: use only for defined decisions with independent oversight and sunset review.
- Phase 5 — revision or expansion: scale only if evidence supports validity, fairness, and operational value.

Governance body

A pilot should be overseen by a multidisciplinary group that includes reconstructive and relevant treating clinicians, nursing, rehabilitation, infection prevention, hospital finance or cost accounting, payer or purchaser expertise, outcomes research, patient representation, and legal or compliance review. No single stakeholder should control the assumptions or validation process.

6. Expected Benefits and Evidence Boundaries

Potential benefits

- Make downstream clinical and resource consequences visible at the time of the index decision.
- Improve comparability by requiring common episode definitions and transparent inputs.
- Reveal when a conclusion depends on one disputed probability, cost range, or time horizon.
- Support investment in durable treatment when avoided downstream burden plausibly exceeds incremental cost.
- Prevent index-cost savings from being mistaken for total-episode savings.
- Create a structured research agenda for validation and calibration.

Claims this brief does not make

- That CASCADE has been proven to reduce healthcare spending or improve outcomes.
- That definitive reconstruction is always less costly or clinically superior.
- That the published illustrative cost ranges apply to every hospital, payer, patient, or wound.
- That episode-based payment is universally preferable to fee-for-service payment.
- That cost should supersede quality, patient preference, access, or clinical judgment.
- That a favorable model result establishes a required reimbursement amount.

EVIDENCE BOUNDARY

The strongest present policy case is for transparent disclosure, careful pilot testing, and validation—not immediate mandatory use of CASCADE for payment, coverage, or treatment selection.

7. Common Objections and Responses

“The index procedure is the only cost that can be measured reliably.”

Response: Index cost may be easier to attribute, but ease of measurement does not make it the complete economic unit. CMS already defines and measures episodes that include post-acute services and complications. The appropriate response to uncertainty is transparent episode definition and sensitivity analysis—not automatic exclusion of downstream events. [2-4]

“Complications cannot be predicted for an individual patient.”

Response: CASCADE does not claim certainty. It uses probability-weighted expected values across defined populations. The analysis should disclose that distinction, show plausible ranges, and avoid presenting a population estimate as an individual prediction.

“This will be used to justify expensive procedures.”

Response: The framework is bidirectional. A more expensive index strategy is favored only when the assumed reduction in failure probability and the downstream cost at risk exceed the incremental cost.

Transparent inputs allow reviewers to challenge optimistic assumptions and may support the less costly strategy when evidence does not show sufficient downstream benefit.

"Episode models encourage rationing or avoidance of high-risk patients."

Response: That is a genuine governance risk. The proposed standard includes clinical-appropriateness protections, risk adjustment, equity review, human oversight, appeals, monitoring for patient selection, and a prohibition on sole-source calculator denials.

"Costs differ across hospitals and payers."

Response: They do. That is why every analysis must state its perspective, cost construct, data vintage, setting, and transferability limits. Local validation is preferable when results will affect local payment or policy.

"CASCADE is not validated."

Response: Correct. The paper says so explicitly. CASCADE should therefore be used as a conceptual and decision-support framework while validation proceeds, not as a mandatory predictive score or universal reimbursement rule.

8. Model Policy Language

Episode-of-Care Value Analysis Standard — concept language

The following language is a drafting concept and should be adapted by legislative counsel, agency counsel, actuarial experts, and affected stakeholders.

Section 1. Purpose

To improve the transparency and integrity of clinical-economic analyses by requiring disclosure of material downstream consequences when an index treatment decision is reasonably expected to affect complications, revisions, readmissions, post-acute services, recovery, disability, or other components of an episode of care.

Section 2. Covered analysis

A "covered episode-value analysis" means an analysis used to materially inform a public coverage, payment, utilization-management, procurement, performance, or institutional-governance decision that compares two or more treatment strategies on the basis of cost, resource use, or value across a defined episode of care.

Section 3. Required disclosures

A covered analysis shall identify the decision question; comparators; population and setting; episode start, end, and included services; perspective; clinical outcomes; probability estimates and sources; resource and cost inputs; calculation methodology; risk adjustment; sensitivity analysis; quality and patient-centered considerations; exclusions; limitations; conflicts; funding; model version; and validation status.

Section 4. Interpretation and use

A covered analysis shall not be represented as determinative of medical necessity, coverage, payment, or appropriate treatment unless independent authority establishes that use. A numerical output shall be accompanied by its assumptions, uncertainty range, and conditions under which the preferred strategy changes.

Section 5. Patient and clinician protections

No covered analysis shall be the sole basis for denial, delay, reduction, or recoupment of medically necessary care. Any material adverse decision shall provide qualified human review, notice of the material inputs and rationale, and a meaningful reconsideration or appeal process consistent with applicable law.

Section 6. Pilot, validation, and review

Before an episode-value model is used prospectively for financial accountability or utilization management, the responsible entity shall conduct or obtain validation appropriate to the intended population and use, monitor for access and equity effects, publish or make available a model description and change history, and establish a defined review or sunset date.

Section 7. Construction

Nothing in this standard shall be construed to establish a particular reimbursement amount, require a specific clinical intervention, supersede professional judgment or informed consent, alter emergency-care obligations, or mandate use of CASCADE or any named proprietary or nonproprietary tool.

9. CASCADE Crosswalk

CASCADE component	Published function	Policy-standard element
Index strategies	Routine closure and definitive reconstruction are defined as alternative strategies.	Comparator definition
Success branch	Full project model records probability, follow-up cost, recovery, and residual burden after successful treatment.	Outcome-state definition
Multiple failure states	Full project model can separate limited, moderate, severe, and catastrophic trajectories rather than relying only on one mean.	Probability-weighted downstream states
Additional procedures	Expected washouts, revisions, salvage procedures, and other interventions are included in the strategy trajectory.	Downstream resource utilization

CASCADE component	Published function	Policy-standard element
Recovery-time burden	Recovery duration, disability, and patient or caregiver burden are reported separately or monetized only with a disclosed method.	Patient-centered and indirect consequences
Incremental reconstruction cost (ΔC)	Additional facility or operative expenditure attributed to the reconstructive strategy in the published model.	Resource and cost inputs
Failure probabilities (P_1 and P_2)	Probability of failure under each strategy; the difference is ΔP.	Probability inputs and risk stratification
Failure trajectory cost (C)	Expected downstream expenditure conditional on failure.	Episode boundaries and downstream resources
Decision rule	$\Delta C < \Delta P \times C$.	Calculation pathway and threshold analysis
Full strategy comparison	ΔETEC compares strategy-specific expected total episode costs and burden profiles.	Comparative result and uncertainty
Clinical Risk Score	Published expert-informed risk-tier assignment; currently nonvalidated.	Population fit and validation status
Sensitivity analysis	Tests how results change across plausible probability and cost inputs.	Uncertainty disclosure
Documentation linkage	Connects risk drivers, failure trajectory, reconstructive mechanism, and anticipated prevented events.	Case-specific clinical support

10. Research and Validation Agenda

- External validation of failure probabilities and risk tiers across institutions and wound categories.
- Retrospective comparison of modeled trajectories with institutional cost-accounting and claims data.
- Prospective assessment of calibration, discrimination, decision thresholds, and clinical utility.
- Inter-reviewer consistency in assigning risk tiers, failure trajectories, and cost inputs.
- Comparison of payer, provider, patient, employer, and societal perspectives.

- Inclusion of recovery time, function, disability, caregiver burden, and patient-reported outcomes.
- Equity and access analysis, including effects on high-risk, rural, disabled, and safety-net populations.
- Governance testing for appeals, human review, conflicts, versioning, and unintended incentives.
- Head-to-head evaluation against simpler index-cost and existing episode-measure approaches.
- Public reporting of null, unfavorable, and subgroup findings as well as positive results.

11. Action Checklist

For legislators and agencies

- Define the policy problem and identify where index-only analysis may omit material downstream consequences.
- Select a narrow pilot population and intended use.
- Require the disclosure schedule, safeguards, validation plan, and sunset review.
- Obtain clinical, actuarial, legal, patient, and equity input before linking results to payment or coverage.

For hospitals and healthcare organizations

- Inventory decisions currently based primarily on index procedure cost.
- Define episode boundaries and cost constructs with clinical and cost-accounting teams.
- Test sensitivity to failure probabilities, downstream pathways, and time horizons.
- Preserve a documented route for clinical exceptions and patient-specific judgment.

For payers and purchasers

- Distinguish payment, allowed amount, charge, and actual cost inputs.
- Share sufficient model logic and data provenance for meaningful review.
- Do not use an unvalidated tool as a sole-source denial rule.
- Monitor selection, access, quality, and appeals—not only aggregate spending.

For researchers

- Pre-specify the population, comparators, outcomes, perspective, time horizon, and analytic plan.
- Use observed data where available and report missingness and transferability limits.
- Publish calibration and sensitivity results, not only point estimates.
- Maintain versioned datasets, formulas, assumptions, and reproducible workpapers.

References and Source Notes

Accessed July 13, 2026. The policy conclusions and model language in this brief are Healthcare Governance positions; the cited sources do not necessarily endorse them.

1. Klapper AM, Dardano AN, Risin M, Maita K. Cost-Trajectory Framework for Total Episode Expenditure in Complex Wound Reconstruction: The CASCADE (Cost Analysis of Surgical Complications and Downstream Expenditure) Model. Cureus. 2026;18(5):e108363. doi:10.7759/cureus.108363. PMID: 42100647. PubMed record

2. Centers for Medicare & Medicaid Services. Bundled Payments. Defines bundled payment and episode of care and describes CMS Innovation Center episode models. CMS page

3. Centers for Medicare & Medicaid Services. TEAM (Transforming Episode Accountability Model). Describes the mandatory 2026–2030 model, covered surgical episodes, 30-day episode window, target prices, risk adjustment, and quality adjustment. CMS TEAM page

4. Centers for Medicare & Medicaid Services. About Cost Measures & Development Process. Describes 2026 MIPS episode-based cost measures and iterative development with expert and public input. CMS cost-measures page

5. Centers for Medicare & Medicaid Services. BPCI Advanced. Historical voluntary episode-payment model and 90-day clinical episode structure; model period ended December 31, 2025. CMS BPCI Advanced page

Citation and use notice

Suggested citation: Healthcare Governance. Value Should Be Measured Across the Entire Episode of Care: A Transparent Policy Framework for Durable Reconstruction, Downstream Burden, and Expected Total Episode Expenditure. Model Policy Brief. Draft 1.0. July 13, 2026.

This document is educational policy analysis and does not constitute legal, medical, actuarial, reimbursement, or patient-specific advice. Model language requires review and adaptation by qualified counsel and affected subject-matter experts. CASCADE is a decision-support framework, not a payment formula or universal treatment mandate.

Measure Value Across the Entire Episode of Care

CASCADE | Treatment trajectories, downstream burden, and expected episode expenditure

The relevant economic question is not only what the index procedure costs; it is what care trajectory the decision is expected to create or prevent.

THE ISSUE

In brief. Payment and coverage decisions often compare the immediate cost of competing treatments while leaving complications, reoperations, readmissions, post-acute care, prolonged recovery, and disability outside the frame. Patients experience a trajectory of care—not an isolated line item. A less expensive index treatment can be more costly overall when it materially changes the probability or burden of downstream events.

WHY IT MATTERS

- Index-price comparisons can reward short-term savings while shifting cost and burden downstream.
- Complication risk and recovery burden may differ meaningfully between treatment strategies.
- Transparent probability ranges expose assumptions better than a single unqualified cost estimate.

POLICY DIRECTION

- Use episode-of-care analysis when an index decision may materially affect failure, revision, readmission, post-acute care, or recovery.
- Disclose index cost, success and failure probabilities, pathway costs, time horizon, data sources, and uncertainty ranges.
- Report nonmonetized clinical and recovery burdens separately when credible valuation is unavailable.
- Require qualified human review, risk adjustment, appeal, versioning, and validation before high-stakes use.

WHAT THE ARTICLE OR FRAMEWORK CONTRIBUTES

Contribution. CASCADE—Cost Analysis of Surgical Complications and Downstream Expenditure—organizes alternative strategies as probability-weighted care pathways. The full project model can compare index cost, success and failure trajectories, additional procedures, recovery burden, and expected total episode cost. The published paper intentionally presents a simpler threshold model for conceptual clarity.

EVIDENTIARY BOUNDARY

Do not overread it. CASCADE is conceptual and requires validation against institutional or claims data. It is not a treatment mandate, payment formula, patient-specific predictor, or proof that a higher-cost procedure is better or less expensive overall. Clinical appropriateness and informed consent remain primary.

BOTTOM LINE **When downstream consequences are material, require decision-makers to compare expected care trajectories—not only the visible index price.**

Source foundation: Cost-Trajectory Framework for Total Episode Expenditure in Complex Wound Reconstruction (Cureus, 2026) | PMID 42100647 | doi:10.7759/cureus.108363

Freedom to Ride, Responsibility to Insure

Florida motorcycle-trauma medical responsibility and public-cost accountability

The freedom to accept personal risk does not require hospitals, taxpayers, insured patients, and trauma professionals to finance an avoidable coverage gap.

THE ISSUE

In brief. Catastrophic motorcycle trauma can exhaust nominal coverage quickly. Emergency treatment cannot wait for fault, litigation, or asset recovery. When credible first-party medical resources are absent or inadequate, costs may be transferred to health plans, public programs, hospitals, clinicians, and other patients. Florida's $10,000 financial-responsibility threshold is linked to the adult helmet exemption, not a general registration requirement.

WHY IT MATTERS

- Fault rules do not finance immediate trauma care, rehabilitation, or long-term disability.
- Health insurance may help but can contain exclusions, cost sharing, coordination rules, or public subsidy.
- A symbolic dollar threshold can create the appearance of responsibility without matching modern severe-trauma exposure.

POLICY DIRECTION

- Require registration-linked proof of meaningful first-party motorcycle medical financial responsibility.
- Permit multiple verified pathways: insurance, qualifying health-coverage combinations, self-insurance, security, or pooled mechanisms.
- Commission a Florida Trauma-Financing Deficit Study before setting permanent indexed benefit floors.
- Evaluate bodily-injury liability separately; add affordability, rural-access, transition, coordination, and market-capacity safeguards.

WHAT THE ARTICLE OR FRAMEWORK CONTRIBUTES

Contribution. The proposal separates personal freedom from cost transfer. It asks Florida to measure episode-level resources, coverage exhaustion, paid and unpaid cost, public financing, and premium effects, then set a credible prospective obligation using actuarial evidence rather than treating the existing $10,000 figure as self-validating.

EVIDENTIARY BOUNDARY

Do not overread it. The editorial does not establish the final coverage amount, prove that every rider is underinsured, assign blame for a crash, or replace emergency-care duties. Coverage design requires actuarial analysis, federal-preemption review, affordability testing, and current Florida counsel review.

BOTTOM LINE **Florida can preserve the choice to ride while requiring a credible, verifiable plan for financing the foreseeable medical risk.**

Source foundation: Freedom to Ride, Responsibility to Insure (motorcycle-trauma financing editorial; final publication citation to be confirmed)

MODEL POLICY BRIEF

Freedom to Ride, Responsibility to Insure

A Florida motorcycle-trauma medical responsibility and public-cost accountability standard

Prepared for: Florida legislators, insurance and transportation agencies, trauma systems, hospitals, riders, insurers, patient advocates, and professional societies

Prepared by: Healthcare Governance

Related paper: Freedom to Ride, Responsibility to Insure (motorcycle-trauma financing editorial; final publication citation to be confirmed)

Version: Draft 1.0

Date: July 13, 2026

Status: Policy position informed by official data and published research; not itself a peer-reviewed publication, insurance product, or legal opinion

RECOMMENDED ACTION

Adopt a Florida Motorcycle Medical Responsibility Standard that requires registration-linked proof of meaningful first-party medical financial responsibility, modernizes the $10,000 helmet-exemption threshold after actuarial review, preserves multiple compliant coverage pathways, and measures the actual trauma-financing deficit before setting permanent dollar floors.

The freedom to accept personal risk does not require hospitals, taxpayers, insured patients, and trauma professionals to finance an avoidable coverage gap.

This brief does not characterize motorcyclists as reckless, make helmet use the sole policy question, or assume every motorcycle crash creates uncompensated care. It addresses the financing gap when severe injury exceeds available first-party resources.

Executive Summary

Florida allows adults over age 21 to ride without a helmet if they are covered by an insurance policy providing at least $10,000 in medical benefits for motorcycle-crash injuries. The threshold has remained embedded in the helmet-exemption statute since the exemption took effect in 2000. FLHSMV states that insurance is not required to register a motorcycle, although financial-responsibility consequences may follow an injury crash and property-damage responsibility applies under chapter 324. [2–7]

The scale of potential injury is materially different from the scale of the helmet-exemption threshold. Florida reported 9,548 motorcycle crashes, 621 motorcycle fatalities, and 2,113 incapacitating motorcycle injuries in 2023. Nationally, 6,228 motorcyclists were killed in 2024; per vehicle mile traveled, motorcyclists were almost 27 times more likely than passenger-car occupants to die and almost five times more likely to be injured. [8,9]

Emergency care appropriately occurs without waiting for an insurance determination. Trauma centers, EMS systems, rehabilitation programs, health insurers, public programs, families, and providers therefore absorb the financial consequences when crash-specific coverage is absent or exhausted. National evidence establishes that motor-vehicle crashes impose costs beyond the people directly involved, while Florida's Brain and Spinal Cord Injury Program operates in part as a payer of last resort using trust-fund and general-revenue support. These facts do not quantify a Florida motorcycle-specific deficit; they justify measuring it. [10–13]

Recommended two-stage reform

- Create a registration-linked duty to maintain motorcycle medical financial responsibility for operators and passengers.
- Direct the Office of Insurance Regulation, Department of Financial Services, FLHSMV, Department of Health, and AHCA to complete an actuarial and trauma-financing study before a permanent minimum is set.
- Permit multiple pathways: motorcycle medical-payments or catastrophic coverage, qualifying private health coverage with defined protections, approved self-insurance or security, and a residual-market or pooled option if commercial products are unavailable.
- Modernize the helmet-exemption proof standard so $10,000 is not treated as evidence of meaningful catastrophic protection; retain the Legislature's separate authority over helmet policy.
- Require electronic verification, grace periods, notice, hardship options, and noncriminal administrative enforcement.
- Publish aggregate, risk-adjusted reports on injury severity, payer mix, paid amounts, uncompensated cost, rehabilitation burden, coverage exhaustion, and outcomes.
- Prohibit any insurance or verification process from delaying emergency screening, stabilization, transfer, trauma activation, or medically necessary care.

CORE POLICY JUDGMENT

Florida does not need to choose between personal freedom and financial responsibility. It can preserve the choice to ride while requiring a credible plan for the foreseeable medical risk.

1. The Policy Problem

Catastrophic trauma can outrun nominal coverage quickly

Severe motorcycle injury may require EMS response, trauma activation, multiple operations, intensive care, implants, blood products, rehabilitation, home services, durable medical equipment, and long-term treatment. A small medical-benefit threshold may satisfy a legal condition without materially financing that trajectory.

The initial payer and the ultimate bearer are not always the same

Stage	Immediate responder or payer	Potential transferred burden
Crash response	Law enforcement, fire-rescue, and ambulance services	Local government, EMS payer mix, uncompensated transport, and public safety resources.
Emergency and trauma care	Hospital, trauma team, physicians, and health plan when available	Uncompensated care, cost shifting, insurer premiums, public programs, and provider losses.
Definitive surgery	Hospital, surgeons, consultants, and rehabilitation clinicians	Multiple episodes may exceed available first-party or liability limits.
Rehabilitation and disability	Health coverage, public programs, family caregivers, and state services	Long-duration medical, work-loss, disability, housing, and caregiver costs.
Long-term consequence	Patient, family, insurers, public programs, and community	Lost earnings, tax revenue, quality of life, and continued care needs.

Fault does not solve the immediate financing problem

A rider may be entirely free of fault and still need care before liability is determined or collected. A liability policy protects against legal responsibility to others; first-party medical responsibility provides a source for the rider's own immediate care. The Legislature should distinguish the two rather than assume one substitutes for the other.

Health coverage does not answer every policy question

Some riders have comprehensive private or public health coverage. Others have high deductibles, limited networks, coverage uncertainty, or no coverage. Even when a health plan pays, premiums and public spending may spread costs across other insureds and taxpayers. A fair policy must define which existing coverage qualifies, avoid unnecessary duplication, and address affordability without pretending that all coverage pathways are equivalent.

2. Florida's Current Structure

The following is a policy summary, not legal advice. Counsel, FLHSMV, the Department of Financial Services, and the Office of Insurance Regulation should confirm operative requirements before bill drafting.

Current element	Florida rule or agency guidance	Policy significance
Helmet requirement and exemption	Protective headgear is generally required. A person over 21 may ride without it if covered by at least $10,000 in medical benefits for motorcycle-crash injuries. Fla. Stat. § 316.211. [2,3]	
Acceptable exemption proof	FLHSMV advises that a health-insurance card, policy, declarations page, or limited motorcycle medical coverage may suffice; passenger-vehicle PIP is insufficient. [3]	
Registration insurance	FLHSMV states that insurance is not required to register motorcycles. If an operator is charged in an injury crash and lacked liability coverage, future coverage may be required to avoid or end suspension. [4]	
Property damage	Chapter 324 requires financial responsibility for property damage for motor vehicles required to be registered, with approved insurance or alternative methods. [5,6]	
Post-crash responsibility	Florida's financial-responsibility framework can trigger security, suspension, and continuing proof requirements after qualifying crashes or offenses. [6,7]	
Four-wheel PIP system	Florida's registration-linked PIP requirement is designed around vehicles with at least four wheels; motorcycle riders cannot assume an automobile PIP policy covers motorcycle injuries. [3,14]	

The structural gap

The current system can require a small medical-benefit threshold for the choice to ride without a helmet while allowing motorcycle registration without a general proof-of-insurance requirement. Financial

responsibility may become enforceable after a serious crash—when the medical and public costs already exist. The proposed standard moves defined responsibility before the loss.

DO NOT CONFUSE THE POLICIES

Helmet requirements reduce injury risk; insurance requirements allocate financial risk. They can interact, but one does not replace the other.

3. Why the Existing $10,000 Threshold Needs Review

A threshold can become symbolic

The statutory amount may confirm that some medical coverage exists, but its meaning should be tested against current emergency, operative, intensive-care, and rehabilitation costs. This brief does not claim that every crash exceeds $10,000. It argues that a 2000-era nominal floor should not be presumed adequate for catastrophic trauma in 2026 without current evidence.

The threshold is tied to helmet choice, not registration

The current medical-benefit condition applies to adults who choose the helmet exemption. It is not a comprehensive motorcycle medical-responsibility standard. A helmeted rider can also sustain severe multisystem injury. If the public purpose is financial responsibility, the duty should be designed around crash exposure and coverage—not only helmet status.

Modernization should be evidence-based

- Measure hospital allowed amounts and actual payments—not only billed charges.
- Separate emergency, inpatient, physician, rehabilitation, pharmacy, durable-equipment, and long-term costs.
- Stratify by injury severity, helmet status, passenger status, age, payer, coverage limits, and crash circumstances.
- Measure uncompensated cost and coverage exhaustion without assuming a charge equals cost.
- Evaluate product availability, premiums, underwriting, exclusions, and market capacity.
- Model multiple coverage floors and combinations before selecting a statutory amount.

4. Proposed Reform: Motorcycle Medical Responsibility Standard

Registration-linked obligation

Before issuing or renewing a Florida motorcycle registration, the state should verify that the owner has an approved mechanism capable of financing motorcycle-related medical injury for the owner and any covered operator. Passenger coverage should be explicitly addressed. The obligation should remain continuous during registration, with reasonable exceptions for stored or surrendered vehicles.

What the standard should cover

- Emergency medical transport and trauma evaluation.

- Hospital, physician, surgical, anesthesia, diagnostic, pharmacy, and rehabilitation services.
- Coverage for motorcycle-crash injury regardless of fault, subject to lawful coordination of benefits.
- Clear treatment of passengers and permissive operators.
- No motorcycle, racing, off-road, helmet, or alcohol exclusion that defeats the statutory minimum for ordinary public-road operation; legal subrogation and fraud remedies may remain.
- A benefit period and exhaustion notice sufficient to identify when additional coverage or public programs become responsible.

Set the permanent floor after study

The Legislature should establish the duty and decision criteria now, then set the permanent dollar floor through a transparent report-and-rule process or subsequent statutory vote. The analysis should present multiple actuarial tiers, expected paid claims, premium effects, market availability, and the proportion of serious trauma expected to exhaust each tier. The final floor should be indexed and reviewed periodically.

Separate bodily-injury liability

First-party medical coverage does not compensate a passenger, pedestrian, or another road user for an at-fault rider's liability. Florida should evaluate a parallel registration-linked bodily-injury liability requirement for motorcycles, with limits and self-insurance pathways assessed separately. Combining the analyses is administratively efficient; conflating the purposes is not.

5. Compliant Coverage Pathways

A single mandated insurance product could create access problems or market failure. The standard should permit several verified pathways that meet common minimum protections.

Pathway	Required protections	Key policy question
Motorcycle medical-payments or catastrophic policy	Motorcycle-specific first-party benefits, no disqualifying road-use exclusion, clear passenger treatment, and regulated claims practices.	Are products available statewide at the required limit and at sustainable premiums?
Qualifying health coverage plus supplemental motorcycle benefit	Confirmed motorcycle injury coverage, defined deductible/out-of-pocket protection, continuity, and a supplemental first-dollar layer.	How can Florida verify benefits without intruding on ERISA plans or duplicating coverage?
Approved self-insurance or security	Liquid, enforceable financial capacity dedicated to covered injury and available promptly after a crash.	What security level and claims administration protect patients and providers?

Pathway	Required protections	Key policy question
Residual-market or pooled option	Standard benefit for applicants unable to obtain commercial coverage, with transparent funding and oversight.	How should risk, subsidy, assessments, and eligibility be allocated?

Coordination without double payment

Rules should establish primary and secondary payer order, subrogation, lien limits, and prohibition of duplicate recovery. The objective is credible payment capacity, not windfall. Existing health coverage should receive appropriate recognition only when the plan actually covers motorcycle injury and meets the standard's consumer-protection criteria.

Affordability and access

- Require a market-conduct and premium study before enforcement.
- Offer monthly payment, low-cost standardized, and residual-market pathways.
- Consider income-based assistance only after fiscal analysis and without using trauma providers as the unfunded insurer of last resort.
- Provide a coverage-transition period and allow voluntary plate surrender or seasonal suspension where administratively feasible.
- Monitor rural availability, young riders, working riders, military personnel, and low-income owners.
- Use safety-course completion, compliant helmet use, anti-lock brakes, and claims history as potential actuarially supported discounts—not moral judgments.

6. Florida Trauma-Financing Deficit Study

Answer the question before fixing the number

Florida should quantify the difference between resources available for motorcycle trauma and the actual amounts paid, unpaid, shifted, or publicly financed. The Department of Health's trauma registry and acute-care registry provide a foundation for severity and utilization analysis, but linkage and access require privacy, data-use, and methodological safeguards. [12]

Required study fields

- Crash date, county, road type, rider/passenger status, helmet status when reliably documented, and crash severity.
- Injury Severity Score, diagnoses, procedures, ICU use, length of stay, transfer, discharge disposition, readmission, rehabilitation, and mortality.
- Primary and secondary payer, motorcycle medical coverage, health coverage, liability coverage, policy limits, deductible, and coverage exhaustion where lawfully available.
- Hospital charges, cost estimates, allowed amounts, payments, contractual adjustments, charity care, bad debt, and uncompensated cost—kept analytically distinct.

- Physician, EMS, rehabilitation, pharmacy, equipment, and post-acute payments where data can be linked.
- Public-program participation and state payer-of-last-resort expenditures, without implying that public beneficiaries are blameworthy.
- Lost-work and long-term disability measures where a lawful, validated source exists.

Required outputs

- Annual number and distribution of motorcycle trauma episodes by severity and payer.
- Median and interquartile ranges for charges, costs, allowed amounts, paid amounts, and uncompensated cost.
- Coverage-exhaustion rates at modeled benefit floors.
- Public, private, patient, hospital, and provider shares of paid and unpaid cost.
- Risk-adjusted comparisons by helmet status and other factors, without converting association into causation.
- Actuarial premium and market-capacity estimates for each proposed coverage pathway.
- A public technical appendix, limitations statement, and de-identified analytic code when permitted.

MEASUREMENT RULE

Charges, costs, allowed amounts, payments, uncompensated care, and societal loss are different constructs. The study must report them separately.

7. Model Legislative Framework

The following is concept language for Florida counsel, agencies, riders, insurers, and trauma stakeholders. It is not final statutory text.

Florida Motorcycle Medical Responsibility Act

Section 1. Purpose

To preserve lawful motorcycle access while ensuring that owners and operators maintain a credible, verified mechanism for financing foreseeable medical consequences of motorcycle crashes and reducing uncompensated trauma burden.

Section 2. Definitions

- “Motorcycle medical financial responsibility” means an approved insurance, health-coverage combination, self-insurance, security, or pooled mechanism meeting statutory minimum protections.
- “Qualifying motorcycle medical coverage” means first-party coverage applicable to injury sustained while operating or riding a motorcycle on a public road.
- “Catastrophic trauma financing deficit” means the difference between episode-level resource cost or allowed payment and identified collectible or paid resources, reported by construct.
- “Coverage exhaustion” means payment or incurred liability reaching the applicable benefit limit.

- "Qualifying health coverage" means coverage verified to include motorcycle injury and meet standards established by rule, subject to federal preemption and coordination law.

Section 3. Registration and continuous responsibility

Require proof of an approved mechanism before registration or renewal and continuous maintenance during the registration period. Authorize electronic verification, notice, grace periods, and plate surrender. Do not require emergency personnel or hospitals to verify coverage before care.

Section 4. Minimum protections

Direct rulemaking on covered services, benefit period, passenger and permissive-operator treatment, prohibited exclusions, coordination, subrogation, claims timeliness, notices, appeals, and fraud controls. Preserve broader coverage and lawful private contracts beyond the statutory floor.

Section 5. Coverage amount

Commission an actuarial and trauma-financing report comparing multiple benefit tiers. Establish a temporary implementation rule only after the Office of Insurance Regulation certifies product availability. Require legislative ratification or clearly bounded rulemaking authority for the permanent floor and indexing method.

Section 6. Helmet-exemption alignment

Replace the standalone $10,000 medical-benefit proof with the qualifying medical-responsibility standard once operational. Preserve the Legislature's independent authority to strengthen, retain, or repeal the helmet exemption and require proof that can be electronically verified.

Section 7. Bodily-injury liability study

Require a separate recommendation on registration-linked bodily-injury liability for harm to passengers and others, including limits, affordability, uninsured-motorist interaction, and self-insurance pathways.

Section 8. Residual market and access

Authorize a standardized residual-market option if the voluntary market does not provide adequate statewide capacity. Require transparent rates, loss data, eligibility, assessments, and sunset review. Provide targeted assistance only through an explicit appropriation.

Section 9. Trauma-financing data

Authorize privacy-protected linkage of crash, trauma, hospital financial, insurance, rehabilitation, and public-program data for aggregate analysis. Prohibit public identification of patients and restrict identifiable use to authorized administration, research, audit, and enforcement.

Section 10. Enforcement

Use administrative notice, cure, registration suspension, and proportionate penalties. Avoid criminalizing inability to pay. Target intentional false proof, repeated evasion, and insurer reporting failures separately. Provide due process and hardship review.

Section 11. Emergency-care protection

State expressly that coverage status does not condition emergency screening, stabilization, trauma activation, transfer, or treatment, and does not alter EMTALA or other applicable duties.

Section 12. Pilot, report, and sunset

Phase the program, publish annual evaluation, monitor access and market concentration, and require legislative review of benefit floors and residual-market authority.

8. Implementation Roadmap

Phase	Actions	Deliverables
0–6 months: design	Convene riders, insurers, OIR, DFS, FLHSMV, DOH, AHCA, trauma centers, EMS, rehabilitation, patient advocates, actuaries, privacy counsel, and economists.	Coverage taxonomy, data map, legal/preemption analysis, and study protocol.
6–18 months: measure	Link authorized datasets; analyze severity, payments, uncompensated cost, payer mix, coverage limits, and product availability.	Florida Motorcycle Trauma Financing Deficit Report and actuarial tier options.
18–24 months: legislate and build	Select pathways and floor; establish electronic verification, notices, residual-market contingency, and consumer forms.	Final statutory language, rules, product filings, and verification system.
24–36 months: transition	Begin voluntary enrollment and registration notices; test verification; provide technical assistance; collect baseline metrics.	Coverage uptake, premium, error, burden, and access report.
36+ months: enforce and evaluate	Activate administrative enforcement after market certification; publish annual results and adjust as authorized.	Public evaluation, corrected data, statutory review, and sunset recommendation.

Performance measures

- Percentage of registered motorcycles with verified qualifying responsibility.
- Availability and premium distribution by county, rider age, and coverage pathway.
- Rate of erroneous verification, cancellation, reinstatement, and appeals.
- Coverage-exhaustion rate by injury severity and selected benefit tier.
- Hospital and professional uncompensated cost associated with motorcycle trauma.
- Public-program and payer-of-last-resort spending, interpreted with eligibility and equity context.
- Changes in registration, unregistered riding, access, and market concentration.
- Emergency-care timeliness and evidence of inappropriate coverage-related delay.
- Crash, injury, fatality, and helmet-use trends, without attributing change to the program absent appropriate design.

9. Safeguards Against Misuse

No emergency delay. Coverage verification must never precede or condition emergency screening, stabilization, trauma activation, transfer, or medically necessary treatment.

No moral presumption. A crash, lack of coverage, public-program enrollment, or helmet choice does not establish recklessness, fault, fraud, or unworthiness of care.

No charge-cost confusion. Hospital charges cannot be presented as actual cost, payment, or deficit without the relevant adjustment and definition.

No double coverage mandate. Existing health coverage should count when it demonstrably meets the standard; coordination should prevent duplicate payment.

No unsupported dollar floor. The permanent minimum should follow Florida-specific actuarial and trauma-financing analysis and product-availability review.

No helmet substitution. Insurance allocates financial risk; it does not prevent injury. Coverage policy should not be described as a substitute for helmet effectiveness or roadway safety.

No raw provider ranking. Public reports should not rank hospitals by uncompensated motorcycle care without severity, transfer, volume, payer, and regional context.

No hidden public subsidy. Any affordability subsidy or residual-market assessment should be explicit, appropriated or authorized, and publicly evaluated.

10. Common Objections and Responses

“Riding is a personal choice; the state should stay out.”

The proposal preserves the choice to ride. It addresses the predictable transfer of medical financing to parties who did not make that choice. Florida already regulates registration, licensing, safety training, property responsibility, and post-crash financial responsibility; prospective medical responsibility fits that framework if designed proportionately.

“Most riders already have health insurance.”

That may be true for many riders, but Florida does not currently publish a comprehensive, linked estimate of qualifying coverage, deductibles, crash-specific exclusions, benefit exhaustion, and uncompensated trauma cost. The proposal counts qualifying existing coverage and requires the state to measure the gap before setting the floor.

“Motorists cause many motorcycle crashes.”

Fault varies and is not the basis of first-party medical responsibility. A rider injured by another driver still needs immediate care before liability is resolved. The proposal should coexist with liability and uninsured/underinsured-motorist protections rather than presume rider fault.

“Insurance will make riding unaffordable.”

Affordability is a real constraint. That is why the brief recommends actuarial study, multiple pathways, residual-market planning, transition, discounts where supported, and market certification before

enforcement. Unfunded trauma care is also a cost; the policy question is how to allocate it transparently and fairly.

"A helmet mandate would be simpler and save more lives."

Universal helmet laws have a strong injury-prevention evidence base. This paper's proposal addresses a different question: who finances the residual trauma risk while Florida retains an adult exemption. The Legislature may consider helmet policy separately; meaningful medical responsibility remains relevant even for helmeted riders.

"The $10,000 threshold is only proof for the helmet exemption."

Correct. That is precisely why it should not be mistaken for a comprehensive financing standard. A registration-linked framework would have a broader purpose and should replace—not merely stack on top of—the existing proof mechanism once operational.

"Hospitals must treat emergencies anyway."

Emergency duties are not a financing mechanism. The obligation to treat protects patients and must remain unconditional. It does not answer how trauma resources, rehabilitation, or uncompensated care should be financed after treatment begins.

11. Evidence Boundaries and Research Agenda

What current evidence supports

- Motorcyclists face substantially higher fatal and injury rates per vehicle mile traveled than passenger-car occupants. [9]
- Florida experiences thousands of motorcycle crashes and serious injuries each year. [8]
- Helmets reduce head injury and universal helmet laws increase helmet use and reduce deaths, injuries, and healthcare costs. [11,15]
- Motor-vehicle crash costs are distributed beyond crash participants through insurance, taxes, public services, and other societal pathways. [10]
- Florida has trauma and acute-care registries capable of supporting authorized research and system planning. [12]
- Florida operates a brain and spinal cord program that can provide payer-of-last-resort assistance and receives trust-fund and general-revenue support. [13]

What has not yet been established

- The current Florida motorcycle-specific total for charges, actual costs, allowed amounts, payments, uncompensated care, and long-term public spending.
- The share of Florida riders whose existing health or motorcycle coverage would meet a defined medical-responsibility standard.
- The premium and product-availability effects of any proposed benefit floor.
- The causal effect of a medical-responsibility mandate on crash behavior, helmet use, registration, or outcomes.

- The proportion of severe motorcycle episodes in which coverage exhaustion materially shifts cost to hospitals, public programs, or families.
- Whether an individual crash was preventable, who was at fault, or whether any patient is undeserving of care.

Priority research questions

- What is the Florida motorcycle trauma-financing deficit when payment constructs are correctly separated?
- Which benefit floors materially reduce exhaustion and uncompensated cost at an acceptable premium?
- How should qualifying health coverage, deductibles, ERISA plans, Medicare, Medicaid, military coverage, and subrogation interact?
- Which insurers and products can provide statewide capacity, and when is a residual market necessary?
- How do helmets, training, anti-lock brakes, impairment, age, motorcycle type, passenger status, and crash type relate to severity and cost?
- Does registration-linked verification reduce uninsured exposure without increasing unregistered operation or inequitable enforcement?
- What is the downstream rehabilitation, disability, caregiver, and work-loss burden by coverage pathway?

12. Decision Checklist for Policymakers

- Does the bill distinguish first-party medical responsibility from liability to others?
- Is the permanent dollar floor supported by Florida-specific cost and premium analysis?
- Can existing coverage qualify without creating gaps or unnecessary duplication?
- Are multiple commercial, pooled, and self-insurance pathways available?
- Does the policy address passengers and permissive operators?
- Are exclusions, coordination, subrogation, claims timing, and appeals defined?
- Is verification electronic, accurate, correctable, and protected by due process?
- Are affordability, rural access, low-income riders, and market concentration evaluated?
- Is emergency care expressly protected from coverage-related delay?
- Are charges, costs, allowed amounts, payments, and uncompensated care kept separate?
- Are public reports aggregate, risk-adjusted, privacy-protected, and nonstigmatizing?
- Will the program be piloted, independently evaluated, adjusted, and sunset if harms exceed benefits?

13. Recommended Action

ADOPT THE PRINCIPLE

Freedom to ride should be paired with a prospective, credible, and verifiable plan for financing the medical risk of riding.

Florida should enact a two-stage Motorcycle Medical Responsibility Standard. The first stage should authorize the statewide trauma-financing and actuarial study, define minimum consumer protections, build electronic verification, and test commercial and residual-market capacity. The second stage should activate a registration-linked coverage floor after the Legislature or properly bounded rulemaking process reviews the evidence.

The reform should modernize the helmet-exemption proof requirement, permit qualifying existing coverage, maintain alternatives to a single commercial product, and separately evaluate bodily-injury liability. It should use administrative—not criminal—enforcement and preserve unconditional emergency care.

This approach does not resolve every dispute about helmet policy, fault, premiums, or personal liberty. It establishes a narrower rule that is difficult to reject: a lawful choice carrying foreseeable catastrophic medical risk should include a credible financing mechanism before the crash, not only financial consequences after the loss has already been transferred.

References and Source Notes

Florida statutes and agency webpages were checked against materials available July 13, 2026. The related editorial's final title, author list, journal status, and citation should be inserted when confirmed. Final bill drafting requires current Florida insurance, transportation, ERISA, Medicaid, privacy, and constitutional counsel review.

1. Freedom to Ride, Responsibility to Insure. Healthcare Governance motorcycle-trauma financing editorial/policy analysis. Working citation; final publication details to be confirmed.
2. Florida Statutes § 316.211, Equipment for motorcycle and moped riders (2025).
3. Florida Department of Highway Safety and Motor Vehicles. Helmet Exemption.
4. Florida Department of Highway Safety and Motor Vehicles. Motorcycle Rider Education & Endorsements: Frequently Asked Questions, including motorcycle insurance guidance.
5. Florida Statutes § 324.022, Financial responsibility for property damage (2025).
6. Florida Statutes § 324.021, Definitions; minimum insurance required (2025).
7. Florida Statutes § 324.051, Reports of crashes; suspensions of licenses and registrations (2025).
8. Florida Department of Highway Safety and Motor Vehicles. 2023 Florida Traffic Crash Facts.
9. National Highway Traffic Safety Administration. Motorcycle Safety. Current national fatality and injury-risk summary.
10. National Highway Traffic Safety Administration. The Economic and Societal Impact of Motor Vehicle Crashes, 2019; agency summary published January 10, 2023.
11. Centers for Disease Control and Prevention. Motorcycle Safety. Updated January 28, 2026.
12. Florida Department of Health. Florida Trauma Registry and Acute Care Trauma Registry.
13. Florida Department of Health. Brain and Spinal Cord Injury Program, including payer-of-last-resort role and funding sources.
14. Florida Department of Highway Safety and Motor Vehicles. Florida Insurance Requirements.
15. Centers for Disease Control and Prevention. MV PICCS Intervention: Universal Motorcycle Helmet Laws.
16. Florida Department of Financial Services. Personal Automobile Insurance Overview.

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

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Keep Complications Traceable to the Care Model

I-95 Corridor | Florida office-surgery continuity, reporting, ownership, and rescue accountability

Emergency departments should rescue the patient. The regulatory system should preserve traceability to the care model that created the postoperative risk.

THE ISSUE

In brief. A patient may be marketed to in one place, operated on in another, recover elsewhere, and seek emergency rescue at an unrelated hospital. When patient acquisition, ownership, surgery, postoperative responsibility, reporting, and rescue are separated, the complication may disappear from the originating facility's ordinary feedback loop—even when the transfer itself was appropriate and lifesaving.

WHY IT MATTERS

- Fragmented episodes make continuity, denominator-based safety analysis, and regulatory learning harder.
- The receiving hospital may bear the visible clinical and financial burden without controlling the originating care model.
- Reporting gaps can obscure repeated patterns, ownership relationships, and adequacy of postoperative arrangements.

POLICY DIRECTION

- Create bidirectional reporting: the originating practice reports defined events and receiving hospitals report qualifying rescue episodes.
- Require a named postoperative clinician, written escalation pathway, records transfer, and safe handoff before surgery.
- Publish ownership and control information sufficient to link brands, facilities, clinicians, and responsible entities.
- Use risk- and scale-appropriate financial responsibility while protecting emergency transfer and avoiding automatic fault findings.

WHAT THE ARTICLE OR FRAMEWORK CONTRIBUTES

Contribution. The I-95 Complication Corridor is a governance metaphor for episodes that cross markets and institutions. It focuses attention on linkage: whether the clinical event, originating facility, responsible entities, postoperative plan, receiving hospital, and downstream outcome can be reconciled for learning and oversight.

EVIDENTIARY BOUNDARY

Do not overread it. The analysis does not establish that office surgery as a category is unsafe, that every complication is preventable or negligent, or that a defined highway corridor has a measured excess complication rate. Denominator-based research and current Florida legal review remain necessary.

BOTTOM LINE **Make rescue immediate, reporting nonpunitive, and postoperative responsibility traceable across organizational and geographic boundaries.**

Source foundation: The I-95 Complication Corridor (working editorial/policy analysis; final publication citation to be confirmed)

MODEL POLICY BRIEF

A Complication Should Remain Traceable to the Care Model That Produced It

A Florida continuity, reporting, ownership, and rescue-accountability standard for office surgery

Prepared for: Florida legislators, agencies, professional boards, hospitals, surgeons, patient-safety organizations, and professional societies

Prepared by: Healthcare Governance

Related analysis: The I-95 Complication Corridor (working editorial/policy analysis; final publication citation to be confirmed)

Version: Draft 1.0

Date: July 13, 2026

Status: Policy position informed by law and published research; not itself a peer-reviewed publication or legal opinion

RECOMMENDED ACTION

Adopt a Florida Office-Surgery Continuity and Accountability Standard that links the originating surgeon and facility to defined postoperative duties, bidirectional complication reporting, transparent ownership and control, and risk-appropriate financial responsibility—without delaying emergency rescue or treating every complication as negligence.

Emergency departments should rescue the patient. The regulatory system should preserve traceability to the care model that created the postoperative risk.

This brief does not characterize office-based surgery as inherently unsafe. It addresses governance failures that can arise when patient acquisition, facility ownership, surgery, postoperative coverage, emergency rescue, reporting, and financial responsibility are divided among different actors.

Executive Summary

Florida has a substantial office-surgery regulatory structure. Certain offices must register with the Department of Health, undergo inspection or qualifying accreditation, designate a physician responsible for compliance, maintain financial responsibility, and report qualifying adverse incidents. Florida law also requires reporting when an office-surgery procedure results in hospitalization. [2–6]

The remaining policy problem is continuity across settings and time. A complication may become evident after discharge, after a patient travels away from the operating facility, or when an emergency department or hospital first recognizes the severity of the event. The surgeon, facility, management company, marketing channel, postoperative coverage arrangement, and rescue hospital may be organizationally and geographically separate. In that fragmented model, emergency care can occur promptly while regulatory traceability, clinical handoff, aggregate learning, and financial accountability remain incomplete.

The I-95 Complication Corridor analysis describes this separation as a governance problem rather than proof that office surgery as a category is unsafe. Large registry analyses report that appropriately selected outpatient plastic-surgery patients can have comparable overall adverse-event rates across office-based and ambulatory settings. Historical Florida data also demonstrate the importance of mandatory reporting and the limits of systems that fail to capture complications recognized after the patient leaves the originating setting. [8,9]

Recommended Florida standard

- Create bidirectional reporting: the originating office continues to report qualifying events, while a receiving hospital reports a limited, de-identified linkage record when it treats a qualifying complication arising from a recent office procedure.
- Require a named postoperative-responsibility plan, 24/7 clinician access, local coverage, escalation instructions, timely records transmission, and direct clinical handoff when emergency transfer or admission occurs.
- Create a public registry that identifies the registered office, designated compliance physician, responsible medical director, owners and controlling entities, management company, and material marketing or referral relationships.
- Modernize financial responsibility using procedure risk, anesthesia level, volume, combined-procedure burden, out-of-area patient volume, and prior regulatory history—while allowing multiple compliant mechanisms and avoiding patient barriers to emergency care.
- Publish risk-adjusted, aggregate statewide trend reports that support prevention without identifying patients, creating raw league tables, or treating a reported complication as proof of negligence.
- Phase implementation through rulemaking, electronic reporting, a pilot period, technical assistance, and independent evaluation before imposing outcome-based sanctions.

CORE POLICY JUDGMENT

A transfer can be clinically appropriate and lifesaving. Reporting the transfer should preserve continuity and system learning—not punish the act of transferring a patient who needs higher-acuity care.

1. The Governance Problem

The episode can become institutionally fragmented

A patient may encounter a digital marketing entity, financing vendor, management company, office-surgery registration, surgeon, anesthesia team, postoperative contractor, hotel or recovery setting, and receiving hospital. Each actor may perform a legitimate function. The governance risk arises when no single record makes responsibility, handoff, ownership, and downstream events traceable across the episode.

Stage	Possible responsible actor	Potential gap
Patient acquisition	Marketing, referral, lead-generation, or financing entity	Promotional identity may obscure the licensed office, operating surgeon, or controlling organization.
Procedure	Surgeon, anesthesia professional, registered office, or licensed facility	Legal and clinical roles may differ from the commercial brand presented to the patient.
Postoperative period	Operating surgeon, covering clinician, contractor, or remote call service	Coverage, physical availability, and escalation responsibility may be unclear after discharge.
Emergency rescue	EMS, emergency department, hospital, intensivist, or consultant	The receiving team may lack operative records, direct handoff, or a reliable originating contact.
Reporting and review	Originating licensee, Department of Health, receiving facility, or AHCA	Events recognized downstream may be reported through a different system or not linked to the originating office episode.
Financial consequence	Patient, insurer, hospital, physician, facility, or public program	Rescue cost and uncompensated burden may be separated from the enterprise that generated the procedural revenue and risk.

Why geography matters

The “I-95 corridor” is a policy metaphor for care that crosses local markets and institutional boundaries. It should not be used as a claim that a defined highway region has a measured complication rate unless supporting denominator-based data are available. Its value is to describe a recurring traceability problem: patients may travel for surgery and later seek rescue elsewhere, separating the adverse event from the originating facility’s ordinary clinical and regulatory feedback loop.

Why the distinction matters

A safe and accountable system must do two things at once: preserve access to appropriately selected office surgery and ensure that complications remain connected to the responsible episode. Overbroad restrictions could shift care, increase cost, or reduce access without improving safety. Underinclusive reporting can hide patterns and transfer downstream burden to hospitals and clinicians who did not select the patient, procedure, or postoperative model.

2. What Florida Already Requires

Any reform should build on—not erase—Florida's existing framework. The following summary is a policy overview, not legal advice. Counsel and the responsible agencies should verify the final statutory and regulatory text before drafting legislation.

Current element	Existing Florida requirement	Policy implication
Registration and inspection	Specified Level II and Level III office surgery and certain liposuction offices must register; the Department of Health inspects before registration and at least annually unless qualifying accreditation applies. Fla. Stat. § 458.328; parallel osteopathic provisions apply. [2,5]	
Designated physician	A registered office must identify a licensed physician responsible for office health-and-safety compliance who practices at that office. [2]	
Financial responsibility	Registered offices and physicians must demonstrate financial responsibility under specified statutory pathways; additional requirements apply to gluteal fat grafting offices. [2,7]	
Standards of practice	Florida law and Board rules address office-surgery scope, levels, equipment, personnel, monitoring, transfer arrangements, records, postoperative care, and procedure-specific safeguards. [2,4,5]	
Office adverse-incident reporting	Qualifying events in physician office practice settings must be reported to the Department of Health; the definition includes a condition requiring transfer to a licensed hospital. [3,6]	

Current element	Existing Florida requirement	Policy implication
Hospitalization after office surgery	If an office-surgery procedure results in hospitalization, the incident must be reported pursuant to the office adverse-incident statute. [2]	
Licensed-facility risk management	Hospitals and ambulatory surgical centers have internal risk-management and adverse-incident obligations administered by AHCA, including reports arising from care before admission in specified circumstances. [10]	

The policy gap is linkage

Current law places important duties on originating offices and licensed facilities, but it does not necessarily create a single episode-linked dataset when the complication is first recognized after discharge at an unrelated hospital. Nor does a registration record necessarily reveal every commercial or management entity that shaped the patient's care pathway. The proposed standard focuses on these interfaces.

DO NOT DUPLICATE WHAT ALREADY WORKS

The legislation should preserve existing registration, inspection, professional discipline, accreditation, and reporting structures. New duties should be narrowly designed to connect downstream events and clarify postoperative responsibility.

3. Proposed Reform One: Bidirectional Reporting

Originating report

The surgeon or registered office should electronically report a qualifying postoperative event within a defined period after learning of it. The duty should include reasonable follow-up and reconciliation when a patient reports emergency treatment, admission, reoperation, intensive care, or death related to the procedure.

Receiving report

A Florida hospital or emergency department that identifies a qualifying complication associated with a recent office procedure should submit a limited linkage notice to the designated state system. The report should identify the originating office and surgeon when known, the procedure date and category, the rescue setting, and the type of qualifying event. Patient identifiers should be restricted to those necessary for secure matching and removed from public outputs.

Data matching and reconciliation

- Use one electronic portal or interoperable exchange between the Department of Health and AHCA.
- Assign a unique episode identifier when feasible and reconcile originating and receiving reports to avoid double counting.
- Allow "unknown" fields when the receiving team cannot reliably identify the office or surgeon; do not delay treatment to obtain reporting information.
- Require the agencies to return a nonpunitive reconciliation request when reports appear incomplete or inconsistent.
- Publish only aggregate, risk-adjusted trends with minimum cell-size protections.

Qualifying events

The Legislature should direct expert rulemaking to define events with sufficient specificity. A starting list could include death, unplanned hospital admission, intensive-care admission, emergency reoperation, major transfusion, thromboembolism, organ injury, neurologic injury, severe infection, transfer for a higher level of care, and other events already reportable under Florida law. The reporting window may differ by event and procedure; a single arbitrary window should not be assumed to capture every clinically relevant complication.

4. Proposed Reform Two: Postoperative Responsibility and Handoff

Named responsibility before surgery

Before the procedure, the patient should receive a written continuity plan naming the operating surgeon, the registered office, the designated compliance physician, the clinician responsible after hours, the location where urgent evaluation can occur, and the process for contacting the team. The plan should state whether the operating surgeon will remain locally available and, if not, identify an appropriately qualified covering clinician.

Minimum continuity elements

- A monitored 24/7 clinical contact capable of reaching the responsible clinician—not only a commercial call center.
- Defined criteria for urgent office evaluation, emergency-department referral, EMS activation, and direct hospital transfer.
- A coverage plan for patients who reside or recover outside the local area.
- Timely access to the operative report, anesthesia record, medication list, implant information, recent laboratory results, and relevant photographs or imaging.
- Direct clinician-to-clinician handoff for a known serious complication, unless immediate emergency conditions make prior contact impracticable.
- Documented follow-up after an emergency visit, admission, transfer, or reoperation.

Emergency-care safeguard

No continuity requirement may delay calling 911, performing a medical screening examination, stabilizing an emergency medical condition, or arranging an appropriate transfer. EMTALA duties remain independent. The office's obligation is to support—not control or obstruct—the receiving team. [11]

CLINICAL PRINCIPLE

"Go to the emergency department" may be appropriate immediate advice. For a known serious complication, it should be followed by records transmission and direct clinical handoff as soon as practicable.

5. Proposed Reform Three: Ownership and Control Transparency

Why ownership matters

The entity visible to a patient may be a brand rather than the registered office or licensed professional responsible for care. Ownership and management information can help patients, regulators, hospitals, and investigators understand who controls staffing, scheduling, marketing, financial policy, and postoperative systems.

Public registry fields

- Legal and trade names of the registered office.
- Physical location and office-surgery registration number.
- Designated compliance physician and responsible medical director, if different.
- Direct and indirect owners and persons or entities with operational control, subject to a reasonable ownership threshold.
- Management company and material changes in management or control.
- Accreditation status, accrediting organization, and inspection pathway.
- Surgeons practicing at the office and dates of affiliation, consistent with existing notification requirements.
- Material marketing, referral, or lead-generation entities using the office's brand, when their relationship could reasonably affect patient understanding of who provides care.

Patient-facing disclosure

The preoperative disclosure should be concise and understandable. It should identify the legal office, operating surgeon, anesthesia provider or group when known, postoperative coverage arrangement, ownership or management relationships material to the patient's decision, and the state webpage where registration information can be verified.

Limits

The registry should not publish protected health information, confidential peer-review material, personal home addresses, proprietary contracts, or unsupported allegations. Ownership transparency is an accountability tool, not a presumption of misconduct.

6. Proposed Reform Four: Risk-Appropriate Financial Responsibility

Build from existing law

Florida already requires registered offices and physicians to demonstrate financial responsibility, with specified minimum pathways and additional requirements for gluteal fat grafting offices. The policy question is whether requirements should be calibrated to the risk and scale of the care model rather than treated as a uniform proxy for the downstream rescue burden. [2,7]

Potential risk and scale triggers

- Procedure category and recognized complication severity.
- Anesthesia depth and duration.
- Number and combination of procedures in one episode.
- Annual procedural volume and growth rate.
- Proportion of patients traveling from outside the local service area.
- Observed transfers or qualifying events after appropriate denominator and risk adjustment.
- Prior reporting, registration, inspection, or continuity-plan violations.

Flexible compliance mechanisms

After actuarial and legal review, Florida could permit professional and facility liability insurance, a bond, escrow, captive arrangement, complication-rescue coverage, stop-loss mechanism, or another approved combination. The standard should focus on credible capacity to respond to claims and required continuity obligations—not on mandating one commercial insurance product.

Essential safeguards

- Do not require payment, proof of coverage, or financial authorization before emergency screening and stabilization.
- Do not shift rescue bills to patients through waivers that disclaim the office's legal responsibilities.
- Avoid requirements so blunt that they eliminate low-risk, high-quality practices without evidence of improved safety.
- Use actuarial study, public comment, and phased thresholds before implementation.
- Review market availability and rural, small-practice, and access effects.

7. Data, Public Reporting, and Learning

The denominator problem

A count of transfers or complications cannot establish comparative safety without knowing the number and type of procedures performed, patient risk, procedure combinations, anesthesia, follow-up completeness, and the reporting window. Raw counts can penalize high-volume centers or practices that appropriately transfer patients. Florida should therefore pair event reporting with standardized denominator data and risk adjustment.

Recommended public report

The Department of Health and AHCA should publish a joint annual report that includes statewide procedure volume by category, qualifying event types, timing after procedure, rescue setting, geographic patterns, reporting completeness, and trends over time. Public reports should suppress small cells and avoid patient, practitioner, and facility identification unless a separate lawful public disciplinary or enforcement process applies.

Regulatory use

Identifiable data may support confidential quality improvement, report reconciliation, inspection targeting, and investigation under existing legal authority. An event alone should not trigger an automatic finding. Agencies should examine the clinical record, risk context, reporting behavior, handoff, and compliance history.

MEASURE WHAT THE SYSTEM NEEDS TO LEARN

Florida should know not only that a hospital treated a postoperative complication, but which care setting generated the episode, whether continuity duties were met, and whether the event was captured by both sides of the transfer.

8. Model Legislative Framework

The following is concept language for counsel, agencies, and stakeholders. It is not final statutory text.

Florida Office-Surgery Continuity and Accountability Act

Section 1. Purpose

To preserve safe access to office surgery while ensuring continuity of postoperative responsibility, timely clinical handoff, accurate episode-linked reporting, transparent ownership and control, risk-appropriate financial responsibility, and statewide patient-safety learning.

Section 2. Definitions

- “Originating office” means the office or facility in which the covered procedure was performed.
- “Originating practitioner” means the physician who performed or was primarily responsible for the covered procedure.
- “Qualifying postoperative event” means an event defined by rule that results in death, transfer, hospital admission, intensive care, emergency intervention, reoperation, major injury, or another material outcome within the applicable reporting period.
- “Postoperative responsibility period” means a procedure-specific period established by rule during which continuity, follow-up, and reporting duties apply.
- “Receiving facility” means a hospital or other licensed facility that evaluates or treats the patient for a potential qualifying postoperative event.
- “Controlling entity” means a person or organization with ownership, management, staffing, scheduling, marketing, or financial authority material to operation of the office-surgery enterprise.

Section 3. Preoperative continuity disclosure

Require a plain-language disclosure of the legal office identity, operating clinician, postoperative contact and coverage, emergency escalation process, ownership or management relationships material to patient understanding, and the public registration link.

Section 4. Postoperative coverage and handoff

Require 24/7 access to a responsible clinician, local coverage appropriate to the procedure and patient geography, timely transmission of essential records, direct clinical handoff for known serious events, and documented follow-up after emergency evaluation or admission.

Section 5. Bidirectional reports

Require originating and receiving reports for qualifying events; authorize secure matching, reconciliation, electronic submission, interagency data exchange, and nonduplicative reporting. Prohibit any reporting step from delaying emergency care.

Section 6. Ownership and control registry

Require disclosure and timely updates of the office's legal identity, trade names, owners, controlling entities, management company, designated physician, medical director, accreditation status, and clinicians practicing at the site.

Section 7. Financial responsibility

Direct a risk and market study; authorize calibrated requirements and multiple compliant mechanisms; prohibit waivers that shift nonwaivable legal obligations to patients; preserve emergency-care protections.

Section 8. Data use and confidentiality

Authorize confidential quality improvement, inspection, and lawful investigation. Require aggregate public trend reports with risk adjustment, suppression rules, and no automatic negligence inference from a reported event.

Section 9. Enforcement

Use education and corrective action for first-time, nonwillful reporting or administrative failures; authorize proportionate penalties for repeated, willful, false, or obstructive conduct; preserve existing professional and facility discipline authorities.

Section 10. Rulemaking, pilot, and evaluation

Direct joint rulemaking by the Department of Health, Board of Medicine, Board of Osteopathic Medicine, and AHCA as appropriate. Require a pilot, stakeholder advisory group, annual evaluation, and legislative report before full implementation of outcome-based consequences.

9. Implementation Roadmap

Phase	Actions	Deliverables
0–6 months: design	Convene agencies, surgeons, hospitals, emergency physicians, nurses, risk managers, patient representatives, privacy counsel, insurers, accreditation bodies, and data experts.	Definitions, event list, reporting windows, data dictionary, legal analysis, and workflow map.
6–12 months: build	Develop electronic reporting and matching; align DOH and AHCA systems; create continuity and ownership forms; issue draft rules.	Test environment, training materials, public registry prototype, and fiscal/market analysis.
12–24 months: pilot	Pilot in selected counties or high-volume settings; use technical assistance and nonpunitive reconciliation.	Completeness, burden, duplicate-report, timeliness, and data-quality metrics.
24–36 months: evaluate	Assess safety signals, access, transfer behavior, unintended effects, insurer availability, and hospital burden.	Independent evaluation and recommendations to revise, scale, or stop specific components.
36+ months: scale	Implement validated components statewide with calibrated enforcement and annual review.	Public aggregate report, updated rules, and continuous improvement cycle.

Operational metrics

- Percentage of qualifying events matched across originating and receiving reports.
- Median time from event recognition to report and from transfer request to records transmission.
- Percentage of patients receiving complete continuity disclosures.
- Frequency of missing or inaccurate ownership and clinician-affiliation records.
- Emergency transfer rates adjusted for procedure, volume, and patient risk.
- Evidence of delayed or avoided transfer, if any.
- Administrative time and cost for offices and receiving facilities.
- Effect on insurance availability, procedural access, and market concentration.

Governance

The state should assign one accountable program office for implementation while preserving each agency's statutory authority. A multidisciplinary advisory group should publish meeting materials,

identify conflicts, and include receiving-hospital clinicians and patient representatives—not only originating providers and regulators.

10. Safeguards Against Misuse

No negligence presumption. A complication, emergency visit, admission, transfer, or report does not independently establish negligence, causation, unprofessional conduct, or liability.

No transfer penalty. Appropriate transfer should be protected. Enforcement should target failure to transfer, failure to hand off, false reporting, or repeated noncompliance—not the act of seeking higher-acuity care.

No emergency delay. Screening, stabilization, and transfer duties under federal and state law take priority over reporting and financial processes.

No raw ranking. Public data should not rank facilities or surgeons without validated denominators, risk adjustment, completeness assessment, and minimum volume.

No specialty favoritism. Comparable procedures and care models should be held to comparable standards regardless of specialty, ownership, payer, or business model.

No false precision. Reporting windows and event definitions should reflect clinical evidence and be revised as data mature.

No patient abandonment by contract. A consent form or financial waiver should not nullify nonwaivable continuity, reporting, professional, or emergency-care duties.

11. Common Objections and Responses

"Florida already regulates office surgery."

Correct. The proposal builds on registration, inspection, designated-physician, financial-responsibility, and adverse-incident requirements. Its principal additions are episode linkage, downstream recognition, clearer continuity duties, and ownership transparency.

"Most office surgery is safe."

Large registry evidence supports the conclusion that appropriately selected patients can undergo outpatient plastic surgery safely in multiple accredited settings. That does not eliminate the need for traceability when a serious complication occurs. [9]

"Receiving-hospital reporting creates duplicative burden."

The receiving report should be short, electronic, and reconciled with the originating report. Its value is greatest when the originating provider does not yet know of the event or the patient presents far from the office. The pilot should measure burden and eliminate fields that do not improve linkage or learning.

"Complications are known risks and do not prove wrongdoing."

Agreed. The statute should expressly bar an automatic adverse inference. Reporting supports surveillance and prevention; discipline or liability requires the applicable separate legal and evidentiary process.

"Ownership disclosure will expose proprietary information."

The registry should disclose identity and control—not contracts, prices, or trade secrets. The public has a legitimate interest in knowing the legal entity and responsible individuals behind a procedural brand.

"Higher financial-responsibility requirements will reduce access."

That risk is real. This brief recommends actuarial study, flexible mechanisms, risk and volume calibration, phased implementation, and access monitoring—not an immediate blanket insurance mandate.

"Reporting will discourage necessary transfers."

Poorly designed enforcement could create that effect. The statute should protect timely transfer and focus on accurate reporting, handoff, and continuity. A reported transfer should not be scored as a failure without clinical review and risk adjustment.

12. Evidence Boundaries and Research Agenda

What the I-95 analysis can support

The I-95 Complication Corridor is best used to describe a potential governance pattern: the separation of patient acquisition, ownership, operative care, postoperative responsibility, rescue, reporting, and cost. Unless the final paper contains denominator-based empirical results, it should not be cited as establishing the prevalence, comparative safety, geographic concentration, or causal effect of that pattern.

What existing evidence shows

- Florida has long-standing mandatory office adverse-incident reporting and office-surgery regulation. [2–6]
- Historical Florida reporting data support continued mandatory reporting and broader capture of events recognized after discharge; the historical counts should not be presented as current rates. [8]
- A large plastic-surgery registry comparison found no significant difference in overall adverse events between office-based surgery facilities and ambulatory surgery centers after appropriate patient selection, reinforcing the need for a targeted rather than categorical policy response. [9]
- Florida licensed facilities have separate risk-management and adverse-incident reporting duties, creating an opportunity for episode linkage across agencies and settings. [10]

Priority research questions

- How many qualifying complications are first recognized after discharge and at a facility unaffiliated with the originating office?

- What proportion of receiving-facility events can be matched to an originating office report?
- Which event definitions and windows capture clinically attributable complications without excessive false linkage?
- How do procedure mix, combined procedures, anesthesia, patient risk, volume, and travel distance affect event rates?
- Do continuity and handoff requirements improve timeliness, reduce duplicated testing, or change outcomes?
- What financial-responsibility mechanisms are available, affordable, and proportionate across practice types?
- Do new requirements change transfer behavior, patient access, market concentration, or hospital uncompensated burden?

13. Decision Checklist for Policymakers

- Does the proposal clearly distinguish existing law from new requirements?
- Is the covered procedure and facility scope defined without targeting a specialty or business model?
- Are event definitions and reporting windows evidence-informed and procedure-specific?
- Can originating and receiving reports be matched without duplicating counts?
- Are emergency screening, stabilization, and transfer protected from delay?
- Does the continuity plan identify a responsible clinician, local coverage, escalation, and handoff?
- Does ownership disclosure reveal legal identity and operational control without exposing protected information?
- Are financial requirements supported by actuarial analysis and multiple compliance options?
- Are public reports aggregate, risk-adjusted, and protected against misleading rankings?
- Is there an explicit no-negligence and no-transfer-penalty safeguard?
- Will the program be piloted, evaluated, revised, and stopped if unintended harms outweigh benefits?
- Have receiving hospitals, emergency clinicians, patients, privacy experts, and small practices participated in design?

14. Recommended Action

ADOPT THE PRINCIPLE

A complication should remain clinically and regulatorily traceable to the office-surgery episode that produced the postoperative risk, even when rescue occurs elsewhere.

Florida should modernize its existing office-surgery framework through four connected reforms: bidirectional event reporting, defined postoperative responsibility and handoff, ownership and control transparency, and risk-appropriate financial responsibility. These reforms should be implemented as a learning system—not a presumption of negligence, a barrier to emergency transfer, or a categorical attack on office surgery.

The first legislative step should authorize a joint DOH–AHCA design process, electronic episode linkage, a public ownership registry, model continuity requirements, and an actuarial study. A time-limited pilot should precede statewide outcome-based enforcement.

The final bill and rules should be reviewed by Florida counsel, the responsible professional boards, AHCA, privacy experts, emergency-care stakeholders, and representatives of both high-volume and small office practices.

References and Source Notes

Legal and regulatory sources were checked against official Florida and federal webpages available July 13, 2026. Final bill drafting requires current counsel review. The I-95 paper's final title, authorship, journal status, and citation remain to be inserted when confirmed.

1. The I-95 Complication Corridor. Healthcare Governance editorial/policy analysis. Working citation; final publication details to be confirmed.
2. Florida Statutes § 458.328, Office surgeries (2025).
3. Florida Statutes § 458.351, Reports of adverse incidents in office practice settings (2025).
4. Florida Administrative Code Rule 64B8-9.009, Standard of Care for Office Surgery; current rule page lists an effective date of September 16, 2024.
5. Florida Statutes § 459.0138, Office surgeries (osteopathic medicine) (2025).
6. Florida Statutes § 459.026, Reports of adverse incidents in office practice settings (osteopathic medicine) (2025).
7. Florida Statutes § 458.320, Financial responsibility (2025).
8. Starling J III, Thosani MK, Coldiron BM. Determining the safety of office-based surgery: what 10 years of Florida data and 6 years of Alabama data reveal. Dermatol Surg. 2012;38(2):171–177. PMID: 22093178.
9. Safety of Outpatient Plastic Surgery: A Comparative Analysis Using the TOPS Registry with 286,826 Procedures. Plast Reconstr Surg. 2023. PMID: 36877624.
10. Florida Statutes § 395.0197, Internal risk management program (2025); and Florida Agency for Health Care Administration, Office of Risk Management and Patient Safety.
11. 42 U.S.C. § 1395dd, Examination and treatment for emergency medical conditions and women in labor (EMTALA).
12. Florida Department of Health, Physician Office Adverse Incident Report form.

Document status and use

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

Suggested website classification: Policy analysis | Draft | Florida | Office surgery | Patient safety | Continuity | Adverse-event reporting

Billing Experts Should Show Their Work

BORS100 | Expert-opinion transparency and qualification-to-opinion fit

The title "billing expert" should not erase the boundaries of the expert's actual experience.

THE ISSUE

In brief. Medical-billing disputes can involve coding, clinical documentation, charge development, payment methodology, medical necessity, benchmark construction, payer policy, and healthcare economics. These fields overlap, but they are not interchangeable. A polished witness may have real experience in one area while presenting broader opinions that a jury or other non-specialist cannot readily separate.

WHY IT MATTERS

- Precise dollar figures, codes, and percentiles can create an impression of authority without revealing the analytical path.
- General credentials do not establish qualification for every opinion category.
- Cross-examination works better when sources, calculations, assumptions, and limits are disclosed before testimony.

POLICY DIRECTION

- Classify each opinion: coding, clinical, charge, payment, benchmark, medical-necessity, or economic.
- Require qualification-to-opinion fit for each category—not merely a broad résumé or occupational title.
- Disclose records, benchmark provenance, method, calculations, assumptions, exclusions, case linkage, and relevant relationships.
- Apply the standard symmetrically and use cure or supplementation before disproportionate sanctions.

WHAT THE ARTICLE OR FRAMEWORK CONTRIBUTES

Contribution. BORS100 is a published seven-domain framework for examining whether the disclosed foundation of a billing or medicolegal opinion is visible, reproducible, case-specific, and auditable. It can organize review, report writing, and comparison without replacing the governing legal standard.

EVIDENTIARY BOUNDARY

Do not overread it. BORS100 is a proposed, pilot-use structured review aid. It does not independently determine truth, admissibility, credibility, payment, bad faith, or whether an expert is qualified under controlling law. A high score does not prove correctness; a low score does not prove misconduct.

BOTTOM LINE **Require the expert to define the opinion, show the method, and disclose the limits before asking a decision-maker to rely on the conclusion.**

Source foundation: Billing Opinion Reliability Score 100 (Cureus, 2026) | PubMed PMID 42436700 | BORS100.com

HEALTHCARE GOVERNANCE | POLICY BRIEF

MODEL POLICY BRIEF

Billing Experts Should Show Their Work - and the Limits of Their Expertise

A structured transparency standard for billing and medicolegal expert opinions

Prepared for: Legislators, courts, agencies, professional societies, and healthcare organizations
Prepared by: Healthcare Governance
Version: Draft 1.0
Date: July 13, 2026
Status: Policy position informed by published research; not itself a peer-reviewed publication

RECOMMENDED ACTION

Adopt a content-neutral Billing Opinion Disclosure Standard that requires a retained expert to identify each opinion, demonstrate qualification for that opinion, disclose the sources and benchmark provenance, explain the method and calculations, connect the analysis to the case, and state material assumptions and limitations.

The title "billing expert" should not erase the boundaries of the expert's actual experience.

This brief proposes a model disclosure framework. It does not recommend that any jurisdiction enact BORS100 as a mandatory score, and it does not alter the legal standards governing admissibility, credibility, evidentiary weight, payment, or professional judgment.

Executive Summary

Medical billing disputes may require expertise in coding, clinical documentation, charge development, payment methodology, medical necessity, clinical complexity, payer policy, benchmark construction, and healthcare economics. These fields overlap, but they are not interchangeable. A witness may have substantial experience in one area while presenting opinions in another, and a polished presentation may make those boundaries difficult for a jury or other non-specialist to see.

The policy problem is not professional disagreement. It is the risk that decision-makers receive a precise conclusion without enough structured information to evaluate the expert's qualification for the specific question, the data and benchmark selected, the analytical pathway, the calculation, the case-specific reasoning, and the limitations of the opinion.

Existing federal law already reflects the importance of expert qualification, sufficient facts or data, reliable principles and methods, reliable application, and pretrial disclosure. Federal Rule of Evidence 702 requires the proponent to demonstrate the rule's conditions to the court by a more-likely-than-not standard. Federal Rule of Civil Procedure 26 requires retained-expert reports to state all opinions and their bases, facts or data considered, exhibits, qualifications, prior testimony, and compensation. [2-4]

A billing-specific disclosure schedule would not replace those rules. It would make them easier to apply in a technical field where similar-sounding opinions may rest on very different expertise and data.

Recommendation

Adopt a jurisdiction-appropriate Billing Opinion Disclosure Standard through court rule, administrative rule, professional guidance, institutional policy, or legislation where constitutionally and procedurally appropriate. The standard should:

- Classify each opinion by type rather than treating "medical billing" as a single undifferentiated field.
- Require qualification-to-opinion fit for each opinion category.
- Require traceable sources, benchmark provenance, methods, calculations, assumptions, exclusions, and case linkage.
- Apply symmetrically to provider, payer, plaintiff, defense, employer, government, and neutral experts.
- Protect privileged, confidential, proprietary, and patient-identifying information through existing safeguards.
- Use proportionate remedies focused first on cure and supplementation.
- Make clear that no score, including BORS100, independently determines admissibility, truth, credibility, payment, or bad faith.

Core policy judgment

Expert testimony should be evaluated at the level of the specific opinion offered. General credentials or a broad occupational title should not substitute for demonstrated qualification, transparent methodology, and case-specific support.

1. The Policy Problem

"Medical billing" is not one field

A single dispute may involve several distinct questions:

- Was a service coded correctly?
- Does the clinical record support the code or modifier?
- Was the billed charge reasonable for the market and service?
- Was an allowed amount or payment reasonable under a contract, statute, or policy?
- Was a benchmark accurately described and fit for the question?
- Was the service medically necessary?
- Did clinical complexity, site of service, geography, timing, or emergency circumstances matter?
- Does an economic conclusion properly distinguish charges, costs, allowed amounts, and payments?

A coding professional, clinician, payer analyst, revenue-cycle professional, statistician, economist, and reimbursement consultant may each contribute legitimate expertise. None should automatically be presumed qualified for every question merely because each question relates to a bill.

The risk to non-specialist decision-makers

Jurors, judges, arbitrators, hearing officers, and organizational leaders may not know where one field ends and another begins. They may hear a witness introduced under a broad title, see precise numbers or percentiles, and reasonably assume the entire analysis rests on a unified body of expertise. Without structured disclosure, the audience may have difficulty distinguishing:

- A code descriptor from an analysis of clinical complexity.
- A billed charge from an allowed amount or paid claim.
- A Medicare rate from a commercial-market benchmark.
- A database percentile from a case-specific valuation.
- Experience with one payer from broader market expertise.
- A replicable calculation from an experience-only conclusion.

The resulting risk is confusion, not necessarily misconduct. An incomplete or overextended opinion may still be offered in good faith. The appropriate policy response is therefore structured transparency, symmetrical application, and proportionate remedies—not labels, presumptions of dishonesty, or automatic exclusion.

Why cross-examination alone may be insufficient

Cross-examination remains indispensable. But it is most effective when the scope, data, benchmark, workpapers, assumptions, and limits of the opinion are disclosed before the witness presents a concise and confident conclusion. Federal Rule of Evidence 705 permits an expert, unless the court orders otherwise, to state an opinion and reasons without first testifying to the underlying facts or data, subject to disclosure on cross-examination. [2] A billing-specific pretrial schedule can reduce avoidable surprise and focus examination on the real analytical disputes.

2. Existing Legal Foundation

Federal Rule of Evidence 702

The current federal rule permits expert testimony only when the proponent demonstrates to the court that it is more likely than not that the expert's specialized knowledge will help the trier of fact, the testimony is based on sufficient facts or data, the testimony is the product of reliable principles and methods, and the opinion reflects a reliable application of those principles and methods to the facts. [2] The 2023 amendment was described by the federal judiciary as clarifying both the proponent's burden and the bounds of expert testimony. [4]

The proposal in this brief does not change that standard. It supplies billing-specific disclosure fields that can help courts and parties identify the relevant qualifications, facts, methods, and application.

Federal Rule of Civil Procedure 26

For retained experts required to provide a report, Rule 26(a)(2)(B) already requires a complete statement of opinions and bases, facts or data considered, supporting exhibits, qualifications, prior expert testimony, and compensation. [3] The proposed schedule operationalizes those categories for billing and reimbursement opinions by requiring, for example, the dataset name, version, year, geography, percentile, population, and the reason a benchmark answers the stated question.

A useful model, not a federal mandate

States and administrative forums have different procedural, evidentiary, and constitutional arrangements. Some state constitutions reserve court-rule authority to the judiciary. Accordingly, legislation should not be copied verbatim across jurisdictions. The preferred route may be a supreme court rule petition, administrative regulation, standard case-management order, professional-society standard, or institutional procurement requirement. Local counsel should review separation-of-powers, privilege, discovery, confidentiality, and due-process issues before adoption.

3. Proposed Billing Opinion Disclosure Standard

The standard should apply to a retained or specially employed witness offering a written opinion concerning medical billing, coding, documentation, charges, reimbursement, payment, benchmark interpretation, medical necessity, clinical complexity as used in a billing analysis, or healthcare economics in a covered proceeding.

A. Define each opinion

The report should separately identify every opinion and classify it as one or more of the following:

- Coding or modifier opinion
- Documentation-sufficiency opinion
- Medical-necessity opinion
- Clinical-complexity opinion
- Billed-charge opinion
- Allowed-amount or payment opinion

- Contract or payer-policy interpretation
- Fee-schedule opinion
- Benchmark interpretation
- Healthcare-economic or market opinion
- Other, specifically described

If an opinion combines categories, the expert should identify which parts depend on clinical judgment, technical coding knowledge, contract or policy interpretation, statistical analysis, or economic reasoning.

B. Demonstrate qualification-to-opinion fit

For each opinion category, the expert should identify the education, training, certification, licensure, work experience, research, publications, or other specialized experience that supports the opinion. A résumé alone is not enough if it does not connect the qualification to the question.

The expert should also state material limits. Examples include lack of clinical licensure, lack of current coding certification, experience limited to a single payer, no role in charge development, no access to contracts, or no expertise in statistical construction of the selected dataset.

C. Identify records and source materials

The report should list the records reviewed, identify materials requested but unavailable, and disclose material exclusions. The list should distinguish medical records, billing records, claim forms, explanations of benefits, contracts, fee schedules, payer policies, coding references, benchmark documentation, and workpapers.

D. Disclose benchmark provenance and fitness for purpose

For every benchmark, database, fee schedule, survey, or published reference, the report should state:

- Name and publisher or custodian
- Version, release year, and date accessed
- Relevant geography and time period
- Population represented and material exclusions
- Charge, cost, allowed-amount, or payment construct measured
- Percentile or summary statistic used
- Adjustments, filters, or normalization
- Known limitations relevant to the opinion
- Why the benchmark is fit for the precise question
- Reasonable alternatives considered and why they were not selected

E. Explain methodology and calculations

The report should provide a step-by-step description of the analytical method and enough information for another qualified reviewer to follow the path from source to conclusion. It should include formulas, raw values or a lawful means to inspect them, inclusion and exclusion rules, adjustments, rounding, weighting, sensitivity assumptions, and workpapers or reproducible exhibits.

A narrative explanation may be sufficient when the opinion is not mathematical, but the report should still identify the reasoning steps and professional standards used.

F. Connect general data to the individual case

The report should explain how the method accounts for the actual services, documentation, code set, modifiers, site of service, geography, date of service, clinical complexity where relevant, contractual or statutory setting, and any unusual resource requirements. If a factor was not considered, the report should say so rather than implying a case-specific conclusion that was not performed.

G. State assumptions, uncertainty, exclusions, and limitations

Material assumptions and exclusions should be stated in one location. Where reasonable changes in inputs could materially change the conclusion, the report should describe that sensitivity qualitatively or quantitatively. Unavailable information should not automatically produce an adverse inference; its effect on the analysis should be explained.

H. Disclose relationships consistently

Existing rules may already require compensation and prior-testimony information. A jurisdiction may also consider requiring a concise, symmetrical disclosure of recurring retention relationships or the distribution of expert work when relevant and lawful. Repeat work does not prove bias. The purpose is disclosure, not condemnation.

4. Model Disclosure Schedule

A one- to three-page schedule should accompany the report. It should not replace the report; it should index the information needed for review.

Field	Required entry	Purpose
Opinion inventory	Separate numbered opinions and category	Prevents broad labels from obscuring distinct questions.
Qualification fit	Specific basis for each opinion	Connects credentials to the actual testimony.
Materials	Reviewed, unavailable, and excluded items	Shows the evidentiary foundation and gaps.
Benchmark	Source, version, date, geography, construct, statistic	Makes provenance and fitness visible.
Method	Sequential analytical steps	Allows meaningful professional review.

Field	Required entry	Purpose
Calculations	Values, formulas, adjustments, workpapers	Supports audit and reproduction.
Case linkage	Service-, date-, geography-, and context-specific analysis	Tests application to the actual matter.
Limitations	Assumptions, uncertainty, exclusions, missing data	Prevents false precision.
Relationships	Compensation and required retention disclosures	Permits consistent evaluation of potential incentives.
Certification	Complete, current, and supplemented if material facts change	Creates accountability for the disclosure.

Table 1. Model Billing Opinion Disclosure Schedule. This schedule is an implementation aid, not a scoring instrument.

5. Where BORS100 Fits

The Billing Opinion Reliability Score 100 (BORS100) is a published conceptual framework that organizes review across seven weighted domains: opinion scope and qualification fit; source and documentation support; methodology and reproducibility; benchmark literacy and fitness for purpose; case-specific clinical or procedural linkage; transparency and auditability; and bias and independence disclosure. [1]

BORS100 can help reviewers identify what is documented, what can be followed, and where limitations remain. It also demonstrates that billing-opinion review can be organized without declaring an opinion true, false, admissible, credible, or payable.

ESSENTIAL SAFEGUARD

The proposed law or rule should not require a BORS100 score. It should require transparent disclosures. BORS100 may be cited as one published framework, used voluntarily as a review aid, or studied in pilot programs.

Current status and limits

- BORS100 is a published conceptual framework and pilot-use structured review aid.
- The scoring tool and interpretation bands have not yet been empirically validated or psychometrically calibrated.
- A high score does not establish substantive correctness.
- A low score does not establish dishonesty, bias, negligence, bad faith, or inadmissibility.

- The domain profile, evidence notes, missing information, narrative, reviewer qualifications, and framework version matter more than a total alone.
- BORS100 should be applied symmetrically to opinions offered by all parties.

6. Implementation Pathways

Pathway	Best use	Key caution
Court rule or standing order	Civil litigation and pretrial expert disclosure	Respect judicial rulemaking authority and existing privilege protections.
Administrative rule	Workers' compensation, insurance, reimbursement, or licensing proceedings	Define covered opinions and avoid conflict with governing statutes.
Legislation	State-regulated proceedings or directive to study/adopt standards	Review separation of powers and avoid dictating admissibility outcomes.
Professional guidance	Expert-report best practices and education	Voluntary guidance needs adoption incentives and clear status.
Institutional policy	Hospitals, payers, employers, counsel, and neutral review programs	Apply symmetrically and protect confidential information.
Pilot program	Testing usability, burden, inter-rater agreement, and outcomes	Do not represent a pilot score as validated or dispositive.

Table 2. Implementation options should be selected for the jurisdiction and forum.

Recommended sequence

1. Convene a balanced working group including judges or hearing officers, plaintiff and defense counsel, provider and payer representatives, clinicians, coding professionals, reimbursement experts, methodologists, and patient or public-interest representatives.
2. Map existing disclosure rules and identify only the billing-specific gaps.
3. Pilot the disclosure schedule without a mandatory score.
4. Measure completion time, supplementation, motion practice, discovery disputes, user comprehension, and unintended effects.
5. Revise the schedule and adopt it through the proper legal authority.
6. Publish implementation guidance, sample forms, and a review date.

7. Remedies and Due-Process Safeguards

Use proportionate remedies

The goal is timely disclosure, not tactical exclusion. Unless governing law requires otherwise, remedies should generally progress from notice and cure to stronger measures:

- Prompt supplementation within a defined period.
- Production of nonprivileged workpapers or a privilege log.
- Limited supplemental deposition or written questions.
- Continuance where late disclosure causes material prejudice.
- Reasonable cost shifting for avoidable additional discovery.
- Limitation or exclusion only under the jurisdiction's existing standards and after an opportunity to be heard.

Protect lawful confidentiality

The standard should not require public disclosure of protected health information, trade secrets, privileged communications, proprietary datasets, or contract terms beyond what governing law permits. Courts and agencies should retain authority to use protective orders, in camera review, redaction, data rooms, summaries, or other methods that preserve meaningful review while protecting lawful interests.

Avoid compelled adoption of a private product

The required disclosure fields should be stated in law, rule, or public guidance. Compliance should not depend on purchasing access to BORS100, using a branded calculator, or accepting proprietary interpretation bands. Public forms should be freely available.

Apply the standard symmetrically

The same disclosure obligations should apply regardless of whether the opinion supports a provider, payer, plaintiff, defendant, employer, government entity, or neutral. A standard that is used only against one side will lose credibility and may distort rather than improve expert review.

8. Expected Benefits and Evaluation

Expected benefits

- Earlier identification of qualification-to-opinion mismatches.
- Clearer distinction among coding, clinical, charge, payment, benchmark, and economic opinions.
- More focused depositions, motions, hearings, and cross-examination.
- Fewer disputes over basic benchmark identity, source versions, and calculation paths.
- Better-quality reports from experts on all sides.
- Improved self-review by counsel, experts, agencies, and healthcare organizations.
- Reduced risk that precision or presentation style substitutes for analytical transparency.

Do not promise unproven outcomes

The proposal has not yet been shown to reduce litigation cost, change verdicts, improve payment accuracy, or increase inter-rater agreement. Those are testable hypotheses, not established benefits. Pilot evaluation should distinguish administrative burden from actual improvements in disclosure and comprehension.

Suggested evaluation measures

- Percentage of reports with complete opinion inventories and benchmark provenance.
- Frequency and type of supplementation requests.
- Time required to complete and review the schedule.
- Expert-disclosure disputes and related hearing time.
- User comprehension among attorneys, hearing officers, and mock jurors.
- Agreement among trained reviewers on whether required fields are present.
- Unintended exclusion, delay, confidentiality, or access effects.
- Whether burdens fall unevenly on smaller practices, claimants, providers, or public agencies.

9. Objections and Responses

Objection: Expert qualifications are already tested through voir dire and cross-examination.

Response: Those mechanisms remain essential. A structured pretrial schedule makes the relevant qualifications, methods, and limits visible earlier, allowing those mechanisms to work more efficiently and reducing the risk that a broad title substitutes for opinion-specific scrutiny.

Objection: Rule 26 already requires a complete expert report.

Response: Rule 26 supplies broad categories. A billing-specific schedule operationalizes them by distinguishing opinion types and requiring benchmark provenance, construct, case linkage, and calculation-path details that may otherwise remain unclear. The schedule should avoid duplicating information that is already easy to locate in the report.

Objection: Billing fields overlap and cannot be divided rigidly.

Response: The proposal does not create impermeable professional silos. It requires the expert to identify which expertise and method support each conclusion, including where a multidisciplinary opinion is appropriate.

Objection: Disclosure will increase cost and report length.

Response: There will be some implementation burden. A short standardized schedule, incorporated by reference to report pages, can limit duplication. Earlier clarity may reduce later disputes, but that claimed benefit should be measured rather than assumed.

Objection: Proprietary benchmarks cannot be disclosed.

Response: Meaningful review does not always require public production of the entire dataset. Source identity, version, construct, filters, inputs, and methods can often be disclosed while access to proprietary material is managed through licensing, protective orders, controlled inspection, or other lawful safeguards.

Objection: A score will become a back-door admissibility test.

Response: The proposed standard requires disclosures, not a score. Any implementing text should expressly state that BORS100 or another framework does not independently determine admissibility, truth, credibility, payment, or evidentiary weight.

Objection: Repeat work does not prove bias.

Response: Correct. Disclosure is not a finding. Any relationship requirement should be symmetrical, limited to information relevant under governing law, and accompanied by a statement that compensation or repeat retention alone does not establish bias.

10. What the Proposal Does Not Do

- It does not label individual experts, firms, or parties as predatory.
- It does not presume that an incomplete report is false or offered in bad faith.
- It does not establish that one profession owns all billing opinions.
- It does not require every expert to possess every type of expertise.
- It does not replace Federal Rule of Evidence 702, Daubert, Kumho Tire, or state-law equivalents.
- It does not determine a reasonable charge, payment, reimbursement, damages award, or case outcome.
- It does not convert publication or use of BORS100 into governmental endorsement.
- It does not eliminate judicial discretion, professional judgment, cross-examination, or opposing evidence.

Appendix A - Model Policy Language

The following is concept language for counsel and rulemakers. It requires jurisdiction-specific legal review before introduction or adoption.

Section 1. Purpose

The purpose of this standard is to improve the transparency and reviewability of expert opinions concerning medical billing, coding, charges, reimbursement, payment, benchmark interpretation, medical necessity, clinical complexity used in billing analysis, and healthcare economics, while preserving existing law governing admissibility, privilege, confidentiality, evidentiary weight, and professional judgment.

Section 2. Definitions

"Billing opinion" means a written or testimonial expert opinion concerning one or more of the covered subjects identified above. "Retained expert" means a person retained or specially employed to provide expert opinion in a covered proceeding. "Benchmark" means a dataset, fee schedule, survey, policy, contract-derived value, statistical reference, or other external comparator used to support a billing opinion.

Section 3. Disclosure required

A party offering a retained expert's billing opinion shall provide a report and Billing Opinion Disclosure Schedule that:

- Separately states each opinion and its category.
- Identifies the qualification supporting each opinion.
- Lists the records, data, and source materials considered.
- Identifies material requested or relevant information that was unavailable or excluded.
- For each benchmark, identifies source, version, date, geography, population, construct measured, statistic used, adjustments, material limitations, and fitness for the stated purpose.
- Describes the methodology and provides the calculation path and nonprivileged supporting workpapers or exhibits.
- Explains the application of the method to the facts and circumstances of the matter.
- States material assumptions, exclusions, uncertainty, sensitivity, and limits of the opinion.
- Provides compensation, prior-testimony, and relationship disclosures required by governing law.
- Certifies that the schedule is complete to the best of the expert's knowledge and will be supplemented when required.

Section 4. Incorporation by reference

The schedule may identify the report page, exhibit, or produced workpaper containing the required information and need not duplicate information that is clearly and specifically located.

Section 5. Confidential and protected information

Nothing in this standard requires disclosure beyond governing law. The court or agency may protect privileged, confidential, proprietary, trade-secret, or patient-identifying information while preserving a fair opportunity for meaningful review.

Section 6. Cure and remedies

Upon a good-faith claim of material noncompliance, the offering party shall have a reasonable opportunity to cure unless delay would cause substantial prejudice or governing law provides otherwise. Any sanction, limitation, cost shifting, or exclusion shall be determined under existing law after notice and an opportunity to be heard.

Section 7. Neutrality and non-dispositive effect

This standard applies without regard to the identity of the retaining party. Compliance or noncompliance does not by itself establish admissibility, truth, credibility, evidentiary weight,

reasonable payment, bad faith, or professional misconduct. No particular private scoring framework is required.

Section 8. Pilot and review

The adopting authority should review implementation after a defined pilot period using measures of burden, completion, supplementation, disputes, comprehension, confidentiality, and access to qualified experts.

Appendix B - BORS100 Domain Crosswalk

BORS100 domain	Weight	Disclosure-standard counterpart
Opinion Scope and Qualification Fit	15	Opinion inventory; qualification-to-opinion statement; limits of expertise.
Source and Documentation Support	15	Materials list; source identity; unavailable and excluded information.
Methodology and Reproducibility	20	Sequential method; calculations; workpapers; assumptions; alternatives.
Benchmark Literacy and Fitness for Purpose	15	Provenance, construct, geography, date, population, statistic, limitations, and selection rationale.
Case-Specific Clinical or Procedural Linkage	15	Application to actual services, context, complexity, setting, geography, and timing.
Transparency and Auditability	10	Traceable values, source versions, arithmetic, exclusions, and complete data path.
Bias and Independence Disclosure	10	Compensation, recurring relationships, and other disclosures required by law or policy.

Table 3. BORS100 totals 100 points. The crosswalk is explanatory only; the proposed disclosure standard does not require scoring.

Appendix C - References and Primary Authorities

1. Klapper AM, Dardano AN, et al. Billing Opinion Reliability Score 100: A Structured Framework for Billing and Medicolegal Expert Reliability. Cureus. Published July 11, 2026. PubMed PMID: 42436700. PubMed record

2. Federal Rules of Evidence, Rules 702-705 (Dec. 1, 2025 edition). U.S. Courts. Federal Rules of Evidence PDF

3. Federal Rules of Civil Procedure, Rule 26(a)(2)(B) and Rule 26(b)(4)(C) (current official compilation accessed July 13, 2026). U.S. Courts. Federal Rules of Civil Procedure PDF

4. Administrative Office of the U.S. Courts. Recent and Proposed Amendments to Federal Rules - Annual Report 2023 (explaining the 2023 Rule 702 amendment). U.S. Courts Annual Report 2023

5. Ninth Circuit Model Civil Jury Instruction 2.14, Expert Opinion Testimony (official judiciary resource; accessed July 13, 2026). Ninth Circuit Model Civil Jury Instruction 2.14

Publication and Use Notice

This document states a Healthcare Governance policy position. It is informed by published research and current legal authorities but is not itself a peer-reviewed publication, legal opinion, or model act approved for introduction. Any proposed legislation, court rule, administrative rule, or institutional policy should be reviewed by qualified counsel in the relevant jurisdiction.

BORS100 is a proposed conceptual framework and pilot-use scoring aid. It has not yet been empirically validated or psychometrically calibrated. Use of the framework does not establish an attorney-client, physician-patient, consulting, expert-retention, or other professional relationship with the authors or Healthcare Governance.

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