IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

TEXAS MEDICAL ASSOCIATION and DR. ADAM CORLEY, Plaintiffs, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEPARTMENT OF LABOR, DEPARTMENT OF THE TREASURY, OFFICE OF PERSONNEL MANAGEMENT, and the CURRENT HEADS OF THOSE AGENCIES IN THEIR OFFICIAL CAPACITIES, Defendants.	)	Case No. 6:21-cv-00425-JDK

BRIEF *AMICI CURIAE* OF
THE EMERGENCY DEPARTMENT PRACTICE MANAGEMENT ASSOCIATION,
THE TEXAS COLLEGE OF EMERGENCY PHYSICIANS,
AND THE VIRGINIA COLLEGE OF EMERGENCY PHYSICIANS
IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION AND INTERESTS OF *AMICI CURIAE*[1]

Amici Curiae the Emergency Department Practice Management Association ("EDPMA"), the Texas College of Emergency Physicians ("TCEP"), and the Virginia College of Emergency Physicians ("VACEP") submit this Brief in support of Plaintiffs' Motion for Summary Judgment. EDPMA is the nation's largest professional physician trade association focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA members include emergency medicine physician groups and the businesses that support them. EDPMA's members handle more than half of the emergency department visits in the United States each year. TCEP exists to promote quality emergency care for all patients and to represent the professional interests of its members. With more than 2,100 members, TCEP is the third largest emergency medicine state association. VACEP is a professional organization representing emergency physicians in Virginia. VACEP promotes high-quality emergency care by ensuring unrestricted access to care regardless of ability to pay, protecting the professional interests of emergency physicians, and representing Virginia patients and physicians on state and federal legislative and regulatory issues.

Amici submit this Brief because the Interim Final Rule ("Rule") challenged by Plaintiffs is contrary to the language and legislative history of the No Surprises Act, Pub. L. 116-260, div. BB, tit. I, 134 Stat. 1182, 2757-890 (2020) ("NSA"), and was published without the notice and comment required by the Administrative Procedure Act, 5 U.S.C. § 553(b). *See* 42 U.S.C. § 300gg-111(c); 45 C.F.R. § 149.510; 86 Fed. Reg. 55,980 (Oct. 7, 2021). If allowed to stand, the Rule will severely undermine the quality and availability of emergency care for the American people.

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[1]All parties provided written consent to the filing of this Brief. No counsel for a party authored this Brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this Brief. No person or entity other than *Amici*, their members, or their counsel made such a monetary contribution. *Cf.* Fed. R. App. P. 29.

Amici strongly support the NSA's goal of protecting patients from "surprise" healthcare bills—that is, bills for emergency services furnished by an out-of-network provider, or non-emergency services furnished by an out-of-network provider at an in-network facility. The NSA accomplishes this goal by prohibiting group health plans and commercial health insurance issuers ("insurers" or "payors") and out-of-network providers from charging patients more than what they would have paid had those services been furnished by an in-network provider. At the same time, the NSA recognizes the importance of ensuring fair compensation for healthcare providers.

Accordingly, the NSA establishes a process whereby patients are removed from billing disputes, and providers and payors negotiate among themselves to arrive at a reasonable payment for the unreimbursed amounts. Should those negotiations fail, the parties may invoke a "baseball-style" arbitration process called Independent Dispute Resolution ("IDR"). The IDR process is, as the name suggests, supposed to be "independent," and not biased in favor of insurers or providers. The IDR entity must consider each of a series of statutory factors and examine the particular facts and circumstances of the claim to determine the appropriate out-of-network rate. The NSA does not constrain the discretion of the IDR entity in weighing the required statutory factors. Nor does it assign primacy to, or create a presumption in favor of, any of the factors.

The Rule is directly contrary to the NSA's unambiguous language. Under the Rule, one of the many statutory factors is given primacy in determining the out-of-network rate: the "qualifying payment amount" ("QPA"). The QPA is the insurer's median contracted (*i.e.*, *in*-network) amount for the service. It is calculated exclusively by the insurer and is not subject to scrutiny by the IDR entity. 86 Fed. Reg. at 55,996 ("[I]t is not the role of the certified IDR entity to determine whether the QPA has been calculated by the [insurer] correctly."). The IDR entity is *required* to choose the offer closer to the QPA absent exceptional circumstances. Contrary to the NSA, which requires

the IDR entity to consider all statutory factors, under the Rule the IDR entity is *precluded* from considering any factor other than the QPA unless the provider "clearly demonstrates" that the QPA is "materially different from the appropriate out-of-network rate." *Id.* at 55,984. And if the IDR entity believes that the offer farther from the QPA better reflects the actual value of the services, it must provide a "detailed explanation" justifying the departure from the QPA. *Id.* at 56,000.

The Rule's one-sided procedure tilts the IDR process decidedly in favor of insurers and, necessarily, toward out-of-network reimbursement rates that are inadequate and below market. All healthcare providers will be materially and adversely affected by the Rule, but *Amici* and their emergency physician members particularly so. Under the Emergency Medical Treatment and Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, emergency physicians and facilities are required to treat and stabilize all emergency room patients, regardless of their insurance status or ability to pay. Indeed, more than two-thirds of uncompensated medical care in this country is provided in emergency rooms. (Ex. 1 at 2.)[2] The situation has long since passed a crisis point. The burden of uncompensated care is growing, closing many emergency departments and hospitals, and threatening the ability of emergency departments to care for all patients, including the indigent and rural populations, who rely on our nation's emergency departments as an important safety net.

The NSA was enacted in part to address these problems, but the Rule will serve only to exacerbate this already bleak picture. Fair reimbursement of providers by commercial payors is critical to the viability of our healthcare system, particularly the delivery of emergency medical care. But implementation of the Rule's IDR process will drive physician reimbursement down to artificially low, below-market rates—not only for out-of-network services, but ultimately for in-

[2]Some health insurers consistently underpay emergency providers. One of the largest insurers recently was found liable for $60 million in punitive damages for cutting reimbursements to out-of-network emergency providers by more than 50% over the course of several years. (Ex. 2.)

network services as well—all to the detriment of patients.

Key congressional architects of the NSA have warned the Departments that the Rule's IDR process "could incentivize insurance companies to set artificially low payment rates, which could narrow provider networks and jeopardize patient access to care—the exact opposite of the goal of the law. It could also have a broad impact on reimbursement for in-network services, which could exacerbate existing health disparities and patient access issues in rural and urban underserved communities." (Ex. 3 at 2.)[3] Indeed, the Departments themselves recognized the perils of physician undercompensation: "[U]ndercompensation could threaten the viability of these providers [and] facilities . . . . This, in turn, could lead to participants, beneficiaries and enrollees not receiving needed medical care, undermining the goals of the No Surprises Act." 86 Fed. Reg. at 56,044.

What members of Congress feared has already come true. *Amici*'s members have received notices from insurers threatening to terminate their contracts (and in some cases terminating their contracts) unless they agree to substantial discounts to their contracted rates. Those notices specifically cite the primacy the Rule accords to QPAs as the legal justification for their actions.

Amici respectfully request that the Court grant Plaintiffs' summary judgment motion.

ARGUMENT

I. The Rule Directly Conflicts with the NSA's Clear and Unambiguous Language.

A. The NSA Does Not Create a Benchmark Rate for Provider Reimbursement, But Instead Provides for a Robust Arbitration Process in Which All Statutory Factors Must Be Considered in Determining the Out-of-Network Rate.

Given the NSA's prohibition against balance-billing patients in excess of their in-network cost-sharing, out-of-network providers must turn to the patient's insurer for payment of

[3]For example, approximately 60 million people—nearly 1 in 5 Americans—live in rural areas. More than 70 of those rural hospitals have ended all services since 2011. *See* https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

unreimbursed amounts. Under the NSA, insurers are obligated to pay providers the "out-of-network rate." 42 U.S.C. §§ 300gg-111(a)(1)(C)(iv)(II),(b)(1)(D). The out-of-network rate is (1) the amount determined by an All-Payer Model Agreement under the Social Security Act; (2) if there is no such Agreement, by a "specified state law"; or (3) if there is no applicable Agreement or state law, by the amount determined through a 30-day open negotiation process culminating, if necessary, in IDR. *Id.* § 300gg-111(a)(3)(K). The third method is at issue in this lawsuit.

Under the open negotiation process, the insurer first pays an amount of its choosing. The provider and insurer then engage in a 30-day negotiation process to attempt to resolve any reimbursement disputes. If the parties cannot reach agreement, either party may initiate IDR. Each party submits an offer for a payment amount. The IDR entity must choose one of the two offers as the "out-of-network rate." *Id.* §§ 300gg-111(c)(1)(A), (c)(1)(B), (c)(5)(B), (c)(5)(A).

The NSA does not set a benchmark for determining the out-of-network rate. Indeed, Congress rejected bills that would have done just that. *See infra* pp. 8-13. Instead, the NSA provides a detailed list of factors that the IDR entity "*shall* consider" in its determination:

1. The QPA for comparable services furnished in the same geographic area. *See* 42 U.S.C. § 300gg-111(c)(5)(C)(i)(I).
2. Five "additional circumstances":
    - The "level of training, experience, and quality and outcomes measurements" of the provider. *Id.* § 300gg-111(c)(5)(C)(ii)(I).
    - The "market share" of the provider or payor in the relevant geographic area. *Id.* § 300gg-111(c)(5)(C)(ii)(II).
    - The "acuity of the individual receiving such item or service" or the "complexity of furnishing such item or service to such individual." *Id.* § 300gg-111(c)(5)(C)(ii)(III).
    - The "teaching status, case mix, and scope of services" of the facility. *Id.* § 300gg-111(c)(5)(C)(ii)(IV).
    - "Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or . . . the plan . . . to enter into network agreements and, if applicable, contracted rates between [those entities]

during the previous 4 plan years." *Id.* § 300gg-111(c)(5)(C)(ii)(V).

3. Any information the IDR requests from the parties. *Id.* § 300gg-111(c)(5)(C)(i)(II).

4. Any additional information submitted by the parties. *Id.*

The NSA also states what the IDR entity "*shall not* consider": (i) usual and customary charges; (ii) amounts the provider would have billed absent the NSA's ban against balance-billing; and (iii) reimbursement rates by a public payor, such as Medicare. *Id.* § 300gg-111(c)(5)(D).

Thus, Congress identified with precision the factors that IDR entities "shall" and "shall not" consider in determining the out-of-network reimbursement rate. Congress left to the discretion of the IDR entity how to balance each of those factors to arrive at the appropriate reimbursement. The NSA does not instruct IDR entities how to weigh the statutory factors, give primacy to the QPA, or create a "presumption" that the QPA is the proper reimbursement. Nor does the NSA place the burden on providers to "clearly demonstrate" that the QPA is "materially different from the appropriate out-of-network rate." There is simply no support in the NSA for making QPA the proxy for, or even the predominant factor in calculating, the out-of-network rate.

Indeed, when Congress wanted to make the QPA the applicable standard, it knew how to do so. The NSA limits patient cost-sharing to the statutory "recognized amount." *Id.* § 300gg-111(a)(3)(H). Like the "out-of-network rate" applicable to provider reimbursement, the "recognized amount" is determined by reference to three standards. The first two standards are the same: (1) the amount in any All-Payer Model Agreement or (2) the amount determined by a "specified state law." *Id.* But in sharp contrast to the third standard applicable to the "out-of-network rate" for providers (the amount determined through IDR), the third standard for determining the "recognized amount" for patient obligations is the QPA. *Id.* If Congress had intended to make the QPA the determinative factor for the provider reimbursement rate as well, it easily could have done so. That it did not demonstrates that Congress did not intend the QPA to

be the predominant determinant of provider reimbursement.

B. The Rule Rewrites the NSA Under the Guise of "Interpretation."

The Rule proceeds from one basic assumption: that the "best interpretation" of the NSA is that the IDR entity *must* accept the offer closer to the QPA, unless the provider satisfies the burden of "clearly demonstrat[ing]" that the QPA is "materially different from the appropriate out-of-network rate." 86 Fed. Reg. at 55,984, 55,996. The Rule does not merely "interpret" the NSA. It materially alters the IDR contemplated by the NSA.

Rather than a robust arbitration process in which the IDR entity is *required* to evaluate *all* the factors Congress believed were relevant to determining a proper reimbursement rate, the Rule turns the IDR process into a truncated, meaningless exercise—one in which the IDR entity is *prohibited* from considering the required statutory factors absent special circumstances, and in which the foregone conclusion is that the QPA will be selected as the reimbursement amount.

The NSA's detailed, carefully balanced, and comprehensive requirements for the IDR process further demonstrate that Congress did not intend additional "interpretation" of the NSA through administrative action. Indeed, while the NSA specifies numerous instances expressly requiring action by an administrative agency (Cmplt. ¶ 42 & n.8), the statute did not do so with respect to the IDR entity's discretion in applying the statutory factors to determine a fair out-of-network reimbursement rate. There is no statutory authority for administrative "gap-filling" here.

Finally, the Rule provides no support for the Departments' conclusion that "the statute contemplates that typically the QPA will be a reasonable out-of-network rate." 86 Fed. Reg. at 55,996. Again, had Congress believed that the QPA—the *in*-network rate calculated solely by the payor—would "typically" be the appropriate amount for *out*-of-network reimbursements, it would have said so. The fact that Congress specified many factors—*in addition* to the QPA—that the IDR entity is required to consider demonstrates that Congress did not believe that the QPA would

"typically" be an adequate and fair reimbursement rate. Indeed, as demonstrated below, the QPA will in fact be lower than the reasonable market value of the services. *See infra* pp. 13-14.

II. The Legislative History Confirms that the Rule Is Contrary to the NSA.

The conclusion that the Rule is contrary to the intent of Congress is confirmed by a review of the NSA's legislative history. Congress rejected all attempts to do what the Rule does: create a benchmark for provider reimbursement, limit the discretion of the IDR entity in applying the statutorily mandated factors, and otherwise skew the IDR process heavily in favor of insurers, granting them a material advantage that they were unable to obtain during the legislative process.

The NSA was the product of more than two years of intense legislative activity to address surprise billing. *See* 166 Cong. Rec. H7290, H7291 (Dec. 21, 2020) (NSA was result of "long-fought and negotiated bipartisan and bicameral compromise"). During that time, health insurers and other payors vigorously lobbied Congress to make median in-network rates the benchmark for provider reimbursement. Other proposals added a form of arbitration, but because the median in-network rate would have been the benchmark, the arbitration process would have been merely "a backstop [that], at most, [would] result in a mere adjustment to the benchmark rate." (Ex. 4 at 2.)

Congress rejected these proposals. Instead, it enacted the NSA's IDR process, under which (a) all disputes over reimbursement, regardless of the amount at issue, may be submitted for resolution to the IDR entity, and (b) the IDR entity is required to take into account all relevant statutory factors to determine the appropriate out-of-network rate.

For example, on July 9, 2019, House Energy and Commerce Committee Chairman Pallone and Ranking Member Walden introduced H.R. 3630. The bill would have set the reimbursement rate at the insurer's median contracted rate for such services. H.R. 3630, 116th Cong. § 2 (2019). Patient-protection provisions such as the ban on balance billing received unanimous support, but the benchmarks tying provider reimbursement to median in-network rates generated stiff

opposition. An amendment provided for an IDR-like process, but it would have applied only to services above a $1,250 threshold. *See* H.R. 2328, 116th Cong. tit. IV, § 402(b) (2019). That threshold would have put IDR out of reach for more than 99% of emergency physician services.

Likewise, in July 2019, Senator Lamar Alexander introduced S. 1895 (Senate Health, Education, Labor and Pensions ("HELP") Committee). That bill would have set a "benchmark for payment" for out-of-network services at "the median in-network rate for such services provided to [health plan] enrollees." S. 1895, 116th Cong. tit. I, §103 (2019). On December 8, 2019, Senator Alexander and Representatives Pallone and Walden announced a proposed compromise that would have required provider bills under $750 to be paid at the median in-network rate, with bills above $750 being eligible for baseball-style arbitration.

Then, in February 2020, leadership in the House Ways and Means Committee and the House Education and Labor Committee released two pieces of proposed legislation, which reflected the two major competing approaches to provider reimbursement: H.R. 5800 (Education and Labor) and H.R. 5826 (Ways and Means). H.R. 5800 was similar to the HELP/Energy and Commerce compromise bill in that it would have required insurers to make a minimum payment of the median contracted rate; if that rate was at least $750, either party could initiate an IDR process. H.R. 5800, 116th Cong. § 2 (2020). H.R. 5826, on the other hand, did not establish any payment standard, but instead provided for an open negotiation process, with a dispute-resolution process if negotiations failed. H.R. 5826, 116th Cong. § 7 (2020).

In his opening statement, Chairman Neal noted that the sponsors of H.R. 5826 had "worked to craft a process where both the provider's offer and the plan's offer receive equal weight"; the resolution entity "considers, but isn't bound by, the plan's median in-network rate"; and "the provider is not left in a position to disprove the adequacy of such a rate." Neal noted his concern

with "giving too much weight to such a benchmark rate":

> [W]e already know insurers are looking for any way they can pay the least amount possible. They will work to push those rates down, regardless of what it means for community providers like physicians, hospitals, and our constituents who they employ. With no federal network adequacy standards, plans can push rates down and drop providers from networks with no consequences, leaving patients holding the bag. . . . Surprise bills would be much less common if insurer networks were more robust.

(Ex. 5.)

In enacting the NSA, Congress ultimately adopted the Ways and Means approach to determining provider reimbursement rates. Congress considered, but rejected, the approach embodied in the Rule, which effectively sets the median in-network rate/QPA as the presumptive reimbursement amount and constrains the IDR process so that it decidedly favors insurers over providers. Indeed, on the day the NSA was passed, the three major House Committees addressing these issues issued a Joint Statement noting that the NSA provides a "free-market solution that takes patients out of the middle and fairly resolves payment disputes between plans and providers." (Ex. 6.) The NSA "[p]rotects patients from surprise bills"; "[e]nsures physicians and other health workers don't face economic harm and uncertainty"; and "[p]rotects all stakeholders, most importantly patients, while also ensuring a pathway for resolution of payment disputes for health care services that are consistent with private market practices." *Id.* The Joint Statement also identifies what the NSA "does not do": "This text includes NO benchmarking or rate-setting."

The Joint Statement goes on to emphasize the individualized nature of the IDR, including the fact that the IDR entity "must equally consider" the many statutory factors:

- If a health care provider is not satisfied with the payment they receive, they can initiate an open negotiation period and, if no resolution is reached, can pursue a dispute resolution process where an independent arbitrator considers relevant factors and determines a fair payment.
- This independent dispute resolution process fairly decides an appropriate payment for services based on the facts and relevant data of each case. This results in savings by stopping bad actors from driving up costs across the health care system . . . .

- There is no dollar amount threshold to enter the open negotiation and independent dispute resolution processes– all claims will be eligible.
- The arbitrator must equally consider many factors, including:
  - Median contracted rates;
  - Education and experience of providers and severity of individual cases;
  - Previously contracted rates going back four years;
  - Good faith efforts to negotiate – bad actors will be held accountable;
  - Market share of both parties – this will help prevent any stakeholder that dominates a region from trying to set rates at an untenable level; and
  - Any other factors brought forward by providers and plans, except for billed charges or government-set rates.

Since promulgation of the Rule, congressional leaders have made clear that the Rule violates the NSA. For example, the principal architects of the legislation, Ways and Means Chairman Neal and Ranking Member Brady, wrote to the Departments expressing their concern that the Rule "do[es] not reflect the law that Congress passed":

> Congress stepped in to protect patients by ending the practice of surprise medical billing. In so doing, Congress sought to promote fairness in payment disputes between insurers and providers--carefully specifying all the various factors that should be considered during the independent dispute resolution (IDR) process. . . .
>
> . . . Despite the careful balance that Congress designed for the independent dispute resolution process, the [Rule] strays from the No Surprises Act in favor of an approach that Congress did *not* enact in the final law and does so in a very concerning manner.

(Ex. 4 at 2.) The NSA "directs the arbiter to consider all of the factors without giving preference or priority to any one factor—that is the express result of substantial negotiation and deliberation among those Committees of jurisdiction, and reflects Congress's intent to design an IDR process that does not become a de facto benchmark." But the Rule "crafts a process that essentially tips the scale for the median contracted rate being the default appropriate payment amount" (*id.*):

> Under the interim final rule, the IDR entity is only allowed to deviate from the median amount where the parties present "credible information about additional circumstances [that] clearly demonstrates that the [median in-network rate] is materially different from the appropriate out-of-network rate." Such a standard affronts the provisions enacted into law, and we are concerned that this approach biases the IDR entity toward one factor (a median rate) as opposed to evaluating all factors equally as Congress intended.

A group of congressional members with healthcare expertise also objected to the Rule, stating that it "does not reflect legislation that could have passed Congress or the law as written":

> Over the last several years, the medical professionals in Congress received copious expert input from providers and physician groups. They repeatedly cited the importance of ensuring a balanced IDR process in determining a payment rate in order to prevent adverse outcomes such as artificially-low payments, the narrowing of provider networks, and reduced patient access. While the QPA was originally intended to be applied as a baseline consideration among other factors during the arbitration process, the [Rule] places a disproportionate emphasis on the QPA, which necessarily undervalues other factors brought to the arbiter, including quality and outcomes data.

(Ex. 7.) As a result, the QPA "is unlikely to reflect actual market-based payment rates for all circumstances." (*Id.*) This failure to reimburse at a fair market rate would adversely affect providers and, consequently, the availability of healthcare, particularly in underserved areas:

> By instructing the IDR entity to rely upon the QPA as the primary factor in determining payment rates, the [Rule] will limit providers' ability to utilize other statutorily required and relevant factors when negotiating with the payor. Under this [Rule], we are concerned that the IDR process will lead to narrower networks and decreased access to medical care for millions of American patients, which would have a disproportionate impact on access to care in rural and underserved areas. If this [Rule] is finalized as written, *providers may no longer be able to afford to serve these communities given the downward pressure on commercial rates coupled with the already delicate payor mix.*

(*Id.* (emphasis added).)

Finally, a letter from 152 members of Congress expressed these same concerns, noting that while the NSA "was one of the most important patient protection bills in American history, . . . its success will depend on your departments following the letter of law in its implementation." (Ex. 3 at 1.) The letter reiterated that "Congress rejected a benchmark rate and determined the best path forward for patients was to authorize an open negotiation period coupled with a balanced IDR process." (*Id.*) The NSA "expressly directs the certified IDR entity to consider each of [the] listed factors should they be submitted, capturing the unique circumstance of each billing dispute without causing any single piece of information to be the default one considered." (*Id.*) The Rule, on the other hand, "do[es] not reflect the way the law was written, do[es] not reflect a policy that could

have passed Congress, and do[es] not create a balanced process to settle payment disputes." (*Id.*) By making the median in-network rate "the default factor considered in the IDR process," the Rule threatens grave consequences for patients, including jeopardizing patient access to care and exacerbating existing health disparities in underserved communities. (*Id.*)

III. The Rule Will Have Serious Adverse Consequences for Healthcare in This Nation.

The Rule is not only contrary to the NSA and its legislative history. If upheld, it will result in a host of adverse consequences for healthcare providers and their patients.

First, there is no basis for the Departments' assumption that the QPA/in-network rate will "typically" be a reasonable out-of-network rate. By requiring the IDR entity to consider a number of factors *in addition to* the QPA, the NSA makes clear that the QPA alone does not accurately represent prevailing market rates. *See supra* pp. 4-6.

The real world of health insurance markets bears this out. Market rates are fairly represented by *actual payments* to providers for actual services rendered, not by a median of *contracted* rates irrespective of the actual utilization of those contracts in the marketplace. Contracted rates are affected by any number of factors, including the market share of the plan and provider, the unique economic and clinical environment in the communities, and penalty and bonus structures.[4] Providers often agree to lower contracted rates in exchange for reimbursement certainty and administrative efficiencies that attend being in a network. In fact, the Departments' first interim rule provides that when insurers calculate median contracted rates, they must exclude risk sharing, bonuses, or penalties, and other incentive-based and retrospective payments or payment adjustments. 86 Fed. Reg. 36,872, 36,894 (July 13, 2021). That, too, artificially reflects

[4] In some contracts, risk-sharing amounts can total 10-15% of the total payments; the contracted rates are adjusted *downward* to reflect the potential for earning such an incentive.

lower rates of actual payment. In short, using contracted rates as the QPA, and the QPA as a proxy for out-of-network rates, will deviate drastically from any representation of the actual prevailing market rate.

Second, as demonstrated above, there is no serious dispute that "benchmarks" result in underpayments to providers and in turn cause the contraction of provider networks and the narrowing of healthcare choices for patients. The California experience is illustrative. California enacted a benchmark payment rate, but that benchmark ultimately became the default payment rate for out-of-network and even some in-network services. California insurers recognized that they could force providers out of network by paying the artificially low benchmark rate and then offering take-it-or-leave it contracts. These narrowed networks jeopardized patient access to care. Small, independent providers could not remain financially viable and were forced to consolidate with larger systems to continue to care for the patients in their communities. This consolidation, in turn, substantially increased healthcare costs. (Ex. 8.)

For emergency physicians, the problem is even more acute. In the experience of *Amici*, the EMTALA requirements cause health plans to be even less inclined to maintain emergency providers in-network. Insurers recognize that that their policyholders are able to receive emergency care regardless of their insurance status or ability to pay. Insurers therefore have no incentive to enter into fair contracted rates with emergency physicians.

Third, the experience in California and elsewhere is already starting to play out nationwide as a result of the Rule. The Rule has had the effect of narrowing provider networks and thereby reducing the availability of healthcare to patients. In the few weeks since publication of the Rule, numerous physician practices have received termination notices from insurers of longstanding network agreements (including agreements that currently protect patients in rural and underserved

communities), or threats to terminate existing agreements unless the providers agree to substantial discounts from their contracted rates. Some of those termination letters even cite the Rule as justification. (*See* Ex. 9; *see also* Ex. 10 (describing other contract terminations).)

Finally, the Departments' assumption that lower provider reimbursement rates will translate into lower costs to patients is without any basis. The Departments state that the Rule will "help limit the indirect impact on patients that would occur from higher out-of-network rates if plans and issuers were to pass higher costs on to individuals in the form of increases in premiums." 86 Fed. Reg. at 55,996. There is no evidence that insurers pass their savings from lower reimbursement rates onto their insureds. In fact, when states provide for fair reimbursement (like New York and Connecticut), the resulting insurance premiums are actually *lower* than the national average. One study examined premiums in New York, Connecticut, and nationwide from 2015-2019. In 2019, the percentage growth in premiums was 73% nationwide, but only 50% in New York and 35% in Connecticut. (Ex. 11.) In other words, there is no evidence of a relationship between higher insurance premiums and laws that improve emergency physician reimbursement.

In short, implementation of the Rule will result in a host of negative consequences for providers and their patients, without any of the hoped-for positives in the form of lower insurance premiums. The Departments should be enjoined from enforcing the Rule. At a minimum, the consequences of the Rule underscore the importance of requiring the Departments to follow the APA notice and comment provisions so that the Departments can be adequately informed of the errors in their assumptions and the adverse effects of the Rule on physicians and patients.

CONCLUSION

Amici respectfully request that the Court grant Plaintiffs' Motion for Summary Judgment.

DATED: December 17, 2021

Respectfully submitted,
/s/Jack R. Bierig

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CERTIFICATE OF SERVICE

I hereby certify that on December 17, 2021, a true and correct copy of the foregoing document was served on all counsel of record through this Court's CM/ECF filing system.

/s/ Jack R. Bierig
Jack R. Bierig

EXHIBIT 1

HEALTH

This report is part of the RAND Corporation research report series. RAND reports present research findings and objective analysis that address the challenges facing the public and private sectors. All RAND reports undergo rigorous peer review to ensure high standards for research quality and objectivity.

RESEARCH REPORT

The Evolving Role of Emergency Departments in the United States

Kristy Gonzalez Morganti • *Sebastian Bauhoff* • *Janice C. Blanchard*

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Sponsored by the Emergency Medicine Action Fund

HEALTH

The research described in this report was sponsored by the Emergency Medicine Action Fund, a consortium sponsored by the American College of Emergency Physicians. The work was conducted in RAND Health, a division of the RAND Corporation.

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Preface

This project was performed to develop a more complete picture of how emergency departments (EDs) contribute to the U.S. health care system. Using a mix of quantitative and qualitative methods, it explores the evolving role that hospital EDs and the personnel who staff them play in evaluating and managing complex and high-acuity patients, serving as the major portal of entry to inpatient care, and serving as "the safety net of the safety net" for patients who are unable to get care elsewhere.

This work was sponsored by the Emergency Medicine Action Fund, a consortium of emergency medicine physician organizations sponsored by the American College of Emergency Physicians. The research was conducted by RAND Health, a division of the RAND Corporation. A profile of RAND Health, abstracts of publications, and ordering information can be found at www.rand.org/health.

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Executive Summary

Emergency departments (EDs) emerged with the rise of hospital-based medicine in the aftermath of World War II. Today, they play a pivotal role in the delivery of acute ambulatory and inpatient care. As our health care system evolves in response to economic, clinical, and political pressures, the role of EDs is evolving as well.

Because EDs charge higher prices for minor illness and injury care than other ambulatory care settings, ED care is frequently characterized as "the most expensive care there is." But this depiction ignores the many roles that EDs fill, and the statutory obligation of hospital EDs to provide care to all in need without regard for their ability to pay. To develop a more complete picture of how EDs contribute to our modern health care system, the Emergency Medicine Action Fund asked RAND to conduct this mixed-methods study.

At the outset of our effort, we reviewed recently published literature regarding ED use and used it to craft a conceptual model that depicts the various choices ED patients and providers make over the course of an episode of care. To quantify the importance of EDs as a major portal of entry to inpatient care, we analyzed four datasets compiled and maintained by the U.S. Department of Health and Human Services. Given a growing focus at the national and state levels on preventing non-urgent patients from seeking care in EDs, we analyzed data from the Community Tracking Study, a decade-long effort that describes changing patterns of health care utilization and delivery in 60 communities nationwide. To add context to the quantitative observations derived from these analyses, we conducted three focus groups with emergency medicine and hospitalist physicians, and interviewed 16 practicing primary care physicians who work in a variety of communities.

Key findings include the following:

- Between 2003 and 2009, inpatient admissions to U.S. hospitals grew at a slower rate than the population overall. However, nearly all of the growth in admissions was due to a 17 percent increase in unscheduled inpatient admissions from EDs. This growth in ED admissions more than offset a 10 percent decrease in admissions from doctors' offices and other outpatient settings. This pattern suggests that office-based physicians are directing to EDs some of the patients they previously admitted to the hospital.
- In addition to serving as an increasingly important portal of hospital admissions, EDs support primary care practices by performing complex diagnostic workups and handling overflow, after-hours, and weekend demand for care. Almost all of the physicians we interviewed—specialist and primary care alike—confirmed that office-based physicians increasingly rely on EDs to evaluate complex patients with potentially serious problems, rather than managing these patient themselves.
- As a result of these shifts in practice, emergency physicians are increasingly serving as the major decisionmaker for approximately half of all hospital admissions in the United States. This role has important financial implications, not only because admissions

generate the bulk of facility revenue for hospitals, but also because inpatient care accounts for 31 percent of national health care spending.

- Although the core role of EDs is to evaluate and stabilize seriously ill and injured patients, the vast majority of patients who seek care in an ED walk in the front door and leave the same way. Data from the Community Tracking Study indicate that most ambulatory patients do not use EDs for the sake of convenience. Rather, they seek care in EDs because they perceive no viable alternative exists, or because a health care provider sent them there.
- Medicare accounts for more inpatient admissions from EDs than any other payer. To gain insight into whether care coordination makes a difference in the likelihood of hospital admission from an ED, we compared ED admission rates among Medicare beneficiaries enrolled in a Medicare Choice plan versus beneficiaries enrolled in Medicare fee-for-service (FFS). We found no clear effect on inpatient admissions overall, or on a subset of admissions involving conditions that might be considered "judgment calls."
- Irrespective of the impact of care coordination, EDs may be playing a constructive role in constraining the growth of inpatient admissions. Although the number of non-elective ED admissions has increased substantially over the past decade, inpatient admissions of ED patients with "potentially preventable admissions" (as defined by the Agency for Healthcare Research and Quality) are flat over this time interval.

Our study indicates that: (1) EDs have become an important source of admissions for American hospitals; (2) EDs are being used with increasing frequency to conduct complex diagnostic workups of patients with worrisome symptoms; (3) Despite recent efforts to strengthen primary care, the principal reason patients visit EDs for non-emergent outpatient care is lack of timely options elsewhere; and (4) EDs may be playing a constructive role in preventing some hospital admissions, particularly those involving patients with an ambulatory care sensitive condition. Policymakers, third party payers, and the public should be aware of the various ways EDs meet the health care needs of the communities they serve and support the efforts of ED providers to more effectively integrate ED operations into both inpatient and outpatient care.

Acknowledgements

Numerous individuals and organizations provided source material or substantive assistance to this report. Our quantitative analysis used data from several sources, including the Agency for Healthcare Research and Quality, the Center for Studying Health Systems Change and the Inter-university Consortium for Political and Social Research and the National Center for Health Statistics at the Centers for Disease Control and Prevention (CDC). Several organizations allowed us to recruit from their memberships for focus groups. These include: the American College of Emergency Physicians (ACEP), the Society for Academic Emergency Medicine, The Patient Centered Primary Care Collaborative, and the Society for Hospital Medicine. Several individuals were particularly helpful to the recruiting effort: Susan Spradlin, Buck Beighley, and Peggy Brock (ACEP); Amy Gibson, Michelle Shaljian, Dr. Paul Grundy, Marci Nielsen, and Deborah Felsenthal (The Patient Centered Primary Care Collaborative), Dr. Joe Stubbs, former President of the American College of Physicians, and Dr. Todd Von Deak, Dr. Mark Williams, and Dr. Larry Wellikson (Society for Hospital Medicine). Finally, we are particularly grateful for the outstanding technical advice and analytical assistance we received from Ryan Mutter of the Agency for Healthcare Research and Quality, and the thoughtful comments and suggestions of Andrew Mulcahy and Lori Uscher-Pines of the RAND Corporation and Stephen R. Pitts of Emory University.

Abbreviations

ACEP	American College of Emergency Physicians
ACO	Accountable Care Organization
ACS	Ambulatory Care Sensitive
AHRQ	Agency for Healthcare Research and Quality
CCS	Clinical Classifications Software
CDC	Center for Disease Control and Prevention
CHIP	Children's Health Insurance Program
COPD	chronic obstructive pulmonary disease
CT	computerized tomographic
CTS	Community Tracking Study
ED	Emergency Department
EMAF	Emergency Medicine Action Fund
EMR	Electronic Medical Record
EMTALA	Emergency Medical Treatment and Labor Act
ER	Emergency Room
FFS	Fee-for-Service
GDP	Gross Domestic Product
HCUP	Healthcare Cost and Utilization Project
HMO	Health Maintenance Organization
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICU	Intensive Care Unit
IT	Information Technology
NEDS	Nationwide Emergency Department Sample
NHDS	National Hospital Discharge Survey
NCHS	National Center for Health Statistics
NIS	Nationwide Inpatient Sample
PCP	Primary Care Physician
PPO	Preferred Provider Organization
PQI	Prevention Quality Indicators
SEDD	State Emergency Department Database
SID	State Inpatient Database

1. Introduction

This report examines the evolving role of hospital emergency departments (EDs) in the U.S. health care system. RAND conducted the study at the request of the Emergency Medicine Action Fund to develop a comprehensive picture of how EDs contribute to modern health care and to suggest how ED care might be more effectively, and more cost-effectively, integrated with community care.

Trends Affecting the Evolution of Hospital EDs

The hospital ED is a relatively recent phenomenon that emerged in the years following World War II (A. L. Kellermann & Martinez, 2011). Beginning in the early 1970s and accelerating through the 1980s and 1990s, ED staffing shifted from part-time coverage by community physicians, rotating house officers, or moonlighters to full-time, around-the-clock coverage by residency-trained, board-certified emergency physicians (IOM, 2007). The highly specialized knowledge and skills these doctors possess have allowed hospital EDs to dramatically expand their capability to diagnose and manage a wide range of problems, from resuscitating critically ill and injured children and adults to managing complex patients with chronic diseases such as HIV–AIDS, cancer, renal failure, and diabetes. The enhanced capability to manage complex and time-critical problems has also given ED staff more options to diagnose and manage problems without resorting to hospital admission.

Overall Growth in Health Care Spending.

The evolving role of EDs in America's health care system must be viewed against the backdrop of a seemingly relentless rise in the rate of health care cost growth. For most of the past 60 years, U.S. health care spending outgrew gross domestic product (GDP) by an average of 2–2.3 percentage points per year (Fuchs, 2012). In 1990, the United States spent 12 percent of GDP, roughly $724 billion, on health care. In 2010, health care devoured 17.9 percent of GDP, $2.6 trillion (Center for Medicare and Medicaid Services, 2012). Spending growth has slowed since 2009 (Davis, 2011), but experts debate whether this reflects changes in health care delivery or a sluggish recovery from the recession that began the previous year.

Health care has grown so expensive that it is threatening the viability of employer-sponsored health insurance (Kaiser Family Foundation, 2012) and the solvency of the Medicare program. (Ginsburg, 2008). States have less money for education and other important priorities (Pew Center on the States, 2012). Between 1999 and 2009, health care cost growth wiped out the income gains of middle class families (Auerbach & Kellermann, 2011).

Spending growth is the top concern of policymakers; however, despite the fact that hospital ED use has increased, the ED contribution to spending growth is small. ED care is widely characterized as the most expensive care there is, but the real issue for EDs—one misunderstood by policymakers—is not the cost of non-urgent use. Rather, it is the growing role that EDs play as gateways to inpatient treatment, which accounts for 31 percent of health care spending.

Growing Use of Hospital EDs

Between 2001 and 2008, use of hospital EDs grew at roughly twice the rate of population growth (Kharbanda et al., 2013). During the same period, hospitals closed about 198,000 beds. With more patients seeking care and fewer inpatient beds available for those who need one, EDs grew crowded with admitted patients who could not be transitioned to inpatient care. (Kellermann, 2006).

Practice intensity has also increased in EDs, in part because EDs are treating older and sicker patients, and in part because emergency physicians are bringing more sophisticated and costly technology, such as more aggressive use of computerized tomographic (CT) scanning and other diagnostic tests, to bear in managing their patients' problems. In 2012, Pitts and colleagues noted that "EDs have become a central staging area for acutely ill patients, for the use of diagnostic technology, and for decisions about hospital admission, all of which makes ED care increasingly complex" (Pitts, Pines, Handrigan, & Kellermann, 2012). The combined effects of steady growth of ED visits, more-intensive workups, and fewer inpatient beds have extended ED lengths of stay, dramatically increasing the number of patients in hospital EDs at any hour of the day (Pitts et al., 2012). The crowding that results compromises patient safety and can worsen patient outcomes (Bernstein et al., 2009).

The increase in practice intensity also generated higher charges. Although emergency medicine's contribution to aggregate physician charges in the United States is relatively small, a team of Harvard analysts determined that emergency medicine has boosted its Medicare charges relative to its 2002 baseline faster than almost every other specialty, ranking second only to radiation oncology (Alhassani, Chandra, & Chernew, 2012).

Basic issues of access are key determinants of ED use. EDs are the only place in the U.S. health care system where the poor cannot be turned away. As a result, they are disproportionately used by low-income and uninsured patients who cannot reliably get care in other settings. In fact, the 4 percent of doctors who staff America's EDs manage 28 percent of all acute care visits in the United States, half of all the acute care provided to Medicaid and Children's Health Insurance Program (CHIP) beneficiaries, and two-thirds of the acute care provided to the uninsured (Pitts, Carrier, Rich, & Kellermann, 2010).

The Rising Cost of ED Care

ED charges for treatment of adults have grown dramatically. Between 2001 and 2010, physician claims for higher-paid services, particularly level 5 visits (the highest level of severity

in Medicare coding), grew from 27 percent to 48 percent of Medicare discharges (Office of Inspector General, 2012).

Politicians are fond of asserting that "emergency department care is the most expensive care there is." The numbers suggest otherwise. EDs provide 11 percent of all outpatient visits and are the portal of entry for roughly half of all hospital admissions (Pitts et al., 2010); however, they account for only 2–4 percent of total annual health care expenditures (American College of Emergency Physicians, 2012). Recently, the McKinsey Global Institute estimated that aggregate national spending on outpatient health care totaled about $850 billion in 2006 (McKinsey Global Institute, 2008). Of that, less than 10 percent ($75 billion) could be attributed to EDs, suggesting that aggregate spending for ED care is in line with its share of outpatient care delivery.

Studies of ED charges versus reimbursement have generated mixed results. Rates of reimbursement for pediatric ED visits decreased significantly from 1996 to 2003 (Hsia, MacIsaac, & Baker, 2008). Among adult patients, charges and associated payments for ED care have increased, due at least in part to the steady growth of ED visits (Pitts, Niska, Xu, & Burt, 2008).

Both inefficiencies in the health care system and legal requirements contribute to ED costs. Providers often feel obliged to repeat tests because they cannot get access to the patient's medical record. High levels of uncompensated care also figure prominently in ED costs. Because EDs are required under federal law to evaluate and stabilize all who present to the ED without regard for ability to pay, they serve as the "safety net of the safety net" for uninsured patients and Medicaid beneficiaries (Schuur & Venkatesh, 2012; Tang, Stein, Hsia, Maselli, & Gonzales, 2010). Nationwide, about 55 percent of emergency services are uncompensated (American College of Emergency Physicians, 2012).

Efforts to Discourage Non-Urgent Use of EDs

Cognizant of the high charges associated with ED visits, health plans and government are taking increasingly aggressive action to discourage non-urgent ED visits (Baker, 1994; Washington, Stevens, Shekelle, Henneman, & Brook, 2002). Arguing that such visits can be readily managed in less costly settings, policymakers and third-party payers have considered a variety of strategies to steer patients away from EDs and to deny payment for non-urgent ED visits (Cutler, 2010). Shifting ED patients to less expensive outpatient or office-based care is appealing in concept, but difficult to accomplish in practice (Florence, 2005). There is no standard definition of non-urgent care. In addition, it is notoriously difficult to determine at ER triage which patients are really sick and which are not (A. L. W. Kellermann, R. M., 2012). Raven and colleagues, analyzing data from the National Hospital Ambulatory Medical Care Survey-ED subsample, determined that many patients with the same presenting complaint as those who were felt to be inappropriate ED visitors were found to require immediate emergency care or hospital admission (Raven, Lowe, Maselli, & Hsia, 2013).

Timeliness also plays a role in ED use. Research teams that have asked patients why they sought treatment in EDs for non-urgent conditions found that the primary motivator is lack of options, not lack of judgment (J. Billings, Parikh, & Mijanovich, 2000; J. Billings, Parikh, N., Mijanovich, T.,, 2000; Delia & Cantor, 2009; Goodell, 2009; A. L. W. Kellermann, R. M., 2012; Taylor, 2006; Young, Wagner, Kellermann, Ellis, & Bouley, 1996)). Indeed, a major driver of ED use is lack of access to primary care. When Americans develop an acute health problem, they see their primary care provider less than half the time, especially when the symptoms involve a potentially serious problem, such as chest or abdominal pain, headache, shortness of breath, or other potentially serious problems (Pitts et al., 2010). A survey by the Centers for Disease Control and Prevention (CDC) conducted in 2011 showed that about 80 percent of adults who visited an ED did so because they lacked access to other providers. Nearly half reported "the doctor's office was not open" as the reason for their most recent ED visit (CDC, 2012).

EDs as Entry Points to Inpatient Care

Little thought has been given to the growing role that EDs play as gateways to inpatient treatment, which accounts for one-third of health care spending. Between 1993 and 2006, hospital admissions from the ED grew by 50 percent (from 11.5 million to 17.3 million). As a result, the share of inpatient stays that originated in the ED increased from 34 percent to 44 percent (Schuur & Venkatesh, 2012).

Although EDs are essential to hospital operations, many administrators consider their ED a "loss leader" (Hsia, Kellermann, & Shen, 2011; Simonet, 2009). This perception is due, in part, to the financial burden of uncompensated care that EDs are legally required to provide, and in part to accounting practices that attribute inpatient revenues to the admitting service, rather than the department where the admission originated (Institute of Medicine, 2007).

Recently, Smulowitz, Honigman and Landon (Smulowitz, Honigman, & Landon, 2013) proposed a novel framework that classifies ED visits into broad categories of severity and seeks to focus the attention of policymakers and health system managers on ED visits that present the most potential for improving outcomes while simultaneously reducing costs. The approach they devised suggests that the current focus on diverting low-acuity visits to less-costly sites of ambulatory care would not produce savings of the magnitude that could be achieved if EDs and their associated health systems focused on reducing preventable hospital admissions and, to a lesser extent, improving ED care of patients with what the authors term "intermediate or complex conditions." After outlining this framework, the authors proposed a variety of ways in which EDs might become more fully integrated into a health care delivery system that puts patients first.

The project described in this report was nearly finished when Smulowitz et al. published their paper; however, in many ways our study results have provided empirical support of their work.

Aims of the RAND Study

In a series of three reports published in 2006, the Institute of Medicine (IOM) examined the strengths, limitations, and future challenges of emergency care in the U.S. health system (Institute of Medicine, 2007). The IOM noted that tremendous progress has been made in the science of emergency medicine, the capabilities of emergency care providers, the development of emergency medical services (EMS), and the regionalization of trauma care. It also noted that hospital-based emergency care has grown so overburdened, it has reached "the breaking point" (Institute of Medicine, 2007).

With the exception of the IOM, few independent groups have examined the various roles that EDs play, the challenges they face, and the contributions they make to the functioning of our nation's health care system. This information gap makes it difficult to understand how EDs should be integrated into community-based care.

The overarching goal of our work was to help fill this information gap. Our study had five specific aims:

1. *Quantify and contrast the number and percentage of hospital admission decisions made by ED physicians compared with those of primary care physicians (PCPs) and other office-based specialists.* We hypothesized that the percentage of admissions entering the hospital through the ED has grown relative to the number of patients directly admitted from their physician's office.
2. *Quantify the proportion of non-elective admissions that enter hospitals through the ED versus direct admissions from physicians' offices and other primary care settings*. We hypothesized that the proportion of hospital admissions that is non-elective has increased and that this increase is being driven by admissions entering via the ED.[1]
3. *Determine the frequency and reasons why office-based physicians refer patients to the ED for evaluation and, if required, hospitalization, rather than directly admitting the patient themselves.* We hypothesized that office-based physicians are increasingly using the ED for evaluating and admitting non-elective patients.
4. *Determine ED admission rates by type of health care insurance for various sub-populations of interest.* We hypothesized that the number and rate of ED admissions (as a percentage of total ED visits by payer group) is growing more quickly among Medicare beneficiaries and privately insured patients than among Medicaid beneficiaries and the uninsured. Furthermore, we hypothesized that patients enrolled in a health plan that offers care coordination are less likely to be hospitalized than otherwise comparable patients who are covered by a fee-for-service (FFS) plan.
5. *Determine if EDs are playing a role in reducing preventable hospital admissions and readmissions of patients with ambulatory care sensitive (ACS) conditions* (e.g., asthma,

[1] Non-elective admissions are urgent/emergent hospitalizations dictated by the patient's medical condition and their treating physician's determination that hospitalization is required to address the problem. Generally speaking, they cannot be postponed. Elective admissions are chosen by the patient or their physician for reasons that are perceived to be beneficial to the patient, but are not urgent.

diabetes, heart failure, other chronic health conditions). We hypothesized that although ED use by patients with ACS conditions is growing, the number of hospitalizations involving these same clinical conditions is either flat or rising at a slower rate. If true, this may indicate that EDs are playing a constructive role in reducing preventable hospital admissions.

Organization of This Report

The discussion that follows is organized as follows. We describe our conceptual model of ED use (Chapter Two), methods (Chapter Three), findings (Chapter Four), and their implications (Chapter Five). We conclude by drawing conclusions for policy and practice (Chapter Six).

EXHIBIT 2

The Washington Post Democracy Dies in Darkness

Nevada jury: Health insurers owe ER doctors $60M in damages

By Ken Ritter | AP

December 7, 2021 at 10:31 p.m. EST

LAS VEGAS — One of the largest U.S. health insurance companies and its branches in Nevada were found liable Tuesday for $60 million in punitive damages for underpaying out-of-network emergency medical providers.

A state court jury said three plaintiffs headed by urgent care staffing service TeamHealth should each receive shares of $20 million from Connecticut-based United Healthcare Insurance Co. and five subsidiaries, including the two dominant providers in the Las Vegas area: Sierra Health and Life Insurance Co., and Health Plan of Nevada Inc.

“They were able to get away with this until now,” plaintiffs’ attorney John Zavitsanos told the eight jurors who last week awarded $2.65 million in compensatory damages to plaintiffs Fremont Emergency Services (Mandavia) Ltd., Team Physicians of Nevada-Mandavia PC and the parent company of Ruby Crest Emergency Medicine.

Appeals are expected. Daniel Polsenberg, a Las Vegas attorney representing defendants, asked Clark County District Court Judge Nancy Allf to schedule post-verdict hearings. No dates were immediately set.

Although attorneys were prohibited in court from telling the jury who might end up paying monetary damages, a company statement after the verdict suggested the costs could be passed to others.

“Everyone agrees health care costs too much, and today’s decision only adds to the problem,” said the statement, provided by Dustin Clark, communications vice president for parent company United Healthcare.

“We will be appealing this decision immediately in order to protect our customers and members from private equity-backed physician staffing companies who demand unreasonable and anticompetitive rates for their services and drive up the cost of care for everyone,” the statement said.

Zavitsanos and Houston-based law partner Joseph Ahmad had asked for punitive damages of between $100 million and $1 billion from United Healthcare. They characterized the parent company, UnitedHealth Group, as a “Fortune 5” member, among the largest businesses in the nation.

“The only thing they understand is money,” Zavitsanos said, as he called for jurors to send a message that defendants also including United Healthcare Insurance Co., United Health Care Services Inc. and UMR Inc. harmed doctors, anesthesiologists and nurses.

Dr. Scott Scherr, emergency department director at Sunrise Hospital & Medical Center in Las Vegas and regional medical director of TeamHealth, testified during the monthlong trial. He expressed relief after the verdicts.

“A jury of my peers realized the value of emergency medicine in Nevada,” said Scherr, who headed trauma teams treating critically injured victims after the deadliest mass shooting in modern U.S. history in October 2017 at a Las Vegas Strip concert. Fifty-eight people died that night; hundreds were injured.

“I hope this sends a message to United Healthcare about the importance of our frontline workers,” Scherr said.

In emergency rooms, where patients cannot by law be turned away, attending medical care providers treating sore throats, broken ankles, heart attacks and gunshot wounds may not be covered by patients’ insurance plans.

Testimony showed that United Healthcare cut reimbursements to out-of-network providers by more than half from 2017 to 2020 — from $528 to $246.

“For too long United just thought they could do whatever they wanted,” Zavatsanos said after the jury was dismissed. “Despite enormous efforts by TeamHealth to have legislators and people in the industry listen, it took eight ordinary citizens to hopefully bring about more change than anything that has been done to date.”

He added: “This today is a victory for all of the frontline heroes in Nevada, front line emergency room workers, physician assistants and nurse practitioners.”

In court, attorney K Lee Blalack II, representing defendants, reminded jurors that the compensatory damages award they reached with their Nov. 29 liability verdict represented about one-fourth of the $10.4 million in disputed billing charges at the heart the breach-of-contact case.

“My clients heard you loud and clear,” he said, adding that he hoped the jury would conduct an equally careful analysis on Tuesday. Jurors deliberated about two hours.

Conceding that punitive damages were on the table, Blalack called $5.5 million a “reasonable sum” for what he said amounted to “a payment dispute between big companies.”

More than that would be “monstrous,” “unjust” and represent “an obscene windfall for the largest ER staffing company in the country,” Blalack said, referring to Tennessee-based TeamHealth.

The civil lawsuit was filed in April 2019 by Fremont and the two other groups representing out-of-network providers at hospitals in and around Las Vegas, and in the rural Nevada cities of Fallon and Elko.

Rebecca Paradise, United Healthcare’s senior vice president for out-of-network payment strategy, underwent intense and repetitive questioning by Ahmed on Tuesday about the effect of the verdict on her company.

In more than an hour of testimony, Paradise refused to specify any changes administrators might make to billing practices based on a verdict she called “impactful” but said had been reached only a week ago.

United Healthcare has tens of millions of insurance policyholders in the U.S.

“I’m not saying I agree or disagree. The verdict is the verdict,” Paradise said. “We believe we are paying fair and reasonable rates. The jury found otherwise in this case and we will have to evaluate that. We need to understand what that means going forward.”

Ahmed showed the jury that while cutting reimbursement rates, the insurer reaped billions of dollars in profits and bought back stock shares, driving up prices for company executives and shareholders.

Wayne Dolcefino, a Houston-based media consultant and former journalist who closely monitored the Nevada trial, said he was aware of similar reimbursement lawsuits pending in states including Arizona, Florida, New Jersey, New York, Oklahoma, Pennsylvania and Texas.

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This version corrects that United Health Care Insurance is one of the largest health insurance companies in the U.S., not the largest.

EXHIBIT 3

Congress of the United States
House of Representatives
Washington, DC 20515

November 5, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Dear Secretary Becerra, Secretary Yellen, and Secretary Walsh:

We write regarding the interim final rule (IFR) released on September 30 entitled "Requirements Related to Surprise Billing; Part II". The bipartisan No Surprises Act, passed by Congress in December 2020, was one of the most important patient protection bills in American history, but its success will depend on your departments following the letter of law in its implementation. We urge you to amend the IFR in order to align the law's implementation with the legislation Congress passed.

Congress passed the No Surprises Act after extensive bipartisan and bicameral deliberations to protect patients from surprise medical bills and create a balanced process to resolve payment disputes between insurance plans and health care providers. During these deliberations, multiple proposals were considered including a benchmark rate, an independent dispute resolution (IDR) process, and a hybrid. Following a comprehensive process that included hearings, markups, and extensive negotiations, Congress rejected a benchmark rate and determined the best path forward for patients was to authorize an open negotiation period coupled with a balanced IDR process.

The No Surprises Act specified an IDR process that takes patients out of the middle of payment disputes. It allows providers and payors to bring any relevant information to support their payment offers for consideration, except for billed charges and public payor information. Per this process, the certified IDR entity shall consider:

- Median in-network rates
- Provider training and quality of outcomes
- Market share of parties
- Patient acuity or complexity of services
- In the case that a provider is a facility: teaching status, case mix, and scope of services
- Demonstrations of previous good faith efforts to negotiate in-network rates
- Prior contract history between the two parties over the previous four years

The process laid out in the law expressly directs the certified IDR entity to consider each of these listed factors should they be submitted, capturing the unique circumstance of each billing dispute without causing any single piece of information to be the default one considered.

Unfortunately, the parameters of the IDR process in the IFR released on September 30 do not reflect the way the law was written, do not reflect a policy that could have passed Congress, and do not create a balanced process to settle payment disputes. The IFR directs IDR entities to begin with the assumption that the median in-network rate is the

appropriate payment amount prior to considering other factors. This directive establishes a de-facto benchmark rate, making the median in-network rate the default factor considered in the IDR process. This approach is contrary to statute and could incentivize insurance companies to set artificially low payment rates, which would narrow provider networks and jeopardize patient access to care – the exact opposite of the goal of the law. It could also have a broad impact on reimbursement for in-network services, which could exacerbate existing health disparities and patient access issues in rural and urban underserved communities.

We appreciate the complex nature of the patient protections that must be established and look forward to a final rule that accurately reflects Congress's multi-year bipartisan and bicameral work to pass this landmark legislation. Therefore, we urge you to revise the IFR to align with the law as written by specifying that the certified IDR entity should not default to the median in-network rate and should instead consider all of the factors outlined in the statute without disproportionately weighting one factor.

Thank you for your continued efforts on this important matter. We look forward to working with you to ensure the best outcomes for our patients and the health of our communities.

Sincerely,

Thomas R. Suozzi
Member of Congress

Brad R. Wenstrup, D.P.M.
Member of Congress

Raul Ruiz, M.D.
Member of Congress

Larry Bucshon, M.D.
Member of Congress

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Ron Kind
Raja Krishnamoorthi
Darin LaHood
Doug LaMalfa
Conor Lamb
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James R. Langevin
Jake LaTurner
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Peter Meijer
Grace Meng
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Carol D. Miller
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Alex X. Mooney
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Frank J. Mrvan
Gregory F. Murphy, M.D.
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David Rouzer
Lucille Roybal-Allard
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Linda T. Sánchez
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David Schweikert
Austin Scott
David Scott
Pete Sessions
Terri A. Sewell
Brad Sherman
Mike Simpson
Albio Sires
Christopher H. Smith
Jason Smith
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Bruce Westerman
Robert J. Wittman
Steve Womack
John Yarmuth
Don Young

CC: Daniel Barry, Acting General Counsel, U.S. Department of Health and Human Services
Laurie Schaffer, Principal Deputy General Counsel, U.S. Department of the Treasury
Peter Constantine, Associate Solicitor for Legal Counsel, U.S. Department of Labor
Lynn Eisenberg, General Counsel, U.S. Office of Personnel Management

EXHIBIT 4

Congress of the United States
U.S. House of Representatives
COMMITTEE ON WAYS AND MEANS
1102 LONGWORTH HOUSE OFFICE BUILDING
(202) 225-3625
Washington, D.C 20515-0348
http://waysandmeans.house.gov

October 4, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Martin Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Re: Implementation of the No Surprises Act

Dear Secretaries Becerra, Yellen, and Walsh:

We write regarding our concerns with respect to the implementation of the historic and bipartisan No Surprises Act by your Departments. We are concerned that the regulation published on September 30, 2021, as well as the decision to delay full implementation of the Advanced Explanation of Benefits (AEOB) and other patient protections, do not reflect the law that Congress passed. While this law represents one of the greatest consumer protection reforms in American history, its success depends on your Departments fulfilling Congressional intent and swiftly implementing all necessary provisions.

For far too long, patients received devastating surprise out-of-network medical bills and suffered from a lack of price transparency. Payers and providers put patients in the middle of their payment disputes. They kept patients in the dark about the cost of their care, then saddled them with insurmountable and unexpected charges. Congress stepped in to protect patients by ending the practice of surprise medical billing. In so doing, Congress sought to promote fairness in payment disputes between insurers and providers—carefully specifying all the various factors that should be considered during the independent dispute resolution (IDR) process. Your

Departments are also charged with ensuring that payers and providers work together to provide patients with transparent information that includes the patients' costs and the network status of their providers in the form of an AEOB.

The IDR process was subject to extensive Congressional consideration for nearly two years prior to the enactment of the No Surprises Act. The law incentivizes insurers and providers to act in good faith and resolve disputes amongst themselves while also recognizing that the parties may be unable to resolve their differences in certain instances. As a result, the law provides for an IDR process overseen by an independent and neutral arbiter who must consider a number of factors equally in deciding whether to select the provider or payer's offer. Such factors include median in-network rates, prior contracted rates during the previous four plan years, the relative market share of both parties involved, the provider's training and experience, the patient's acuity, the complexity of furnishing the item or service, and in the case of a provider that is a facility, its teaching status, case mix and scope of services, demonstrations of good faith efforts (or lack of good faith efforts) to enter into a network agreement, and other items. Congress deliberately crafted the law to avoid any one factor tipping the scales during the IDR process.

As you know, the Committees of jurisdiction worked through multiple proposals to end surprise billing throughout the 116th Congress. The compromise reflected in the No Surprises Act balanced the various approaches alongside the significant political and economic considerations at issue. Multiple proposals that ultimately did not become law relied on the median in-network rate as the benchmark for payment, with baseball-style arbitration designed as a backstop to, at most, result in a mere adjustment to the benchmark rate. In contrast, the legislation reported out of the Committee on Ways and Means, which was adopted in the No Surprises Act, authorizes IDR but does not preference in-network rates to determine the payment amount. The law Congress enacted directs the arbiter to consider all of the factors without giving preference or priority to any one factor—that is the express result of substantial negotiation and deliberation among those Committees of jurisdiction, and reflects Congress's intent to design an IDR process that does not become a de facto benchmark.

Despite the careful balance Congress designed for the IDR process, the September 30, 2021 interim final rule with comment strays from the No Surprises Act in favor of an approach that Congress *did not* enact in the final law and does so in a very concerning manner. The rule crafts a process that essentially tips the scale for the median contracted rate being the default appropriate payment amount. Under the interim final rule, the IDR entity is only allowed to deviate from the median amount where the parties present "credible information about additional circumstances [that] clearly demonstrates that the [median in-network rate] is materially different from the appropriate out-of-network rate." Such a standard affronts the provisions enacted into law, and we are concerned that this approach biases the IDR entity toward one factor (a median rate) as opposed to evaluating all factors equally as Congress intended.

In addition, we are concerned by the Administration's decision to delay the implementation of certain key transparency provisions slated to take effect on January 1, 2022. In guidance from August 2021, the Centers for Medicare and Medicaid Services delayed the compliance date for when consumers should receive a good faith estimate of the cost of services

through an AEOB despite the date specified by Congress. We are concerned that without a strict implementation deadline, payers and providers will not work toward expanding the current data transfer technology framework to ensure full compliance with the law. This provision was enacted to bring unprecedented transparency to patients about the cost of their health care, and delaying its implementation will leave patients vulnerable.

We understand that implementing the No Surprises Act to end the practice of surprise medical billing in a year is no small task, and that complexities exist as your individual Departments work together, but we must remain steadfast in ending this predatory practice. We request a written follow-up explaining how the regulation issued last week establishing the IDR process and designing a new test for how factors should be considered comports with the law Congress enacted. We are also requesting a timeline for full implementation that declares interim plans to build on current technology available to allow for implementation of these patient protections, specifically the AEOB and true and honest cost estimate, as soon as practicable. Finally, we ask that you revisit this interim final rule and consider adjustments that better align with the law Congress enacted.

Sincerely,

Richard E. Neal
Chairman
Committee on Ways and Means

Kevin Brady
Ranking Member
Committee on Ways and Means

EXHIBIT 5

NEAL OPENING STATEMENT AT MARKUP OF SURPRISE MEDICAL BILLING, HOSPICE, AND HEALTH CARE INVESTMENT TRANSPARENCY LEGISLATION

Feb 12, 2020 | Press Release

(As prepared for delivery)

Good morning and welcome. Today, the Committee will mark up three important bills to protect patients and encourage more transparency in our nation's health care system.

First, we will consider H.R. 5821, the Helping Our Senior Population in Comfort Environments (HOSPICE) Act. This bill implements more oversight for Medicare hospice providers and greater transparency for enrollees to ensure patients receive the high-quality care they deserve at the end of life.

The Inspector General of the Department of Health and Human Services released two alarming reports in July that identified significant deficiencies in the quality of care delivered to Medicare hospice enrollees. Almost 90 percent of hospices had at least one care deficiency between 2012 and 2016. That is unacceptable. H.R. 5821 provides HHS with more tools to oversee hospices and to help poor-performing hospices improve. Thank you to Representatives Panetta and Reed for quickly coming together to introduce this important legislation.

Next we will consider H.R. 5825, the Transparency in Health Care Investments Act. This bill requires private equity firms that own and control medical care providers to report certain information. This transparency will shed sunlight on the impacts these investment activities may have on patient care and costs.

Increasingly, private equity firms are investing in areas such as emergency departments, ambulatory surgery centers, trauma units, nursing homes and hospitals, as well as health insurance companies. This reporting will enable policy makers and regulators to better understand private equity's effects on the health system.

Finally, we will consider H.R. 5826, the Consumer Protections Against Surprise Medical Bills Act of 2020. Ranking Member Brady and I worked together for many months to craft this bipartisan legislation that protects patients from unexpected medical bills for out-of-network services. At the outset, we agreed that any approach must first and foremost protect the patient from these surprise bills and provide incentives for providers and health plans to sort out payment disputes on their own.

The need to protect the patient is something I think we all agree on. But throughout this process we have asked what is the best approach? The doctors and insurance companies blame each other while the patient is caught in the middle.

I think the legislation we have before us today is the right approach – it protects the patient, but also recognizes the private market dynamics between insurance plans and providers.

There are two important provisions that I specifically want to highlight. First, we have included transitional assistance through the medical expense deduction which will provide some relief from surprise medical bills for patients during the time period between this proposal becoming law and it actually being implemented through the regulatory process.

Second, we have ensured that uninsured individuals are able to get a good faith estimate of their out-of-pocket expenses prior to a procedure – and in the event their final bill substantially differs from that estimate, they can access dispute resolution to help resolve the discrepancy.

Surprise medical bills cause tremendous emotional and financial distress for Americans when they are already in a particularly vulnerable state. This legislation ensures that such bills will be a thing of the past. It will remove the patient from any billing dispute, allowing them to focus on their health instead of worrying about the potential cost of their care.

We know that once the patient is removed from the billing dispute, health plans and providers are generally able to come to a resolution on their own. However, for those instances where resolution is elusive, this legislation provides a fair and balanced approach to settle plan-provider payment issues.

The first step is open negotiation, where the plan and provider exchange information in a way that I believe will help the parties understand what a reasonable offer is and get them to a resolution.

But if that exercise fails, the second step is a mediated resolution process. Ranking Member Brady and I have worked to craft a process where both the provider's offer and the plan's offer receive equal weight.

In addition, the resolution entity considers, but isn't bound by, the plan's median in-network rate. And likewise, the provider is not left in a position to disprove the adequacy of such a rate.

My concern with giving too much weight to such a benchmark rate is that we already know insurers are looking for any way they can to pay the least amount possible. They will work to push those rates down, regardless of what it means for community providers like physicians, hospitals, and our constituents who they employ.

With no federal network adequacy standards, plans can push rates down and drop providers from networks with no consequences, leaving patients holding the bag.

While this legislation doesn't take on network adequacy, it is something Congress must examine. Surprise bills would be much less common if insurer networks were more robust.

In addition, the legislation before us today does not yet address the "surprise" bills that come from insurance companies. These are bills, for example, when a patient received prior authorization only to find out later that the insurance company is going back on that agreement and sticking the patient with the bill.

I look forward to working with Ranking Member Brady and our committee colleagues on these two issues, among others, going forward. The problem of surprise medical billing is a complex issue that has real consequences for patients. The solution Congress finds will affect every part of our nation's health care system. As this measure moves along in the process, I intend to refine it, but I think we have a very good start before us today.

And I am not alone in that assessment. Many organizations are supportive of our work to protect the patients and allow a fair and balanced process between providers and insurance companies. These include consumer groups like AARP and Community Catalyst as well as the hospitals and doctors who provide care for our neighbors and are cornerstone of our communities – the Massachusetts Hospital Association, the Massachusetts Medical Society, the American Medical Association, the American Hospital Association, the Federation of American Hospitals, Catholic Health Association, America's Essential Hospitals, and National Alliance of Safety Net Hospitals.

With that, I will recognize Ranking Member Brady for the purpose of an opening statement.

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EXHIBIT 6

E&C REPUBLICANS

WAYS AND MEANS
REPUBLICANS | KEVIN BRADY, REPUBLICAN LEADER

COMMITTEE ON EDUCATION & LABOR · REPUBLICANS · EST 1867

Protecting Patients from Surprise Medical Bills

Key Points:

- No American should delay care or face financial ruin because of surprise medical bills.
- The Committees on Energy and Commerce, Ways and Means, and Education and Labor have collaborated over several years to find a bipartisan path forward to end surprise medical bills.
- This bipartisan, bicameral agreement is a free-market solution that takes patients out of the middle and fairly resolves payment disputes between plans and providers.

The real-world impact of surprise medical bills:

Drew Calver, a teacher from Texas, was rushed to an out-of-network hospital when he had a heart attack. Afterwards, he was hit with a surprise bill of $108,951.

Sonji Wilkes gave birth at an in-network facility and her son was sent to the NICU for treatment. However, the NICU was not in-network and Wilkes and her family received a $50,000 bill.

Elizabeth Moreno had back surgery and was prescribed an opioid; a routine follow-up drug test resulted in a $17,850 bill.

What the agreement does:

- Protects patients from surprise bills.
- Ensures physicians and other health workers don't face economic harm and uncertainty.
- Protects **all** stakeholders, most importantly patients, while also ensuring a pathway for resolution of payment disputes for health care services that are consistent with private market practices.
- Empowers consumers by providing a true and honest cost estimate that describes which providers will deliver their treatment, the personalized cost of services, and provider network status.

What the agreement does not do:

- This text includes **NO** benchmarking or rate-setting.
- This doesn't increase premiums for patients or interfere with any strong, state-level solutions already on the books.

How it works:

- First and foremost, patients are protected from surprise medical bills – under this agreement, they don't have to pay any more than their in-network cost sharing.
- If a health care provider is not satisfied with the payment they receive, they can initiate an open negotiation period and, if no resolution is reached, can pursue a dispute resolution process where an independent arbitrator considers relevant factors and determines a fair payment.
- This independent dispute resolution process fairly decides an appropriate payment for services based on the facts and relevant data of each case. This results in savings by stopping bad actors from driving up costs across the health care system, and those savings will be reinvested in important priorities like community health centers.
- There is no dollar amount threshold to enter the open negotiation and independent dispute resolution processes– all claims will be eligible.
- The arbitrator must equally consider many factors, including:
    - Median contracted rates;
    - Education and experience of providers and severity of individual cases;
    - Previously contracted rates going back four years;
    - Good faith efforts to negotiate – bad actors will be held accountable;
    - Market share of both parties – this will help prevent any stakeholder that dominates a region from trying to set rates at an untenable level; and
    - Any other factors brought forward by providers and plans, except for billed charges or government-set rates.

EXHIBIT 7

Congress of the United States
Washington, DC 20515

November 5, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

The Honorable Kiran Ahuja
Director
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415

Dear Secretary Becerra, Secretary Walsh, Secretary Yellen, and Director Ahuja:

We write to express deep concern with the departments of Health and Human Services, Labor, Treasury, and the Office of Personnel Management's Interim Final Rule (IFR) entitled "Requirements Related to Surprise Billing; Part II," published as required by the No Surprises Act, which was included in the Consolidated Appropriations Act, 2021 (P.L. 116-260).

We are Members of Congress with health care expertise, and we worked intimately in a bipartisan fashion with our Congressional colleagues to pass legislation into law with the express purpose of protecting patients from surprise medical bills. This IFR, which establishes the Independent Dispute Resolution (IDR) process, does not reflect legislation that could have passed Congress or the law as written. As your agencies disregarded both the letter and the spirit of the law in issuing this IFR, immediate revisions are necessary to ensure the final implementing regulation upholds our clear statutory language and intention.

The No Surprises Act was the result of two years of bipartisan, bicameral deliberations and negotiation on solutions to protect patients from surprise medical billing and create a balanced process for providers and payors to settle payment disputes. Multiple proposals for resolving this issue were considered, including a benchmark rate, an IDR process, and a blend of both. **As a result of this careful deliberation and negotiation, the final law explicitly required an independent entity to consider a broad range of criteria and weigh all relevant factors equally when deciding appropriate payments for out-of-network services.**

To keep patients out of the middle of these payment disputes, Congress established a mechanism to determine patient cost-sharing. The first IFR issued by the Administration outlined the requirements for determining the qualifying payment amount (QPA) — typically the median in-network rate — which determines patient cost-sharing. While we appreciate that the formula for determining the QPA will help keep patient costs to a minimum, we recognize that it is unlikely to reflect actual market-based payment rates for all circumstances.

Separately, the IDR process established under the law explicitly states providers and payors can bring any relevant information to the IDR process aside from billed charges and public payor information. In addition, the statute clearly states that the IDR entity "**shall consider**" the QPA; level of training; experience; quality and outcomes measurements; market share of parties; patient acuity or complexity of services; teaching status, case mix, and scope of services in the event that the provider is a facility; demonstrations of previous good faith efforts to negotiate in-network rates; and prior contract history between the two parties over the previous four years.

Unfortunately, the IFR as written not only deviates from the letter of the law but also fails to recognize the critical context of how Congress ultimately reached this deliberate bipartisan, bicameral compromise after months of negotiation. We were dismayed to learn that the IFR has eschewed the letter of the law by requiring IDR entities to begin the arbitration process with the presumption that the QPA is the appropriate out-of-network amount, circumventing the congressionally-required consideration of all relevant factors when determining the payment amount, not just a single data point.

Over the last several years, the medical professionals in Congress received copious expert input from providers and physician groups. They repeatedly cited the importance of ensuring a balanced IDR process in determining a payment rate in order to prevent adverse outcomes such as artificially-low payment rates, the narrowing of provider networks, and reduced patient access. While the QPA was originally intended to be applied as a baseline consideration among other factors during the arbitration process, the Administration's proposed rule places a disproportionate emphasis on the QPA, which necessarily undervalues other factors brought to the arbiter, including quality and outcomes data.

The medical professionals in Congress met with the Centers for Medicare and Medicaid Services in June to learn about agency priority interpretations during the rulemaking process, as well as the anticipated impact on American patients. During this conversation, we specifically reminded your Administration the letter of the law requires implementation of a fair and balanced process to settle disputes between health plans and providers. We also highlighted the legislative intent by explaining the different policies Congress explored to address surprise medical billing and the solution Congress ultimately passed into law.

By instructing the IDR entity to rely upon the QPA as the primary factor in determining payment rates, the IFR will limit providers' ability to utilize other statutorily required and relevant factors when negotiating with the payor. Under this IFR, we are concerned that this IDR process will lead to narrower networks and decreased access to medical care for millions of American patients, which would have a disproportionate impact on access to care in rural and underserved areas. If this IFR is finalized as written, providers may no longer be able to afford to serve these communities given the downward pressure on commercial rates coupled with the already delicate payor mix.

As Members of Congress and health care professionals, we strongly encourage your Administration to revise the proposed IFR to align with the statute and congressional intent to protect patients from these negative outcomes. We also request timely implementation of the other patient protections included in the No Surprises Act, like the advanced estimate of benefits and crackdown on inaccurate provider directories. The medical professionals in Congress stand ready to collaborate with your offices to ensure implementation meets statutory requirements before regulations take effect on January 1, 2022.

Sincerely,

Michael C. Burgess, M.D.
Member of Congress

Andy Harris, M.D.
Member of Congress

Brad Wenstrup, D.P.M.
Member of Congress

Bill Cassidy, M.D.
United States Senator

Roger Marshall, M.D.
United States Senator

Brian Babin, D.D.S.
Member of Congress

Larry Bucshon, M.D.
Member of Congress

Earl L. "Buddy" Carter, R.Ph.
Member of Congress

Scott DesJarlais, M.D.
Member of Congress

Neal P. Dunn, M.D.
Member of Congress

A. Drew Ferguson, IV, D.M.D.
Member of Congress

John Joyce, M.D.
Member of Congress

Mariannette J. Miller-Meeks, M.D.
Member of Congress

Gregory F. Murphy, M.D.
Member of Congress

Ronny L. Jackson, M.D.
Member of Congress

Jefferson Van Drew, D.M.D.
Member of Congress

cc: Daniel J. Barry, Acting General Counsel, U.S. Department of Health and Human Services; Peter J. Constantine, Solicitor, U.S. Department of Labor Associate; Laurie Schaffer, Principal Deputy General Counsel, U.S. Department of the Treasury; Lynn D. Eisenberg, General Counsel, U.S. Office of Personnel Management

EXHIBIT 8

CMA Surprise Billing Survey Results

Physicians Decry Unintended Consequences of California's Surprise Billing Laws

A new survey of California physicians illustrates serious unintended consequences from California's surprise billing law (AB 72) that will have long term impacts on patient access to care if not corrected. While the California law has protected patients from surprise bills, physicians are reporting serious problems that will substantially increase health care costs by accelerating consolidation in the health care market, jeopardizing the emergency care safety net and restricting patient access to in-network physicians.

Over a period of nine days, 855 physician practices representing thousands of physicians responded to the survey. The vast majority of respondents reported difficulties contracting with insurers since the passage of California's law. As independent physician practices can no longer remain viable without contracts or reasonable reimbursement rates, they have been forced to consolidate with larger hospital systems or private equity groups, which studies have shown can drive up health care costs by as much as 30%. These unintended consequences totally shift the market leverage to already powerful insurance companies at the expense of patients.

Congress is currently modeling federal legislation on California's surprise billing law. While California has succeeded in protecting patients from surprise medical bills, these survey results clearly demonstrate that rest of the law is not working. California's experience should be a warning to state and federal policymakers.

Summary of the Survey Results

- Physician respondents represent all modes of practice in a broad range of specialties across 52 counties.
- 94% of physicians agree that the Congressional bills modeled after the California law will economically incentivize insurers to terminate contracts with physicians.
- 91% of physicians agree that the Congressional proposals modeled after the California law will accelerate consolidation of independent physician practices into larger hospital systems or private equity groups.
- 88% of physicians said the California law allowed insurers to shrink physician networks, decreasing patient access to in-network physicians in their community.

CALIFORNIA MEDICAL ASSOCIATION
cmadocs.org
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- 79% of physicians said the California law negatively impacted the availability of emergency and on-call physician specialists who respond to emergencies.
- 94% of physicians have experienced contracting difficulties since the passage of California's law.
- More than one third of physician respondents have experienced insurers suddenly terminating contracts, refusing to renew their long-standing contracts, and/or closing their panels and refusing to offer new contracts.
- 59% reported insurers have insufficient physician networks in their specialty in their county.
- 62% said their patients experience challenges with timely access to care.
- 77% agree that the federal legislation will disproportionately harm rural areas.
- 92% said the law has reduced physician leverage to negotiate fair and reasonable contracts.

FOR SPECIFIC PHYSICIAN STORIES AND COMMENTS, SEE APPENDIX 1.

Background: California Surprise Billing Law

In 2016, California's Legislature enacted AB 72 to protect patients from surprise medical bills when a patient goes to an in-network facility but, as part of the patient's care, receives treatment from a physician that is not contracted with the patient's insurance company. The law became effective in July 2017. It establishes an interim payment rate at the greater of the insurer's average contracted rate or 125% of Medicare rates, as well as an independent dispute resolution (IDR) process.

California's interim payment rates—which are set at the median contracted rate—are similar to those being proposed by the U.S. Senate HELP Committee and the U.S. House Energy Commerce committee. Moreover, the California dispute resolution process has been burdensome and is not working as intended. To date, arbiters have ignored all IDR criteria and have merely chosen to confirm whether the insurer paid the correct interim rate in the law. One hundred percent of the disputes have been decided in favor of the insurers.

Since the passage of California's law, the California Medical Association (CMA) has received complaints from physician groups representing thousands of physicians across the state who have experienced contracting problems, including terminations, non-renewals, significant rate cuts and refusals to enter into new contracts. Physicians have advised CMA that these actions by insurers were out-of-the-ordinary based on historical insurer contracting behavior over the last 10-20 years and that many insurers reported to

physicians that it was the result of AB 72. CMA documented all of these reports in a paper titled, "The Unintended Consequences of California's Surprise Billing Law."

California Physician Survey Results

To obtain additional information, CMA surveyed its physician members with the assistance of its component county medical societies and state specialty societies. Over a period of nine days, 855 physician practices representing thousands of physicians responded to the survey. These physician practices represent a broad range of practice sizes and medical specialties from 52 counties in the state, representing urban, suburban and rural areas.

SURVEY OVERVIEW

Physicians overwhelmingly agree about the negative impacts of Congressional legislation modeled after California's law.

- In one of the most significant findings of the survey, physician respondents overwhelmingly agree (91%) that the Congressional legislation modeled after the California law will accelerate consolidation of independent physician practices with large hospital systems or private equity groups, increasing health care costs.
- 86% agree that the Congressional bills modeled after the California law will seriously erode access to in-network physicians, including emergency physicians, surgeons, anesthesiologists and on-call specialists who respond to emergencies.
- 77% agree that the Congressional bills will disproportionately harm rural areas.
- 94% agree that the Congressional bills will economically incentivize insurers to terminate contracts with rates higher than their median contracted rate or reduce rates above the median rate as a means of suppressing rates for out-of-network physicians.

Physicians report insufficient provider networks and patient access to care problems.

- 41% of physician respondents said that since the passage of AB 72 insurers are contracting with fewer hospital-based physicians. Less than 3% of physicians said insurers are contracting with more hospital-based physicians. Forty eight percent reported that they didn't know.

- Patient access to in-network care is not optimal. Almost two thirds (62%) of physicians report that their patients experience challenges with timely access to care or have to travel long distances for specialty care.
- 59% of physicians reported that there are insurers with insufficient physician networks in their specialty and county.
- The vast majority of physicians (88%) agree that California's surprise billing laws and low out-of-network interim rates have allowed insurers to shrink physician networks, decreasing patient access to in-network physicians in their community.
- 79% of physicians agree that California's surprise billing laws and low out-of-network interim payments are negatively impacting the availability of emergency and on-call physicians to respond to emergencies.

California's surprise billing law has tipped the scales overwhelmingly in favor of insurers and has directly incentivized contract terminations and physician rate cuts, making it harder for patients to access in-network physicians

- The low interim payment rate under California's law has disincentivized insurers from contracting with physicians. Ninety four percent (94%) of physician practice respondents reported difficulties contracting with insurers. The most common contracting challenges include[1]:
- Insurers refusing to renew current contracts with the practice (31%);
- Insurers terminating existing contracts (23%);
- Insurers closing their panels and/or refusing to enter into new contracts with the practice (29%);
- Insurers offering rates below the cost to provide care (71%), and/or
- Insurers substantially reducing rates from the last contract (57%).
- Physicians overwhelmingly agree (91%) that California's surprise billing law and the low out-of-network interim rates have reduced physician leverage to negotiate fair and reasonable rates.

[1] Respondents allowed to select all that applied. Percentages are weighted.

- Insurers are taking advantage of the low out-of-network interim payment rate under California's law and using it to drive down all in-network payment rates. Almost two thirds of physician respondents (64%) report that insurers have imposed higher rate cuts since the passage of AB 72.
- 80% of physicians experienced reimbursement cuts up to 30%.
- 13% experienced reimbursement cuts from 31-50%.
- 7% experienced reimbursement cuts of more than 50%.
- Nearly 70% of emergency physician respondents report insurers are not complying with the 2009 California Supreme Court decision in the Prospect case, which prohibits physicians from balance billing patients for out-of-network emergency services but also requires insurers to reimburse at reasonable and customary rates pursuant to the Gould criteria for such out-of-network care. Emergency physicians are not subject to AB 72. Emergency physician respondents reported the following substantial reduction in payment rates, demonstrating that insurers are not paying "reasonable and customary rates" mandated by the Prospect decision. Since the Prospect decision:
- 71% of ER physicians experienced rate cuts up to 30%.
- 22% of ER physicians experienced reimbursement cuts from 31-50%.
- 7% of ER physicians experienced reimbursement cuts more than 50%.

Appendix 1

Physician stories on the unintended consequences their practices have experienced since the passage of California's surprise billing laws (sample).

- One of our largest payors, cancelled our contract and demanded 40% reduction in-order to re-contract. Another sent renewal contract then when we signed and returned, they wrote back saying they decided to not renew after-all because they wanted to renegotiate a 30% lower contract, a third payor just flat out cancelled a contract that had been in place for 10 plus years, a fourth payor had agreed to modest cost of living increase for contract we had had for over 10 years with no increase, then as soon as ab 72 passed told us eye to eye in person that we would not see a raise in our life time because of ab 72.

- Allcare was contracting with hospital and surgeons. However, they were not willing to reimburse anesthesiologists in good faith. This only leads to insurance companies dictating reimbursement that are not linked to market rates. Rural hospitals have to subsidize the difference in order to get emergency anesthesia coverage. There is no leverage for small groups to negotiate with behemoth insurance companies. This is the reason for consolidation of anesthesia groups. The insurance companies are paying four times the market rate when they are cornered by big consolidated anesthesia groups. Second hospital are not able to recruit and retain anesthesiologists. The cost shifting to hospital is breaking a thin bottom line that is needed for hospitals to survive. Only going to bankrupt vulnerable rural hospitals.

- In the last 3 years the Sacramento area has seen a shortage of anesthesiologists. Of 10 practices I'm familiar with only 2 are fully staffed. Any disincentive to practice in California will only make the physician shortage problem worse. The Surprise Billing acts are making this problem worse.

- My practice has been seeing decreasing reimbursements. Some payors are not contracting with us. This has led my anesthesiology group to pay less to the new members of our group and have difficulty retaining them.

- When talking with payors, they use AB72 as a weapon and a verb… "we will AB 72 you."

- Since the passage of this bill our group has seen reimbursements shrink and insurance companies have tremendously more leverage negotiating contracts.

- We are losing physicians on our emergency call panels, placing a greater burden on those who remain, who are often paid miserably low rates for high risk emergency care. I am considering leaving the state.
- Considering departing emergency medicine for urgent care, cash only clinical setting.
- We are at a pediatric hospital which has a high percentage of underserved population. We contracted with health plans to provide care, they have cancelled our contracts, because they realized they can pay us less. Now we are having a hard time recruiting physicians to take care of this population.
- Insurers are using this bill to reduce physician rates and will not enter in good faith negotiations. We have rates that have been in place for 10 years and the insurers come to us and requested a 30% reduction in current rates. The currents rates in place are far below market. AB 72 puts insurers in a position where fair and good faith negotiation has ceased to exist. All power is in their hands and they are unfairly using the current law to negatively impact physicians. Ultimately the people who are most harmed by this are the patients. Access will be narrowed, prices will go up and it will be very harmful to heath care as a whole.
- Doctors retiring early
- I'm a plastic surgeon specializing in breast reconstruction. Breast surgeons I work with have requested I contract with two private medical ins groups (IPA) because they can't get the current in network plastic surgeons to see and schedule reconstruction cases in cancer patients in a timely manner. However, neither IPA would even respond my application to join them.
- We have experienced payors specifically citing AB-72 as a reason for their unwillingness to negotiate fair and reasonable contracts with our group. We have had other payors refuse to meet or discuss contracts up for renewal.
- Our large anesthesia group has insurers who simply stopped communicating and stopped paying. Then they let contracts expire and continue to avoid our calls for discussion. Frustrating. Their patients keep showing up.
- Recruiting to the Central Valley in CA is very difficult. This will make it impossible! There simply won't be enough providers and quality will suffer.

- Since 2016, two of our commercial contracts had reduced their rates up to 46% and 1 of them wouldn't renegotiate the reimbursement rate at all. We terminated that contract and have now lost about 15% of our business due to it.
- Payors have actually told me that "since we don't see any active out-of-network billing from your office there's no reason for us to contract with you or provide competitive rates". If payors want to ensure that their members have access to an in-network provider, then those same payors should set up call panels of in-network physicians.
- Blue Cross and others refuse to negotiate contracts. 125% Medicare take or leave it while reducing networks. We have to see their patients in ED (EMTALA) but they really won't negotiate a contract and they pay us whatever they want and dare us to take them to DMHC (not helpful) or court (expensive). New law would reduce our leverage even more. And hospital coercively pressuring us to contract at 125% Medicare rates and even put it in their version of our new contract (illegal). If we don't contract eventually, they will likely force us into their "Foundation" and make us employees.
- If this trend continues, we will not be able to recruit and retain physicians to our Anesthesia practice in the Silicon Valley.
- Large payors have refused to negotiate reasonable rate increases, and a smaller payor has terminated its contract altogether in reliance on the lower rate they will be able to pay under AB72.
- Anthem Blue Cross unilaterally, and without the appropriate notification required by law, reduced reimbursement rates for Pathology across all billing codes from 50-70%. Some codes now pay as little as $1.00 for services requiring formalin bottles, transport, gross evaluation, and a formal report. They are uninterested in negotiating payment rates. There are no other Pathology providers in this area, although there are plenty listed on their website. These 'other' providers include all of the pathologists in our non-contracted group, listed individually, and practices 60-100 miles from here.
- I am the President of a 63-person anesthesia group in Southern California. Most payers simply refuse to negotiate new contracts. And the majority of offers we get are for massive pay cuts - 50+ % reductions. This bill has been a nightmare for our practice.
- Blue Cross has refused to negotiate as has United after passage of California's surprise billing law. They stood to benefit the most from the way this law was structured, not patients. Insurance companies have no reason to negotiate now because of this law.

- Insurers are using this as leverage in negotiating lower reimbursement rates for anesthesia care. They are, in effect, daring us to go out of network to negotiate lower rates.
- Payors have become hostile and antagonistic, almost taunting us with ab72. What used to be professional businesslike discussions have become insurers laughing at the physicians.
- United and Blue Cross will not negotiate with us!!!!
- Large payor proposed rates at a substantially lower level and essentially refused to negotiate, stating they would terminate our contract if we did not sign.
- Currently looking at anesthesiology positions out of California as are many of my colleagues.
- Many insurers have canceled long standing contracts to renegotiate for 10,20,30% lower reimbursement rates.
- Payors have cited AB72 with take it or leave it contract terms that are less than half our rates prior to AB72 and less than the cost of providing care. Combined with the low Medí-Cal rates our practice is on the verge of collapse.
- Payers now already engaging in “take it or leave it” negotiations. Some have reported that they want us to terminate our contracts.
- These discussions almost always involve the payers citing the surprise billing laws and even the legislative discussions on this topic in DC.
- A major payor cancelled us without cause and basically gave us a take it or leave it 25% cut offer from an already lower end contract we had with them. We are in danger of losing our business entirely if this continues. Its all unintended consequences from a bill hoping to protect consumers which the payors figured out they can abuse for profits!!
- Payers cancelled our long-standing contract which had not had an increase rate in 9 years. They offered a 20% reduction in reimbursement and threatened to just use AB 72 against our group to further reduce reimbursements.
- Due to lower reimbursement and higher competing rates from locums companies, our practice has been unable to recruit physicians and has had to stop providing services at the local hospital.
- Huge Anthem payment cut likely not just coincidence.

- I am routinely unable to refer patients to outpatient specialty services in a timely manner outing their health at risk or at times forced to admit to the hospital to obtain needed work ups which drive up costs as inpatient is always more expensive than outpatient.
- One payer we attempted to contract with simply refused saying they don't need to contract with new providers because state law pretty much makes every provider accept what they offer. Several players refused to consider negotiating updated rates which had been in place for several years. Assuming a take the old terms or leave it attitude, citing that they were in a process of adjusting their rates to reflect the impact of recent state legislation.
- Payors have refused to negotiate contracts with us, have proposed steep cuts to our reimbursement, PPO networks have shrunk while Medicare has increased. Payors are daring us to go out of network in order to drop our rates to the regional average.
- Payors threaten cancellation and refuse to negotiate at end of contract.
- Payor would not even return our calls when we tried to contract with them prior to AB 72 going into effect.
- Blue Cross refuses to renew my current contract and gave me a take it or leave it offer at a lower rate. They know that if I refuse then I have to accept their self-determined rates.
- AB 72 was used to strong arm our group to a substantially lower rate with threat of cancellation and Medicare rates, which are usually 1/2rd of commercial.

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EXHIBIT 9

BlueCross BlueShield of North Carolina Abuses No Surprises Act Regulations to Manipulate the Market Before Law Takes Effect

Insurance company jeopardizing patient access to care through 'take it or leave it' ultimatums to in-network clinicians

CHICAGO – Today, the American Society of Anesthesiologists expressed grave concern about the strong-arm tactics of BlueCross BlueShield of North Carolina and its abuse of the new federal law designed to protect patients from out-of-network bills. The letters being sent to anesthesiology and other physician practices in the state threaten contract termination and the physicians' in-network status unless the physicians immediately agree to payment reductions ranging from 10 to over 30%. Implementation of the *No Surprises Act* is cited in the letters as the impetus for the reductions. The clear intent of the insurance company in taking this action is to improve its negotiating position against community physician practices in the dispute resolution process outlined in the recently released Interim Final Rule implementing the legislation.

The *No Surprises Act*, which was passed in December 2020, was designed to protect patients from surprise out-of-network bills. Although the law intended to resolve payment disputes through an impartial arbitration system, recent rules promulgated by the Departments of Health and Human Services, Labor, and Treasury will create a system that unfairly favors insurance companies. The evidence of this bias and this insurance company's intention to exploit the new rules is clearly demonstrated in the demand letters from BlueCross BlueShield of North Carolina weeks before the law even takes effect.

"Instead of expanding in-network access for patients, BlueCross BlueShield of North Carolina has demonstrated what we explained to Congress and the rule-making agencies would happen: insurance

companies will use their overwhelming market power and the *No Surprises Act*'s flawed rules to push more physicians out of insurance networks and fatten their own bottom line." said ASA President Randall M. Clark, M.D., FASA. "Insurance companies are threatening the ability of anesthesiologists to fully staff hospitals and other health care facilities. Left unchecked, actions like these of BlueCross BlueShield of North Carolina will ultimately compromise timely access to care for patients across the country."

ASA has previously called upon the U.S. Department of Justice to address these and other recent anticompetitive insurance company tactics.

THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Founded in 1905, the American Society of Anesthesiologists (ASA) is an educational, research and scientific society with more than 54,000 members organized to raise and maintain the standards of the medical practice of anesthesiology. ASA is committed to ensuring physician anesthesiologists evaluate and supervise the medical care of patients before, during and after surgery to provide the highest quality and safest care every patient deserves.

For more information on the field of anesthesiology, visit the American Society of Anesthesiologists online at asahq.org. To learn more about the role physician anesthesiologists play in ensuring patient safety, visit asahq.org/madeforthismoment. Like ASA on Facebook and follow ASALifeline on Twitter.

# # #

BlueCross BlueShield of North Carolina

November 5, 2021

[redacted]

Re: Necessity to amend rate agreement, response needed before November 21, 2021.

Dear Provider:

[redacted] is likely aware of the passage of the federal "No Surprises Act" in December of 2020, with an impending effective date of January 1, 2021. Under this law, payments from health plans to out-of-network providers in many circumstances will be set at the "Qualifying Payment Amount" (QPA) which is generally calculated at the median in-network contracted rate for the same or similar specialty within the applicable geographic area. The law applies with respect to out-of-network emergency services, out-of-network professional services at a visit to an in-network facility, and air ambulance services. It applies to our commercial networks (non-Medicare Advantage, non-Medicaid). The QPA paid by health plan to the out-of-network provider constitutes payment in full unless certain limited exceptions apply for a given QPA. These exceptions include express prior patient disclosure and consent, or successful challenge in arbitration.

This new federal law allows a significant change to Blue Cross and Blue Shield of North Carolina's contracting approach with emergency service providers, hospital-based providers, and air ambulance services. Where previous state law could result in an obligation to pay at full charges if no contract is in place, the new law sets reasonable limits on payment at the median in-network rate. Where Blue Cross NC may have previously contracted at what we deemed an inflated rate that is at least somewhat lower than charges in order to avoid paying at full charge, we are now able to seek to contract at a rate more in line with what we consider to be a reasonable, market rate.

We have identified [redacted] as one of our outlier in-network providers with respect to rates. While the exact, final QPAs are not yet available pending upcoming finalization of the Rules to the No Surprises Act, the Interim Final Rules provide enough clarity to warrant a significant reduction in your contracted rate with Blue Cross NC. If we are unable to establish in-network rates more in line with a reasonable, market rate, our plan is to terminate agreements where the resulting out-of-network QPA would reduce medical expenses to the benefit of our customers' overall premiums.

Our ask of you at this point is as follows. We are seeking an immediate reduction in rates under our commercial agreement, as in interim step to the January 1, 2022 effective date of the No Surprises Act. This interim reduction will buy us breathing room to negotiate the final rates in light of the QPA amounts established in accordance with the upcoming Rules. With the interim reduction in place, we will not need to quickly terminate outlier contracts as a means of avoiding

payment levels after January 1, 2022 that are significantly higher than the default out-of-network QPA. Our reduction proposal, for a **December 15, 2021 effective date**, is **-15%**. We ask that you respond to this letter indicating your intention to agree, or providing a specific, comparable counterproposal. If we are able to reach agreement on the rate reduction we will quickly provide a simple rate amendment for your execution. If we are unable to reach agreement on the reduction, our intention is to proceed with identifying and executing on terminations of outlier contracts where the out-of-network QPA will result in significant savings to the benefit of our customers.

Thank you for your prompt attention to this request and your response before November 21, 2021. We hope and trust that we can update and maintain our ongoing partnership for January 1, 2022 and well beyond. If you have any questions, please contact Sr. Contract Manager, Colleen Thedieck, Colleen.Thedieck@bcbsnc.com at (984) 960-3749.

Sincerely,

Mark Werner
Vice President, Provider Networks

EXHIBIT 10

BECKER'S
PAYER ISSUES

4 disputes involving UnitedHealth, physician staffing firms

Morgan Haefner - Wednesday, July 22nd, 2020 Print | Email

TEXT

Here are four recent disputes involving UnitedHealth Group and physician staffing firms:

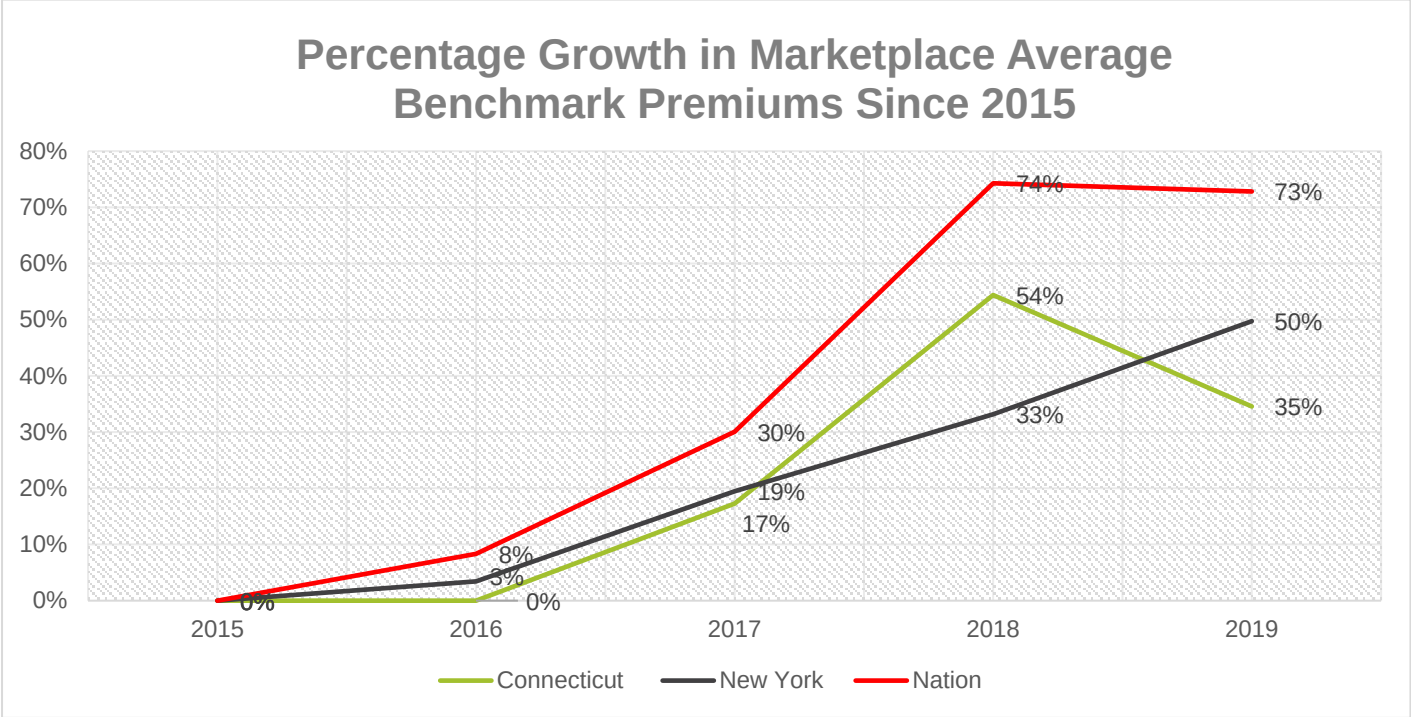
1. TeamHealth (Knoxville, Tenn.). UnitedHealth moved to end high-reimbursement in-network contracts with TeamHealth in 2019. The changes took effect between Oct. 15, 2019, and July 1, and affected contracts across 18 states. Earlier that year, UnitedHealth reduced TeamHealth's reimbursements for certain out-of-network claims by about 50 percent, prompting TeamHealth to sue UnitedHealth in eight states. According to Moody's Investors Service, the dispute could indirectly affect hospitals and other providers.

2. Mednax (Sunrise, Fla.). UnitedHealth plans to end its contracts with Mednax physicians in four states, beginning as early as March, the physician staffing group said in February. The contracts will end at staggered dates throughout the year from March 1 to Dec. 15. UnitedHealth said throughout the last few months it submitted proposals to Mednax that would reduce the amount it reimburses its physicians to a rate that was more consistent with what it pays other providers in Arkansas, Georgia, North Carolina and South Carolina. UnitedHealth said Mednax did not respond with counterproposals; however, Mednax said the firm "has engaged in numerous discussions with United regarding this matter. At no time were these discussions presented to Mednax as negotiations. Rather, United reinforced its unacceptable payment terms on a 'take it or leave it' basis."

3. U.S. Anesthesia Partners (Dallas). In March, Moody's Investors Service changed its outlook of U.S. Anesthesia Partners, a group of nearly 5,000 anesthesia providers, from stable to negative due to a contract termination from UnitedHealth. UnitedHealth canceled its in-network contracts with the provider group in Texas. The contract represents about 10 percent of U.S. Anesthesia Partners' annual revenues, and was expected to be terminated in April 2020.

4. Envision Healthcare (Nashville, Tenn.). UnitedHealthcare and Envision, one of the country's largest providers of emergency room services, agreed to extend their contract, effective January 2019. The agreement came after UnitedHealthcare argued Envision wrongfully sued the payer and by doing so broke an arbitration clause in their agreement. The insurer also called Envision's emergency room billing practices "egregious." In March 2018, Envision sued UnitedHealthcare for allegedly lowering contracted payments to Envision physicians and not allowing new Envision medical practices to join its network.

EXHIBIT 11



Source: Graph using data from Kaiser Family Foundation (2015-2019): "Marketplace Average Benchmark Premiums." Retrieved from https://bit.ly/2tqy25F.