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

TEXAS MEDICAL ASSOCIATION, DR. ADAM CORLEY, and TYLER REGIONAL HOSPITAL, LLC,	)	
Plaintiffs,	)	
v.	)	Case No. 6:22-cv-00372-JDK
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,	)	Lead Consolidated Case
Defendants.	)	

BRIEF *AMICUS CURIAE* OF
THE EMERGENCY DEPARTMENT PRACTICE MANAGEMENT ASSOCIATION
IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION AND INTERESTS OF *AMICUS CURIAE*[1]

The Emergency Department Practice Management Association ("EDPMA") submits this Brief in support of Plaintiffs' Motion for Summary Judgment (Dkt. 41). The Final Rule 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"). *See* 42 U.S.C. § 300gg-111(c); 45 C.F.R. § 149.510; 87 Fed. Reg. 52,618 (Aug. 26, 2022). In February 2022, this Court invalidated the Interim Final Rule ("IFR") because the IFR improperly established a presumption in the Independent Dispute Resolution ("IDR") process that the Qualifying Payment Amount ("QPA") is the appropriate reimbursement rate for out-of-network healthcare services. *Texas Med. Ass'n v. U.S. Dep't of Health & Human Servs.*, No. 6:21-cv-425-JDK, 2022 WL 542879, 587 F. Supp. 3d 528 (E.D. Tex. Feb. 23, 2022) ("*TMA I*"). The Final Rule purports to comply with this Court's ruling by not explicitly requiring a "presumption" in favor of the QPA. But contrary to the express language of the NSA, and the Court's ruling, the Final Rule effectively creates precisely such a presumption. The Final Rule will exacerbate the existing crisis in emergency medicine care in this country and severely undermine the quality and availability of emergency care to patients.

EDPMA is the nation's only professional physician trade association focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups of all sizes, as well as billing, coding, and other professional support organizations that assist physicians in our nation's emergency departments. EDPMA's members provide direct patient care and/or support the provision of care for approximately half of the 146 million patients that visit emergency departments each year. For more than 25 years, EDPMA has advocated for the rights of emergency medicine physicians and their patients at the state and federal levels, including with respect to the NSA.

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[1] All parties consented to the filing of this Brief.

EDPMA strongly supports the NSA's goal of protecting patients from "surprise" healthcare bills—that is, bills for emergency services furnished by out-of-network physicians, or non-emergency services furnished by out-of-network physicians at in-network facilities. The NSA accomplishes this goal by prohibiting insurers and out-of-network physicians from charging patients more than what they would have paid had those services been furnished in-network. At the same time, the NSA recognizes the importance of ensuring fair compensation for physicians.

Accordingly, the NSA establishes a process whereby patients are removed from billing disputes, and physicians and payors negotiate among themselves to arrive at a reasonable payment for the unreimbursed amounts. Should those negotiations fail, the parties may invoke the IDR, a "baseball-style" arbitration process. The IDR process is, as the name suggests, supposed to be "independent," and not biased in favor of either party. The IDR entity must consider each of the statutory factors and examine the particular facts 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 statutory factors. Nor does it assign primacy to, or create a presumption in favor of, any of those factors.

Like the IFR that this Court invalidated, the Final Rule is directly contrary to the NSA's unambiguous language. The IFR created a rebuttable presumption granting the QPA an elevated status over all the other statutory criteria that the IDR entity must consider. The QPA is the insurer's median contracted (*i.e.*, *in*-network) amount for the service. The QPA is calculated exclusively by the insurer, is not subject to scrutiny by the IDR entity (or meaningful oversight by Defendants), and has been the subject of widespread insurer noncompliance, as Defendants themselves acknowledged. *See* 86 Fed. Reg. 55,980, 55,996 (July 13, 2021) ("[I]t is not the role of the certified IDR entity to determine whether the QPA has been calculated by the [insurer] correctly."); *infra* p. 8. In the Final Rule, the QPA is once again given primacy in determining the out-of-network reimbursement rate. The previous express QPA presumption is replaced by new,

extrastatutory requirements that effectively result in that very same QPA presumption. The Final Rule requires the IDR entity to *first* consider the QPA and *not* to consider *any* of the other statutory factors unless additional criteria are satisfied—new criteria that do not apply to the QPA. As a result, the arbitrator's discretion to weigh all NSA-mandated factors is severely circumscribed, and the QPA will once again be the *de facto* benchmark reimbursement rate.

The Final 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 physicians will be materially and adversely affected by the Final Rule, but emergency physicians 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. 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 emergency departments as an important safety net. (Ex. 1 at 2.)[2]

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

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

exacerbate the existing shortage of emergency physicians, to the detriment of patients.

Key congressional architects of the NSA warned the Departments that the IFR "could incentivize insurance companies to set artificially low payment rates, which could narrow 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.) Indeed, Defendants 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. EDPMA'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 cited the primacy accorded to QPAs as the legal justification for their actions. *See infra* pp. 14-15. The Final Rule will serve only to reinforce these practices.

ARGUMENT

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

A. The NSA Does Not Create a Benchmark Reimbursement Rate, 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 physicians must turn to the patient's insurer for payment of unreimbursed amounts. Under the NSA, insurers are obligated to pay physicians the "out-of-network rate." 42 U.S.C. §§ 300gg-111(a)(1)(C)(iv)(II),(b)(1)(D). The statutory provision at issue here states that the out-of-network rate is the amount determined through a 30-day open

negotiation process culminating, if necessary, in IDR. *Id.* § 300gg-111(a)(3)(K).

Under the open negotiation process, the insurer must first pay an amount it reasonably believes will be payment in full for the services. *See* 87 Fed. Reg. at 52,626 n.29. The parties then engage in a 30-day negotiation process; if that fails, either party may initiate IDR. Each side 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 the out-of-network rate. 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.*[3]

Thus, Congress identified with precision the factors that IDR entities must consider in determining the 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

[3] 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. 42 U.S.C. § 300gg-111(c)(5)(D).

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. There is no support in the NSA for making QPA the proxy for, or even the predominant factor in calculating, the out-of-network rate.

B. The Final Rule Is Contrary to the NSA and This Court's Prior Ruling.

In *TMA I*, this Court ruled that the IFR was contrary to the NSA because it improperly created an extrastatutory presumption in favor of one factor—the QPA—and constrained the IDR entity's discretion to weigh all statutory factors in determining an appropriate reimbursement rate.

The Court held that Congress "spoke clearly on the issue relevant here" and "unambiguously established the framework for deciding payment disputes." 2022 WL 542879, at *7-8. The Court held that the NSA "plainly requires arbitrators to consider all the specified information in determining which offer to select." *Id.* at *7. The NSA does not "instruc[t] arbitrators to weigh any one factor or circumstance more heavily than the others" and does not "suggest anywhere that the other factors or information is less important than the QPA." *Id.* at *8. The IFR "impermissibly altered" the NSA by treating the QPA "as the default payment amount" and "impos[ing] on any provider attempting to show otherwise a heightened burden of proof that appears nowhere in the statute." *Id.* at *8-9. The NSA does not accord primacy to the QPA or "restrict arbitrators' discretion and limit how they could consider the other factors"; the NSA "clearly sets forth a list of considerations and does not dictate a procedure or a procedural order for [those] considerations." *Id.* (internal quotations omitted). Thus, the IFR's "thumb on the scale" in favor of the QPA "rewrites clear statutory terms." *Id.* at *8-9 (internal quotations omitted).

The Final Rule purports to "remove from the regulation the language vacated" in *TMA I*. *See* 87 Fed. Reg. at 52,625. But the Final Rule replaces that language with other, extrastatutory requirements that similarly constrain the discretion of the arbitrators and give improper weight to the QPA. Rather than a robust arbitration process in which the IDR entity is *required* to evaluate

all the factors that Congress believed were relevant to determining a proper reimbursement rate, the Final Rule, like the IFR, turns the IDR process into a truncated, meaningless exercise—one in which the IDR entity must first consider the QPA, is prohibited from considering the other required statutory factors unless a series of extrastatutory criteria is satisfied, and in which the foregone conclusion is that the QPA will be selected as the reimbursement amount.

The Departments previously concluded that the NSA "contemplates that typically the QPA will be a reasonable out-of-network rate." 86 Fed. Reg. at 55,996. The Final Rule reinforces the primacy of the QPA. For example, the Final Rule requires arbitrators to consider whether the other, non-QPA information is "credible," but the QPA is exempt from this "credibility" requirement because the QPA allegedly "is worthy of belief and is trustworthy." 45 C.F.R. § 149.510(a)(2)(v). Furthermore, the Final Rule prohibits giving any weight to factors that allegedly are already reflected in the QPA—the so-called "double-counting" prohibition. *Id.* § 149.510(c)(4)(iii)(E). Thus, although the NSA requires arbitrators to consider patient acuity and complexity of service, the Final Rule prohibits consideration of these factors unless they are both "credible" *and* not already reflected in the QPA. *Id.* There is no basis for these provisions.

First, 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. 13-15.

Furthermore, the QPA is calculated by insurers and not subject to investigation by the arbitrator or any meaningful oversight by the Departments. Insurers are required to disclose only very limited information about how they calculated QPAs. 45 C.F.R. § 149.140(d). And while the

Departments are authorized to audit insurers' QPA calculations, 42 U.S.C. § 300gg-111(a)(2), HHS has stated that it plans to conduct no more than nine audits per year. 86 Fed. Reg. at 36,935.

Finally, Defendants themselves have acknowledged widespread insurer noncompliance with the QPA rules, such as including "ghost rates" in the QPA—that is, including in the rates for certain specialty services the rates of other, unrelated specialists who rarely or never bill for the service. Because these physicians never bill for that service, they typically do not negotiate the rate and simply accept the low rate offered by the insurer. (*See* Pls.' Br. at 7; Ex. 13.)

Accordingly, the Final Rule, just like the IFR, is contrary to the plain and unambiguous language of the NSA. As with the IFR invalidated by this Court, the Final Rule exalts the QPA to the practical exclusion of other statutory factors and constrains the arbitrators' statutorily mandated discretion in weighing all relevant factors in arriving at a fair and reasonable reimbursement rate.

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

That the Final Rule is contrary to congressional intent is confirmed by the NSA's legislative history. Congress rejected all attempts to do what the Final Rule does: create a benchmark for reimbursement based on only one factor (the QPA); limit the discretion of the IDR entity in applying the statutorily mandated factors; and skew the IDR process heavily in favor of insurers, granting them a material advantage they could not 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). Health insurers and other payors vigorously lobbied Congress to make median in-network rates the benchmark for 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 all disputes,

regardless of the amount at issue, may be submitted to the IDR entity, which 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, which would have set the reimbursement rate at the insurer's median contracted rate. H.R. 3630, 116th Cong. § 2 (2019). Patient-protection provisions such as the ban on balance billing received unanimous support, but the benchmarks tying physician reimbursement to median in-network rates generated stiff opposition.[4]

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 physician reimbursement: H.R. 5800 (Education and Labor) and H.R. 5826 (Ways and Means). H.R. 5800 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" (Ex. 5):

> [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

[4] Similarly, in July 2019, Senator Alexander introduced S. 1895 (Senate Health, Education, Labor and Pensions Committee), which 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).

> 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.

In enacting the NSA, Congress ultimately adopted the Ways and Means approach to determining reimbursement rates.[5] Congress considered, but rejected, the approach embodied in the IFR, 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 physicians. 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." *Id.*

The Joint Statement goes on to emphasize the individualized nature of the IDR process, 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 . . . .

[5] Key congressional leaders issued a press release confirming that the IDR entity must consider all statutory factors: "When choosing between the two offers the arbiter is required to consider the median in-network rate, information related to the training and experience of the provider, the market share of the parties, previous contracting history between the parties, complexity of the services provided, and any other information submitted by the parties." (Ex. 12.)

- 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 IFR, congressional leaders have made clear that the IFR violated the NSA. For example, the principal architects of the NSA, Ways and Means Chairman Neal and Ranking Member Brady, wrote to the Departments expressing their concern that the IFR did not reflect the law that Congress passed:

> 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 [IFR] 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 IFR "craft[ed] 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 IFR, stating that it did "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 [IFR] 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 physicians and, consequently, the availability of healthcare, particularly in underserved areas (*id.*):

> 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 [the IFR], 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 [the 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.

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 IFR, on the other hand, did not "reflect the way the law was written," or "reflect a policy that could have passed Congress," or "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 IFR threatened grave consequences for patients, including jeopardizing patient access to care and exacerbating existing

health disparities in underserved communities. (*Id.*) The Final Rule did not cure these deficiencies.

III. The Final Rule Will Have Serious Adverse Consequences for Healthcare in This Nation—and Particularly for the Delivery of Emergency Care to Patients.

The Final Rule is not only contrary to the NSA and its legislative history. If upheld, it will result in a host of adverse consequences for physicians 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. The real world of health insurance markets bears this out. Market rates are fairly represented by *actual payments* to physicians 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 physician, the unique economic and clinical environment in the communities, and penalty and bonus structures.[6] Physicians 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 lower rates of actual payment. Thus, using contracted rates as the QPA, and the QPA as a proxy for out-of-network rates, will result in reimbursement rates that deviate drastically from the actual prevailing market rate.

EDPMA's members have submitted offers (or expect to submit offers) in the IDR process.

[6] 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.

They anticipate that their offers will almost always be higher than the QPA and the insurers' offers, because the QPA—which is calculated by the insurers—does not accurately reflect the cost of providing emergency medical services. By placing a thumb on the scale for the QPA, the Final Rule will make it more challenging for EDPMA's members' bids to be chosen, and the amounts they are reimbursed for their out-of-network services will decrease. Indeed, the QPAs submitted to physicians today are well below pre-NSA amounts. (Ex.14.)

Second, there is no serious dispute that "benchmarks" result in underpayments to physicians and in turn cause the contraction of provider networks and the narrowing of healthcare choices for patients.[7] For emergency physicians, the problem is even more acute. In the experience of EDPMA and its members, the EMTALA requirements lead health plans to be even less inclined to maintain emergency physicians 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 IFR and now the Final Rule have had the effect of narrowing provider networks and thereby reducing the availability of healthcare to patients. 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 physicians agree to substantial discounts from their contracted rates. Some of those termination letters even cited the Rules as justification. (*See* Ex. 9; *see also* Exs. 10, 17.) The only recourse for physicians who are forced out-of-network is the

[7]For example, California enacted a benchmark payment rate, but it ultimately became the default payment rate for out-of-network and even in-network services, resulting in narrowed networks and jeopardizing patient access to care. (Ex. 8.)

IDR process. Indeed, since the start of the program in April 2022, IDR requests have exceeded CMS's projections by more than 700% (Exs. 15-16), causing a severe backlog for arbitration claims and creating additional pressures on emergency physicians.

Finally, Defendants' assumption that lower reimbursement rates will translate into lower costs to patients is without any basis. In promulgating the IFR, the Departments stated that it would "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. 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. Implementation of the Final Rule will therefore result in a host of negative consequences for physicians and their patients without any of the hoped-for positives in the form of lower insurance premiums.

CONCLUSION

The EDPMA requests that the Court grant Plaintiffs' Motion for Summary Judgment.

DATED: October 19, 2022

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CERTIFICATE OF SERVICE

I hereby certify that on October 19, 2022, 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

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

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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

Additional Signatories

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John Garamendi
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Jimmy Gomez
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Mark E. Green, M.D.
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Josh Harder
Andy Harris, M.D.
Brian Higgins
J. French Hill
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Chrissy Houlahan
Richard Hudson
Ronny L. Jackson, M.D
Sheila Jackson Lee
Chris Jacobs
Dusty Johnson
Eddie Bernice Johnson
Henry C. "Hank" Johnson Jr.
John Joyce, M.D.
John Katko
Mike Kelly
Daniel T. Kildee
Derek Kilmer
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Ron Kind
Raja Krishnamoorthi
Darin LaHood
Doug LaMalfa
Conor Lamb
Doug Lamborn
James R. Langevin
Jake LaTurner
Barbara Lee
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Julia Letlow
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Peter Meijer
Grace Meng
Dan Meuser
Carol D. Miller
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Alex X. Mooney
Joseph D. Morelle
Frank J. Mrvan
Gregory F. Murphy, M.D.
Stephanie Murphy
Jerrold Nadler
Grace F. Napolitano
Dan Newhouse
Eleanor Holmes Norton
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Bill Pascrell, Jr.
Ed Perlmutter
Dean Phillips
Bill Posey
Tom Reed
Guy Reschenthaler
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David Rouzer
Lucille Roybal-Allard
Bobby L. Rush
Tim Ryan
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
Lloyd Smucker
Elise Stefanik
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Jackie Walorski
Daniel Webster
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.

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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.

IMPACT OF SURPRISE BILLING LAWS SURVEY RESULTS

- 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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Vice President of Strategic Communications
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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:

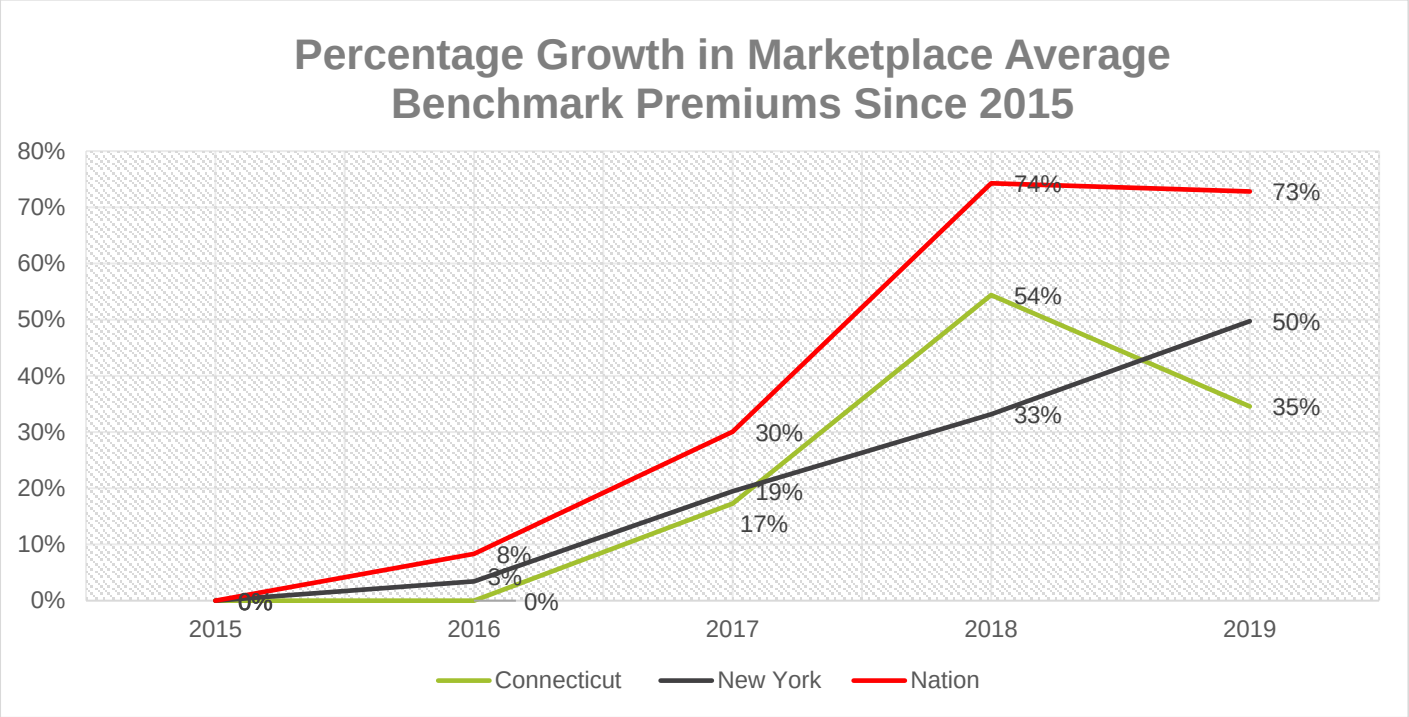
1. TeamHealth (Knoxville, Tenn.). UnitedHealth moved to end high-reimbursement in-network contracts with TeamHealth in 2019. The changes took effect between Oct. 15, 2019, and July 1, and affected contracts across 18 states. Earlier that year, UnitedHealth reduced TeamHealth's reimbursements for certain 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.

EXHIBIT 12

HOUSE COMMITTEE ON
ENERGY & COMMERCE

CHAIRMAN FRANK PALLONE, JR.

(/)

Search

CONGRESSIONAL COMMITTEE LEADERS ANNOUNCE SURPRISE BILLING AGREEMENT

Dec 11, 2020 | Press Release

Legislation Will Protect Patients from Surprise Medical Bills and Establish Fair Framework to Resolve Disputes Between Providers and Insurers

Today, key House and Senate Committee leaders announced a bipartisan agreement on legislation to protect patients from surprise medical bills and establish a fair framework to resolve payment disputes between health care providers and health insurance companies.

The deal was agreed to by House Energy and Commerce Committee Chairman Frank Pallone, Jr. (D-NJ) and Ranking Member Greg Walden (R-OR), House Ways and Means Committee Chairman Richard E. Neal (D-MA) and Ranking Member Kevin Brady (R-TX), House Education and Labor Committee Chairman Robert C. "Bobby" Scott (D-VA) and Ranking Member Virginia Foxx (R-NC), and Senate Health, Education, Labor, and Pensions (HELP) Committee Chairman Lamar Alexander (R-TN) and Ranking Member Patty Murray (D-WA).

"We have reached a bipartisan, bicameral deal in principle to protect patients from surprise medical bills and promote fairness in payment disputes between insurers and providers, without increasing premiums for patients or interfering with strong, state-level solutions already on the books," the bipartisan, bicameral Committee leaders said. **"Under this agreement, the days of patients receiving devastating surprise out-of-network medical bills will be over. Patients should not be penalized with these outrageous bills simply because they were rushed to an out-of-network hospital or unknowingly treated by an out-of-network provider at an in-network facility. This is a win for patients and their families that will improve America's health care system.**

"We are pleased to share this language for stakeholder feedback and look forward to continuing to work together to finalize and attach this important new patient protection to the end-of-year funding package. We're hopeful this legislation will be signed into law in the coming days so we can give Americans confidence they will no longer receive financially ruinous surprise out-of-network medical bills."

The bipartisan, bicameral agreement protects patients and establishes a fair payment dispute resolution process including:

- Holds patients harmless from surprise medical bills, including from air ambulance providers, by ensuring they are only responsible for their in-network cost-sharing amounts, including deductibles, in both emergency situations and certain non-emergency situations where patients do not have the ability to choose an in-network provider.
- Prohibits certain out-of-network providers from balance billing patients unless the provider gives the patient notice of their network status and an estimate of charges 72 hours prior to receiving out-of-network services and the patient provides consent to receive out-of-network care.

- Creates a framework that takes patients out of the middle, and allows health care providers and insurers to resolve payment disputes without involving the patient.
- Under the agreement, insurers will make a payment to the provider that is determined either through negotiation between the parties or an independent dispute resolution (IDR) process. There is no minimum payment threshold to enter IDR, and claims may be batched together to ease administrative burdens.
- If the parties choose to utilize the IDR process, both parties would each submit an offer to the independent arbiter. When choosing between the two offers the arbiter is required to consider the median in-network rate, information related to the training and experience of the provider, the market share of the parties, previous contracting history between the parties, complexity of the services provided, and any other information submitted by the parties.
- Following an IDR process, the party that initiated the dispute may not take the same party to arbitration for the same item or service for 90-days following a determination by the arbitrator. However, all claims that occur during the 90-day period are eligible for IDR after the 90-days.
- Provides additional consumer protections when insurance companies change networks, including a transition of care for people with complex care needs and appeal rights for consumers.
- Empowers consumers by providing a true and honest cost estimate that describes which providers will deliver their treatment, the cost of services, and provider network status.

As part of the legislative agreement, the package includes a long-term extension of expiring public health programs, including: Community Health Centers, National Health Service Corps, Teaching Health Centers, and Special Diabetes Programs.

Legislative text is available HERE (https://urldefense.proofpoint.com/v2/url?u=http-3A__r20.rs6.net_tn.jsp-3Ff-3D001kEM-2DJy7Ynzbi6tnDbxVLSbO5ccKd6mwATsb1fW4iv5NvPS6DXhCkVFCPOqYHSpUsX7hRIoRkHAfveVDZCn8aaoc2wVJHvJjt2v6kb3MVqh-5FXGiLiibpwXq2vGtZFGyqd-2DaqsA6fBap-5FxhrMSzgmtVtw0X8-2DGhwd50FgF09xZ-2DouhKTSNlUBA7ISKAYnbv7S5sNIJ0v4wpCbRTRu6B-2D1jK2IXO2-5FZWTUQAfMC5adjHe20vKUYRXl2Y-5FvBGBxbBnp-2DrlYCyyJzD7JaBpM1CQQ17gESQZ0AbK3zmfl2BGyGUzJB691-2Dz4n2-5Fw-3D-3D-26c-3Dj3BsjW5QQvovoJXYKm692DZLX-5FvqgBBHKbrcp5ASc29JS-2DwoxnMcjg-3D-3D-26ch-3DdU-5FaGVZI2nA-5FIZeoY7WePd6zlEzdC3gzDoMMT1kBOjADPwuvMrBYXQ-3D-3D&d=DwMFaQ&c=L93KkjKsAC98uTvC4KvQDdTDRzAeWDDRmG6S3YXllH0&r=aIAAKLZfZ4e6Bq6Xm3Bqw_zAuczSD3YrkInId1y2HtU&m=he04MOHpCE&s=GK2M6W_dc5xFiot5y_gvaOuWkG1BeTDYoJ7kbWbPsgA&e=).

Section-by-section is available HERE (https://urldefense.proofpoint.com/v2/url?u=http-3A__r20.rs6.net_tn.jsp-3Ff-3D001kEM-2DJy7Ynzbi6tnDbxVLSbO5ccKd6mwATsb1fW4iv5NvPS6DXhCkVGujL3bLuXBz8v0VAcn0yAvpk2FY5V-2DZR30WiP5vm26GgZ1Ph0v4WqUTNAAkrplJ4KwWGYAGGVGtOogvr04npELaTtcDvu36fr6dWPNSUkJ6356j9mRTOXmM2tLZJbQ9VLQlDvULfUpn-2DQvUjXzIXWpRBDjV5K1xFmBSIdGbRpUDMvLrGxLKY4hhcwnfJ6KUUYsCB6vwIIN5o-2DvbhQIpHrnNau4iSg00OK72xKfGK0qKVycUsYFqZcy6qd-5FXDcgSFNz5E9wijJvDrmyXKel-2DXMA-3D-26c-3Dj3BsjW5QQvovoJXYKm692DZLX-5FvqgBBHKbrcp5ASc29JS-2DwoxnMcjg-3D-3D-26ch-3DdU-5FaGVZI2nA-5FIZeoY7WePd6zlEzdC3gzDoMMT1kBOjADPwuvMrBYXQ-3D-3D&d=DwMFaQ&c=L93KkjKsAC98uTvC4KvQDdTDRzAeWDDRmG6S3YXllH0&r=aIAAKLZfZ4e6Bq6Xm3Bqw_zAuczSD3YrkInId1y2HtU&m=he04MOHpCE&s=2EzGvAZvhCuA7KPjTLAK_Q6gO1tEpMnT7bEgC3fFIlc&e=).

###

Subcommittees:
Health (116th Congress) (/subcommittees/health-116th-congress)

EXHIBIT 13

PCP Contracting Practices and Qualified Payment Amount Calculation Under the No Surprises Act

Avalere Health | 08.2.2022

Avalere Health
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Executive Summary

The qualifying payment amount (QPA) is a calculation used to determine individual cost sharing for items and services covered by balance-billing protections under the No Surprises Act (NSA). The QPA is defined as the median in-network contracted rate recognized by a plan for the same or similar service that is furnished by a provider in the same or similar specialty, and in the same geographic region. The QPA is impacted by all contracts, regardless of how frequently a service is rendered. However, public plans such as Medicare Advantage or Medicaid managed care plans, are not included in any insurance market for purposes of determining the QPA.

To assess the extent to which a QPA may be impacted by including rates from low or no volume contracts in the calculation, Avalere Health surveyed individuals involved in contracting at primary care practices to solicit information on whether they contract with insurers for specialized services they rarely or never provide, whether those services include anesthesia, emergency services, or advanced imaging, and if they actively negotiate the rates for such services they rarely or never provide.

Key Findings

- Many primary care providers (PCPs), who significantly outnumber other specialties, are contracting with insurers for services the providers rarely or never provide.
- Most PCPs who rarely or never provide certain services do not actively negotiate payment rates for those services.
- The existence of PCP contracted rates for services rarely or never provided could cause the QPA to provide an inaccurate representation of the rates commonly paid for services rendered.

Background and Objective

QPA Background

A surprise medical bill occurs when insured patients are issued unexpected medical invoices after receiving medical care from out-of-network (OON) providers. In December 2020, Congress sought to address the issue of surprise medical bills by passing the NSA. The NSA was included in the Consolidated Appropriations Act of 2021 and went into effect on January 1, 2022. The law defines surprise bills as bills patients receive from providers who are outside of their health plan's network after receiving emergency care or when seeking services at an in-network facility.[1]

1 Centers for Medicare & Medicaid Services. “No Surprises Act: Overview of rules & fact sheets.” https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets (accessed June 1, 2022).

The NSA protects insured patients from receiving surprise bills for most emergency services, regardless of whether those services were rendered by an OON provider.[1] The law includes provisions to determine the amount the health plan will pay the provider when the plan and provider do not agree on the payment amount. The same requirements apply when a patient schedules care at an in-network facility and is treated by an OON provider, unless the OON provider obtains the patient's consent to waive the requirement.[2] The law establishes the basis for patient cost-sharing liability, provider payment, and an independent dispute resolution (IDR) process for determining OON provider payment in instances where a rate is not agreed upon.

Congress debated including a benchmark or standard for determining payment rates to OON providers or facilities during the drafting of the legislation. However, a benchmark was ultimately not included in the law, and the resolution of a final payment rate was left to arbitration.[3] Determining patient cost sharing often requires knowledge of the underlying payments from insurers to providers, for example, when a plan includes coinsurance.[4] In the absence of a mandated payment rate, a methodology is customarily needed to calculate patient cost sharing in the scenarios impacted by the law.

To determine patient cost-sharing amounts in the scenarios protected under the law, the NSA introduced a new term, Qualifying Payment Amount (QPA). The law specifies that the QPA will be used to determine patient cost sharing in many scenarios.[5] Interim final regulations implementing the NSA have defined QPA as a health plan's median contracted payment rate to providers in a given region. The NSA requires the QPA to be calculated based on rates for providers with the "same or similar specialty" and facility type; however, the interim final regulations provide health plans with the flexibility to define specialties based on their own contracting practices and to calculate separate QPAs per specialty "where the plan or issuer otherwise varies its contracted rates based on provider specialty [6] .While the interim final rule aims for an "apples-to-apples" comparison of rates, stakeholders have expressed concerns that the administration did not clearly define what may be considered the "same or similar specialty" or articulate enforcement mechanisms for that nuance of the calculation. [7]

The interim final rules stated that the QPA must be a factor considered by an arbitrator during the IDR process for determining payment, and directed the arbitrator to choose the offer closest

2 Department of Health & Human Services. "HHS Announces Rule to Protect Consumers from Surprise Medical Bills." https://www.hhs.gov/about/news/2021/07/01/hhs-announces-rule-to-protect-consumers-from-surprise-medical-bills.html (accessed June 1, 2022).

3 Commonwealth Fund. "Summary of the No Surprises Act." https://www.commonwealthfund.org/sites/default/files/202101/Surprise_Billing_Law_Summary_ v2_UPDATED_01-1920 21.pdf (accessed June 1, 2022).

4 Coinsurance definition: Cost sharing that is a percentage of the total amount the provider will be paid by beneficiaries.

5 "In cases where a specified state law applies, the recognized amount (the amount upon which cost sharing is based) and out-of-network rate for emergency and non-emergency services subject to the surprise billing protections is calculated based on such specified state law." Where there is no specified state law, the "QPA would apply to determine the recognized amount, and either an amount determined through agreement between the provider and issuer, or an amount determined by an IDR entity would apply to determine the out-of-network rate."

6 Requirements Related to Surprise Billing; Part I, 86 FR 36872, (July 13, 2021)

7 Regulations.gov "Requirements Related to Surprise Billing; Part I CMS-9909-IFC Display." https://www.regulations.gov/docket/CMS-2021-0117/comments. (accessed June 1, 2022).

to the QPA unless significant evidence is provided to indicate another amount is appropriate.[8] Currently, regulatory provisions related to the QPA are being challenged in court in six different lawsuits across several states.[9] Due to the suits, certain provisions, including the requirement that the IDR entity select the offer closest to the QPA, are currently vacated.[10] The lawsuits are on hold pending updates to the rule, which are expected to be released in 2022.[11]

Objectives

Avalere conducted a study to assess the impact of physician contracting practices for services rarely or never provided, and how contracted rates for services rarely or never provided may influence the QPA calculation.[12]

Survey Methodology

1. Approach

Avalere surveyed 75 primary care practice employees who have a role in contracting with insurers to capture key insights related to payer contracting practices. These surveys solicited information on whether those surveyed contract with insurers for services they rarely or never provide, as well as their negotiation practices related to these services. In the survey, the term "rarely" was defined as a service that is provided fewer than 2 times per year. Participants were asked if their primary practice negotiated reimbursement rates with commercial payers for anesthesia services, emergency services, and advanced imaging services.

2. Rationale

Primary care providers were selected for this survey because they outnumber other specific specialties when comparing total number of providers (Figure 2), and do not typically provide the specialized services of focus: anesthesiology, emergency medicine, and advanced imaging. As such, contracting practices within primary care offices may impact the QPA in ways not anticipated by policymakers when the QPA was defined. The survey questions were intended to provide insight into whether QPA for services that are rarely provided are influenced by such contracts and the degree of that impact.

8 "If a certified IDR entity does not choose the offer closest to the QPA, the written decision's rationale must include a detailed explanation of the additional considerations relied upon, whether the information about those considerations submitted by the parties was credible, and the basis upon which the certified IDR entity determined that the credible information demonstrated that the QPA is materially different from the appropriate out-of-network rate."

9 Keith, Katie. "The Six Provider Lawsuits Over The No Surprises Act: Latest Developments." Health Affairs. February 16, 2022. https://www.healthaffairs.org/do/10.1377/forefront. 20220216.824139/

10 Vacated definition: to annul, set aside, or render void.

11 Keith, Katie. "Court Sets Aside Key Parts of No Surprises Act Rule." Health Affairs. February 24, 2022. https://www.healthaffairs.org/do/10.1377/forefront.20220224.298748/

12 The survey of primary care providers focused on scenarios impacted by the NSA.

3. Survey Questions

A list of 5 screening questions and 5 key survey questions was provided to guide survey participants and ensure response consistency. Questions articulated specific areas of rationale and targeted the collection of specific data/information related to:

- The type of organization to which a provider belongs (multi-practice provider group, independent practice, etc.), their position within the organization, and their role in negotiating reimbursement rates with commercial payers.
- Whether respondents generally contract for services they rarely or never provide.
- Whether PCPs' rate schedules include services likely to be provided in the scenarios covered by the NSA: anesthesiology, emergency medicine, and advanced imaging.
- Whether PCPs who contract for services they rarely or never provide negotiate those rates with insurers and if negotiation practices have shifted since 2019.

Key Findings

The majority (72%) of the 75 primary care professionals surveyed represented independent practices. Most of the survey respondents reported having a high level of authority in contracting decisions, with 37% of respondents identifying as independent decision makers. The second largest category of decision makers (33%) included respondents who make the final decision with input from staff.

According to survey results, most respondents do contract for services they rarely or never provide:

- 68% of respondents contract for services they rarely provide (i.e., services that are provided fewer than 2 times per year)
- 57% of respondents contract for services they never provide

Many PCPs contract for services typically provided by anesthesiologists, emergency physicians, or radiologists:

- 23% contract for anesthesiology services
- 59% contract for emergency services
- 56% contract for advanced imaging

Most survey respondents (41%) who contract for services they rarely or never provide do not actively negotiate the rates for those services, implying they accept the rates offered by insurers.

Discussion

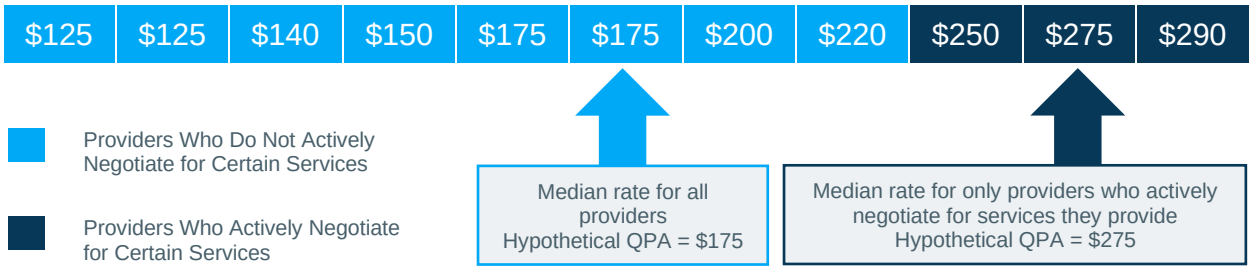
PCPs outnumber anesthesiologists, emergency physicians, and radiologists (Figure 1). The existence of PCP contract rates for services rarely or never provided may cause the QPA to reflect an inaccurate view of the rates commonly paid for in-network services. The inclusion of rates that are not actively negotiated may cause the QPA to be lower than the rates for some services in the market today.

Figure 1 — Total Number of Providers by Type[13]

Provider Type	Total Number of Providers
Primary Care Physicians	496,065
Anesthesiologists	51,282
Emergency Physicians	60,204
Radiologists	48,823

The illustration below (Figure 2) depicts a hypothetical example of a large number of non-negotiated rates for no/low volume procedures, (e.g., PCP rates) in the calculation of a QPA for an NSA-impacted service. In this example, there are a total of 11 rates included in the determination of the median for a QPA. The total is comprised of 8 rates that are not negotiated (e.g., from contracts with providers in other specialties who rarely or never provide the service) and 3 are negotiated rates from providers who regularly provide the service. The QPA changes depending on which providers are included in the calculation. If all providers are included, the QPA for the service would be $175. When providers who rarely or never provide the service, and who therefore may not negotiate payment and accept a lower rate, are excluded, the QPA for the service would be $275.

Figure 2 — Hypothetical Example of Contracted Service Rates[14]



13 Kaiser Family Foundation. "Professionally Active Physicians" and "Professionally Active Specialist Physicians by Field" QPA: Qualifying Payment Amount; IDR: Independent Dispute Resolution

14 The hypothetical illustration includes fictitious contracted service rates but serves to reflect where real data would be placed. The illustration depicts actual projections of the potential impact of contracted service rates on the QPA.

Consistent with this example, PCP rates could directly impact payments to anesthesiologists, radiologists, and emergency medicine physicians. While this study was limited to specific specialties, it may suggest larger implications. Furthermore, the effects of other recent policy initiatives that focus on contracted rates, such as the Transparency in Coverage rule, may also be affected by the contracting practices explored in this research.

Conclusion

This analysis suggests that for QPA calculations, including rates for providers who rarely or never provide a service may lead to QPA values that do not reflect payments typically accepted by in-network providers. Using the example of anesthesiology, emergency medicine, and advanced imaging services, the majority of primary care practices have contracted rates for these services that they never or rarely provide and that they do not negotiate with payers.

When policymakers consider methodologies to approximate market rates, approaches that include contracted rates for providers who rarely or never provide a service may result in estimated values that are not reliable estimates of real-world payment rates. If policymakers aim to approximate market rates, approaches that incorporate utilization rates could mitigate unintended consequences of the contracting practices identified in this research.

About Us

A healthcare consulting firm for more than 20 years, Avalere Health partners with leading life sciences companies, health plans, providers, and investors to bring innovative, data-driven solutions to today's most complex healthcare challenges. For more information, please contact info@avalere.com. You can also visit us at **avalere**.com.

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EXHIBIT 14

SYNOPSIS OF SURVEY FINDINGS

A 2022 national survey of Emergency Medicine (EM) practices yielded the findings listed below concerning the federal NSA program. The respondents represented 59 different practices of different sizes across 35 states—small local groups, regional practices, and large national staffing organizations. The data collected was based on the first 5 months (January-May 2022) of paid claims subject to the federal NSA program.

- ✓ **MOST CLAIMS ARE LACKING THE REQUIRED QUALIFYING PAYMENT AMOUNT (QPA).**
  The required QPA was missing 90.6% of the time from remittance documentation.

- ✓ **THE QPAs ARE BEING USED TO SET THE PAYMENT LEVELS FOR PROVIDERS**
  When QPAs were provided, the payer's allowed amounts were exactly equal to the QPAs 95% of the time. The assumption has to be that when the QPAs are not provided, they still account for setting the allowed amounts. But the QPA was intended by law to be the basis for calculating an out-of-network (OON) patient's equivalent in-network financial responsibility—not the provider's out-of-network reimbursement.

- ✓ **THE ALLOWED AMOUNTS BASED ON THE QPA ARE IMPOSSIBLY LOW**
  The allowed amounts for key Emergency Medicine services range from a weighted average of 126% to 145% of current year Medicare (2022). These levels represent cuts of 20%-50% on average from pre-NSA average contracted levels for Emergency Medicine. Given these draconian reductions for emergency physicians, the urgency of timely corrective action is imperative. A regimen designed for patient protections has resulted in the unintended consequence of punitive and unfair provider reimbursements.

- ✓ **NON-USE OF THE SPECIALLY DEVELOPED NSA REMITTANCE ADVICE REMARK CODES**
  The Tri-Agencies published a helpful list of Remittance Advice Remark Codes (RARCs), but did not require the health plans to use them in claims adjudication. As a result, potentially helpful RARC codes are missing 96% of the time. Nothing guides or informs providers concerning the adjudication jurisdiction of the claim—is it under the federal NSA or not? Such an obvious and fundamental flaw must be corrected immediately—health plans should be mandated to clearly define the status of each claim as either "Under NSA" or "Not Under NSA). In the absence of such payer-supplied information, the delays, inaccuracies, and costs for provider reimbursements are excessive and unsustainable.

- ✓ **HISTORICAL COMPARISON BETWEEN MEDICARE'S OFFICIAL "CONVERSION FACTOR" (payment per RVU) VERSUS THE BUREAU OF LABOR STATISTICS (BLS) OFFICIAL INFLATION FACTORS FOR MEDICAL CARE OVER THE SAME PERIOD**
  For any who promote basing provider reimbursement on some version of Medicare, the attached historical comparison is instructive. The contrast is between Medicare's historical official payment (dollars) per Relative Value Unit (RVU)—termed the "conversion factor"--and the real medical services cost-of-business increases as reported by the federal Bureau of Labor Statistics (BLS).

EXHIBIT 15

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Washington, DC 20201

Center for Consumer Information & Insurance Oversight

TECHNICAL GUIDANCE NO. 2021-01

DATE: SEPTEMBER 30, 2021

SUBJECT: CALENDAR YEAR 2022 FEE GUIDANCE FOR THE FEDERAL INDEPENDENT DISPUTE RESOLUTION PROCESS UNDER THE NO SURPRISES ACT

I. Introduction

Section 9816(c) of the Internal Revenue Code (Code), section 716(c) of the Employee Retirement Income Security Act of 1974 (ERISA), and section 2799A–1(c) of the Public Health Service Act (PHS Act), as added by the No Surprises Act (NSA), direct the Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) to establish a federal independent dispute resolution (IDR) process that nonparticipating facilities, nonparticipating providers, and plans and issuers may use following the end of an open negotiation period to determine the out-of-network rate for out-of-network emergency services and certain items and services provided by nonparticipating providers at in-network facilities, when a specified state law or All-Payer Model Agreement does not apply. Code section 9817, ERISA section 717, and PHS Act section 2799A–2(b), also added by the NSA, direct the Departments to establish a similar Federal IDR process that nonparticipating providers of air ambulance services, plans, and issuers may utilize following the end of an open negotiation period to determine payment for qualified services furnished by nonparticipating providers of air ambulance services where an All-Payer Model Agreement or specified state law does not apply.[1]

The Departments issued interim final rules titled, *Requirements Related to Surprise Billing; Part II* to implement the Federal IDR process under the NSA. Under the *Requirements Related to Surprise Billing; Part II*, each party to an IDR payment determination under the Federal IDR process must pay an administrative fee for participating in the Federal IDR process at the time the certified IDR entity is selected. The administrative fee is paid by each party to the certified IDR entity and remitted to the Departments. The administrative fee is established annually in a manner so that the total administrative fees collected for a year are estimated to be equal to the amount of expenditures estimated to be made by the Departments to carry out the Federal IDR process for that year.

[1] Section 102 of the NSA amends the Federal Employees Health Benefits Program statute to require each contract with a carrier to require the carrier to comply with the provisions of these sections of the Code, ERISA, and the PHS Act. Accordingly, the Federal IDR process will be available to resolve eligible disputes involving FEHB carriers.

Additionally, under the *Requirements Related to Surprise Billing; Part II*, each party must also pay a certified IDR entity fee to the certified IDR entity at the time that party submits its offer. However, the non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the IDR services it performed. The certified IDR entity fee that was paid by the prevailing party will be returned to the prevailing party by the certified IDR entity at the conclusion of the process. In the case of batched claims,[2] the certified IDR entity may make different payment determinations for each qualified IDR item or service under dispute. In these cases, the party with fewest determinations in its favor is considered the non-prevailing party and is responsible for the certified IDR entity fee. In the event that each party prevails in an equal number of determinations, the certified IDR entity fee will be split evenly between the parties. If the parties reach a settlement before the certified IDR entity makes a payment determination, the certified IDR entity fee will be split evenly between the parties, unless the parties agree on an alternative method for allocating the certified IDR entity fee.

The interim final rules also provide that, as part of its application for certification, the IDR entity must submit to the Departments the amount of the IDR entity fees it intends to charge for payment determinations, which are limited to a specific fixed IDR entity fee amount for single determinations and a separate fixed IDR entity fee amount for batched determinations. Each of these fixed IDR entity fees must be within a range set forth in guidance by the Departments, unless the certified IDR entity receives written approval from the Departments to charge an IDR entity fee outside that range. The certified IDR entity may update its IDR entity fees and seek approval from the Departments to charge fixed IDR entity fees beyond the upper or lower limits for IDR entity fees annually.

This guidance announces the administrative fee for participating in the Federal IDR process for calendar year 2022. This guidance also announces the allowable ranges for certified IDR entity fees related to single determinations and batched determinations for calendar year 2022. Finally, this guidance describes the information that IDR entities seeking certification and certified IDR entities must provide to the Departments if they seek approval to charge certified IDR entity fees outside of the allowable ranges set by the Departments, and the process for providing that information.

II. Administrative Fee for Calendar Year 2022

The *Requirements Related to Surprise Billing; Part II* provide that the administrative fee amount will be established by the Departments in a manner so that the total administrative fees collected by the certified IDR entities and paid to the Departments during a calendar year are approximately equal to the estimated amount of expenditures by the Departments in carrying out the Federal IDR process for that calendar year. In setting the administrative fee for 2022, the Departments considered the estimated costs for the Departments to administer the Federal IDR process for the calendar year, including the staffing and contracting costs related to certification and oversight of certified IDR entities; the costs of developing and publishing reports as required

[2] Batched determinations involve multiple qualified IDR items or services that are considered jointly as part of a one payment determination by a certified IDR entity for purposes of the Federal IDR process.

under Code sections 9816 and 9817, ERISA sections 716 and 717, and PHS Act sections 2799A-1 and 2799A-2; the costs of collecting the administrative fees from certified IDR entities; and the costs of maintaining the Federal IDR portal. Based upon this review of anticipated expenditures by the Departments in carrying out the Federal IDR process for 2022, for the calendar year beginning January 1, 2022 the administrative fee due from each party for participating in the Federal IDR process is **$50**. In future years, estimated costs will be informed by the actual costs incurred by the Departments to carry out the Federal IDR process.

III. Certified IDR Entity Fee Range for Calendar Year 2022

The preamble to the *Requirements Related to Surprise Billing; Part II* states that the Departments will consider certain factors in setting the permitted certified IDR entity fee range, including the current IDR entity fees for state-managed IDR processes that are similar to the federal IDR process, the anticipated volume of the Federal IDR process, and the adequacy of the Federal IDR process capacity to efficiently handle the volume of IDR initiations and payment determinations. Based upon the Departments' research regarding existing IDR processes in states that have implemented similar surprise billing protections, the Departments understand that IDR entities typically charge between $300-$600 per arbitration.[3] The Departments found that entities in several states charge lower fees, often ranging between $225-$500.[4] The Departments acknowledge that in some states, individual arbitrators have charged as little as $270 and as much as $6,000 per arbitration.[5] However, the Departments are of the view that such drastic ranges of certified IDR entity fees would risk inflating costs of care that ultimately could be passed on to consumers. Based on research discussed above and the typical range charged, the Departments estimate that on average the certified IDR entity fee will be approximately $400. In listening sessions, stakeholders stated that Federal certified IDR entity fees should be similar to those charged in most states, which stakeholders considered reasonable, so that participating in the Federal IDR process would not be cost-prohibitive, especially for smaller providers and facilities.

Certified IDR entities may charge a different fixed fee for batched determinations. States that allow batching have different models for the fee structure: some permit a fixed fee, some have a

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[3] See Hoadley, J., and Maanasa, K. "How States are Using Independent Dispute Resolution to Resolve Out-of-Network Payment in Surprise Billing," *To the Point* (blog), Commonwealth Funds, Feb. 27, 2020. https://doi.org/10.26099/pqt4-vy24.

[4] American College of Emergency Physicians, "Independent Dispute Resolution: The Best Federal Solution to Protect Patients from Surprise Billing" (estimating arbitration fee costs between $225-$325), *available a*t: https://www.acep.org/globalassets/sites/acep/media/advocacy/federal-advocacy-pdfs/acep-idr-facts.pdf; Virginia State Corporation Commission, "Arbitrator Search," *available at:* https://scc.virginia.gov/balancebilling#/Arbitrators (showing arbitrators charging $250-$500); *see also* Colorado Department of Regulatory Agencies, Division of Insurance, "List of Qualified Arbitrators and Their Fees for the Out-of-Network Payment Arbitration Program" (charging generally $365-450), *available at*: https://doi.colorado.gov/list-of-qualified-arbitrators-and-their-fees-for-the-out-of-network-payment-arbitration-program.

[5] https://www.kff.org/private-insurance/fact-sheet/surprise-medical-bills-new-protections-for-consumers-take-effect-in-2022/amp/.

tiered system, and some permit IDR entities to charge a flat rate per claim in a batched case.[6] Based upon the Departments' review, the fixed fee for batched determinations may average approximately 34% more than that for individual determinations.[7] Therefore, the Departments have determined a similar range for batched determinations under the Federal IDR process is appropriate. The Departments are of the view that a fixed fee is the best approach to ensure a certified IDR entity's time is compensated based on the level of effort, that administrative costs are reasonable, and that the Federal IDR process remains accessible.

In setting the certified IDR entity fee ranges, in addition to comparing potential certified IDR entity fee ranges with IDR entity fees charged in states with IDR processes similar to the Federal IDR process, the Departments considered the anticipated time and resources needed for certified IDR entities to meet the requirements of the Federal IDR process, such as the time and resources needed for IDR entity certification, making payment determinations (including determining whether the dispute belongs in the Federal IDR process), data reporting, and responding to audits. The Departments also considered the anticipated volume of the Federal IDR process and the adequacy of the Federal IDR process capacity to efficiently handle the volume of IDR initiations and payment determinations. The Departments estimate that 17,333 claims from nonparticipating providers and nonparticipating emergency facilities and 4,899 claims from nonparticipating providers of air ambulance services will go through the Federal IDR process annually. The fee ranges established by the Departments reflect the Departments' attempt to minimize the administrative costs of participating in the Federal IDR process in order to help reduce the likelihood of these costs from being passed on to consumers in the form of higher premiums. The Departments are of the view that these fee ranges will fund a robust Federal IDR process and keep the volume of disputed claims manageable. In particular, making batching claims more cost-effective will help protect against backlogs in certified IDR entities' workstreams.

For the calendar year beginning January 1, 2022, certified IDR entities must charge a fixed certified IDR entity fee for single determinations within the range of **$200-$500**, unless otherwise approved by the Departments pursuant to section IV of this guidance. This range was selected to keep administrative costs reasonable, thereby reducing the potential for excessive certified IDR entity fees that could result in inflated health care and insurance costs that could ultimately be passed on to consumers.

If a certified IDR entity chooses to charge a different fixed certified IDR entity fee for batched determinations, that fee must be within the range of **$268-$670**, unless otherwise approved by the Departments pursuant to section IV of this guidance.

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[6] For example, New Jersey permits IDR entities to disaggregate claims involving multiple claim lines and more than $2,000. State of New Jersey, Department of Banking and Insurance, "Claims Payment: Claims Handling Appeals and the Program for Independent Claims Payment Arbitration (PICPA)," *available at*: https://www.state.nj.us/dobi/chap352/352appealqanda.html#5;

[7] For example, Virginia provides public information on the fees charged by its arbitrators, who charge a separate fee for batched determinations. See Arbitrator Search, available at https://scc.virginia.gov/balancebilling#/Arbitrators.

The certified IDR entity is not permitted to charge more than the approved certified IDR entity fee by the Departments on the IDR entities application for certification for any particular determination. Therefore, to the extent the certified IDR entity seeks to pass incidental costs onto parties – for example, for service or processing fees – it must factor the costs of those fees into its certified IDR entity fee. Under no circumstances may a certified IDR entity charge a party for additional costs beyond the certified IDR entity fee and administrative fee.

As noted in the *Requirements Related to Surprise Billing; Part II*, the Departments will review relevant data, such as time and resources needed for certified IDR entities to make payment determinations, IDR entity reporting, and audits, as well as volume of disputes, and stakeholder feedback and adjust the allowable certified IDR entity fee ranges for individual determinations and for batched determinations annually. Accordingly, the Departments also will publish guidance annually related to adjustments of these fee ranges.

IV. Process for IDR Entities Seeking Certification and Certified IDR Entities to Apply to Charge a Fixed Fee Beyond the Upper or Lower Bounds for Calendar Year 2022

As stated in section I of this guidance, under the *Requirements Related to Surprise Billing; Part II*, a certified IDR entity may not charge a certified IDR entity fee that is beyond the upper or lower limits for fees set forth in this guidance unless the certified IDR entity requests, and can provide justification for, a higher or lower fee, and the Departments provide written approval for the certified IDR entity to charge a fee beyond the upper or lower limits for fees set forth in this guidance. An IDR entity seeking certification or a certified IDR entity can seek approval to charge a fee outside the permitted range at the time of certification, or annually thereafter.

To request approval to charge a certified IDR entity fee outside the permitted range, the IDR entity seeking certification or certified IDR entity must provide a justification for the higher or lower fee. Specifically, the IDR entity seeking certification or certified IDR entity must submit a written proposal through the Federal IDR portal[8] that includes:

(1) the alternative fixed fee the IDR entity seeking certification or certified IDR entity proposes as appropriate;

(2) a description of the circumstances that require the alternative fixed fee (this description could include, for example, a cost analysis showing the historical and anticipated volume of payment determinations the IDR entity seeking certification or certified IDR entity has conducted and expects to conduct, the historical and anticipated time and resources needed for the IDR entity seeking certification or certified IDR entity to meet and maintain compliance with applicable federal requirements, the number of personnel employed to make determinations, and the impact of inflation, market and geographic variations, and consistency of fees over time); and

(3) a description of how the alternative fixed fee will be used to mitigate the effects of these circumstances. The Departments will review the justification submitted with an IDR entity's

[8] The federal IDR portal can be accessed at https://www.nsa-idr.cms.gov.

certification application (or certified IDR entity's request) and issue written approval or denial of the request to vary fees beyond the permitted range in conjunction with an IDR entity's certification approval notice, as applicable, or following the certified IDR entity's request.

Any certified IDR entity that has received written approval from the Departments to charge a certified IDR entity fee outside of the permitted ranges generally may not be selected by the Departments to make a determination in a situation in which the Departments randomly select a certified IDR entity on behalf of the parties. However, if there are insufficient certified IDR entities that charge a fee within the allowed range of certified IDR entity fees available to adjudicate the dispute, the Departments will select a certified IDR entity that has received approval to charge a fee outside of the allowed range of certified IDR entity fees.

V. For Further Information Contact

For further questions about the Federal IDR process or fee guidance, please contact us at FederalIDRQuestions@cms.hhs.gov.

EXHIBIT 16

Federal Independent Dispute Resolution Process Status Update

August 19, 2022

On April 15th, 2022, the Departments of Health and Human Services (HHS), Labor, and the Treasury (the Departments) launched the federal Independent Dispute Resolution (IDR) portal for providers, facilities, and providers of air ambulance services, as well as group health plans and health insurance issuers (collectively, disputing parties), to facilitate the federal IDR process for items and services subject to the surprise billing protections in the No Surprises Act. Since launching the federal IDR portal, the Departments have received status update requests from stakeholders asking the Departments to share data about the disputes initiated through the federal IDR portal. The No Surprises Act requires that the Departments publish certain information about the federal IDR process for each calendar quarter. Due to a pause in the launch of the federal IDR portal to address a court ruling (see February 28, 2022, guidance at: https://www.cms.gov/files/document/memorandum-regarding-continuing-surprise-billing-protections-consumers.pdf), the federal IDR system first went live on April, 15, 2022. There is no data to report for the first quarter of 2022. The Departments are continuing to collect and review data on the IDR process for public reporting.

The figures provided here are an initial status update on the current implementation of the federal IDR process. The Departments will also continue to make more information available on the federal IDR process and are committed to transparency in this process.

High Volume of Disputes

Between April 15th and August 11th, disputing parties initiated over **46,000** disputes through the federal IDR portal, which is substantially more than the Departments initially estimated would be submitted for a full year. Of the disputes initiated between April 15th and August 11th, certified IDR entities rendered a payment determination in over **1,200** disputes. Between April 15th and August 11th, non-initiating parties challenged over **21,000** disputes' eligibility for the federal IDR process, which constitutes nearly half of all disputes initiated. This does not necessarily mean that these disputes are ineligible, only that a party has challenged the eligibility of a dispute and that additional review by the certified IDR entities is necessary to determine eligibility. As a result of eligibility challenges, preliminary data suggests that certified IDR entities have already found over **7,000** disputes ineligible for the federal IDR process. Certified IDR entities have also determined a number of disputes to be eligible for the federal IDR process despite eligibility challenges made by non-initiating parties.

Contested Dispute Eligibility

The primary cause of delays in the processing of disputes is the complexity of determining whether disputes are eligible for the federal IDR process. Eligibility for the federal IDR process turns on a number of factors, such as state/federal jurisdiction, correct batching and bundling, compliance with applicable time periods, and completion of open negotiations.

Eligibility reviews conducted by certified IDR entities are processed more quickly when both parties provide all of the information required for federal IDR initiation, including the disclosures (in particular, disclosures of the qualifying payment amount and necessary contact information) required of plans and issuers when they make an initial payment or provide a notice of denial of payment and a complete submission by the initiating party. For this reason, the Departments published a checklist for plans and

issuers including the information that they are required to disclose with the initial payment or notice of denial of payment. The Departments are of the view that increased understanding and compliance with the disclosure requirements and complete submissions by initiating and non-initiating parties will foster the exchange of necessary information within the federal IDR process, resulting in faster completion of the eligibility review. To that end, the Departments are continuing to publish guidance to help disputing parties and certified IDR entities resolve disputes expeditiously, including the most recent set of guidance for certified IDR entities.

Future Guidance and Data

The Departments understand that many disputing parties are still learning how to navigate the federal IDR process and how to comply with the No Surprises Act. The Departments' approach to implementation of the federal IDR process is and will continue to be marked by an emphasis on helping parties understand the new law to facilitate compliance. The Departments have worked to provide guidance, trainings, webinars, and other resources to stakeholders to help them understand the federal IDR process, and will continue to publish additional guidance to help certified IDR entities and disputing parties resolve disputes expeditiously. Concurrently with this update, the Departments have issued a final rule relating to information that must be disclosed by plans and issuers to nonparticipating providers, facilities, and providers of air ambulance services about the qualifying payment amount (QPA) and to provide guidance to certified IDR entities related to making payment determinations under the federal IDR process. The final rule and guidance are available on the Department of Labor's and HHS' websites at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act and https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance#No_Surprises_Act.

For more information on the federal IDR process please visit: https://www.cms.gov/nosurprises/help-resolve-payment-disputes/payment-disputes-between-providers-and-health-plans. Click here to initiate a dispute.

EXHIBIT 17

Gregory Lipson
Senior Vice President
Strategic Initiatives and Provider Contracting
Arizona Network Management

[redacted]

VIA CERTIFIED MAIL RETURN RECEIPT REQUESTED

[redacted]

Re: Notice of termination with Intent to Renegotiate – Cigna HealthCare of Arizona, Inc. Hospital Based and/or Hospitalists Provider Group Services Agreement – Cigna Commercial (group and individual) and Cigna Medicare Advantage participation

[redacted]

In accordance with the terms of the above-mentioned agreement between Cigna HealthCare of Arizona, Inc. and [redacted] dated [redacted] as amended ("Agreement"), this letter serves as 120 day prior written notice of termination of the Agreement for all lines of business, with intent to renegotiate. The termination is effective [redacted] unless Cigna rescinds the termination following the conclusion of negotiations.

Cigna's hope is that the parties can avoid termination by renegotiating certain unfavorable provisions in the Agreement. We value our relationship and look forward to working with you to reach mutually beneficial terms during our upcoming discussions.

Cigna Medicare Advantage appeal
This termination applies to the Arizona Medicare Advantage line of business. Group has the right to appeal the decision regarding termination of participation in Cigna Medicare Advantage for Arizona, for itself and its Represented Providers. If you wish to appeal and request a hearing, please send a written request via certified mail to the following address:

Cigna HealthCare of Arizona, Inc.
Cigna Medicare Advantage – Provider Appeals
Network Operations, ATTN: Director
25500 N. Norterra Drive
Phoenix, AZ 85085

The appeal request must be received by Cigna within 30 days of receipt of this notification. Upon receipt of a written appeal request from Group, we will contact you with details about the Medicare-required appeal and hearing procedures, including the process for submitting any additional information you wish to provide on behalf of Group and its Represented Providers. Cigna will convene a panel of peer physicians to review any such material.

Thank you for your cooperation during this process.

Sincerely,

Greg Lipson

Gregory Lipson
Senior Vice President
Strategic Initiatives and Provider Contracting
Arizona Network Management

cc: Arizona Network Management
Arizona Medical Management