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. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEPARTMENT OF LABOR, DEPARTMENT OF THE TREASURY, OFFICE OF PERSONNEL MANAGEMENT, and the CURRENT HEADS OF THOSE AGENCIES IN THEIR OFFICIAL CAPACITIES, Defendants.	)	Case No. 6:22-cv-00450-JDK Lead Consolidated Case

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

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   Full report available at https://www.rand.org/pubs/research_reports/RR280.html.

2. Letter from 152 Members of Congress to Defendant Departments (Nov. 5, 2021), available at https://wenstrup.house.gov/uploadedfiles/2021.11.05_no_surprises_act_letter.pdf.

3. FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55 (Aug. 19, 2022), available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-55.pdf

4. PCP Contracting Practices and Qualified Payment Amount Calculation Under the No Surprises Act (Avalere Health Aug. 2, 2022), available at https://www.emergencyphysicians.org/globalassets/emphysicians/all-pdfs/2022-8-15-avalere-qpa-whitepaper_final.pdf

5. "Neal Opening Statement at Markup of Surprise Medical Billing, Hospice, and Health Care Investment Transparency Legislation" (Feb. 12, 2020) (as prepared for delivery)

6. Qualifying Payment Amounts and Health Plan Compliance Under the No Surprises Act (EDPMA 2022)

7. Technical Guidance No. 2021-01, Calendar Year 2022 Fee Guidance For The Federal Independent Dispute Resolution Process Under The No Surprises Act (CMS Sept. 30, 2021)

8. Federal Independent Dispute Resolution Process Status Update (CMS Aug. 19, 2022).

9. January 19, 2023 Letter from ACEP and EDPMA to Departments

10. April 25, 2022 Letter from ACEP and EDPMA to Departments

11. "UnitedHealth Reports 2022 Results" (UnitedHealth Group Jan. 13, 2023)

12.. "Physicians Decry Unintended Consequences of California's Surprise Billing Laws" (Cal. Med. Ass'n Nov. 1, 2019), available at https://www.cmadocs.org/Portals/CMA/files/public/CMA%20Suprise%20Billing%20Survey%20Results%202019.pdf

13. American Society of Anesthesiologists, "BlueCross BlueShield of North Carolina Abuses No Surprises Act Regulations to Manipulate the Market Before Law Takes Effect"(Nov. 22, 2021) (including sample letter), available at https://www.asahq.org/about-asa/newsroom/news-releases/2021/11/bcbs-abuses-no-surprises-act-regulations#/

14. Becker's, "4 Disputes Involving UnitedHealth, Physician Staffing Firms" (July 22, 2020), available at https://www.beckershospitalreview.com/payer-issues/4-disputes-involving-unitedhealth-physician-staffing-firms.html

15. Cigna Termination Letter

16. Percentage Growth in Marketplace Average Benchmark Premiums Since 2015, available at https://www.edpma.org/downloads/EDPMA_one-pager_CT-NYMarketplace.pdf

INTRODUCTION AND INTEREST OF *AMICUS CURIAE*

The Emergency Department Practice Management Association ("EDPMA") submits this Brief in support of the TMA Plaintiffs' Motion for Summary Judgment (Dkt. 25). The July Rule that Plaintiffs challenge is directly contrary to the unambiguous language of, and congressional intent behind, the No Surprises Act ("NSA"), 42 U.S.C. § 300gg-111. *See* 45 C.F.R. § 149.140; 86 Fed. Reg. 36,872 (July 13, 2021), *as amended*, 87 Fed. Reg. 52,618 (Aug. 26, 2022).

The methodology set forth in the Rule for calculating a component of the reimbursement rate to out-of-network physicians—the Qualifying Payment Amount, or "QPA"—conflicts with the NSA in several key respects, skewing the QPA unfairly downward. This deviation from the command of Congress has resulted in unwarranted decreases in payments for the services of out-of-network physicians—with a concomitant reduction in the ability of these physicians to care for patients. For example, out-of-network payments to emergency physicians have decreased *92% of the time* compared to pre-NSA rates, with an average decrease in payment of more than 32% for each emergency room visit. The July Rule has exacerbated the existing crisis in the emergency medical delivery system and the availability of emergency medical physicians in this country. If the Rule is allowed to stand, the system will reach a breaking point that cannot readily be repaired.

EDPMA is a 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, physician groups, and their patients at the state and federal levels, including with respect to the NSA.

EDPMA strongly supports the NSA's goal of protecting patients from "surprise" healthcare bills—bills for emergency medical services furnished by out-of-network physicians and facilities, 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 services. Should those negotiations fail, either party may invoke the Independent Dispute Resolution ("IDR") process, a "baseball-style" arbitration. 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 a fair and reasonable out-of-network rate.

This Court invalidated the October 2021 Interim Final Rule ("IFR") regarding the IDR process, holding that the IFR conflicted with the NSA because it "treat[ed] the QPA—an insurer-determined number—as the default payment amount and impose[ed] on any provider attempting to show otherwise a heightened burden of proof that appears nowhere in the statute." *Texas Med. Ass'n v. U.S. Dep't of Health & Human Servs.*, 587 F. Supp. 3d 528, 543 (E.D. Tex. Feb. 23, 2022) ("*TMA I*"). This lawsuit challenges another aspect of the Departments' implementation of the NSA: the July Rule's provisions regarding calculation of the QPA and the attendant disclosures insurers must make to physicians to enable them to evaluate the insurer's calculation of the QPA.

The QPA is the insurer's median contracted (*i.e.*, in-network) amount for the service provided by physicians of the same or similar specialty in the same geographic region. The QPA

is calculated exclusively by the insurer, is not subject to scrutiny by the IDR entity or meaningful oversight by the Departments, and has been the subject of widespread insurer noncompliance.[1]

The July Rule violates the NSA through a series of provisions that artificially depress the QPA. Among other things, the July Rule (1) allows insurers to include in the calculation of the QPA non-negotiated, unreasonably low contracted rates for services that are not actually provided by the contracting physician, typically because the services are outside his or her specialty ("ghost rates"), and "zero-pay payments," used by insurers to lower the median rate; (2) excuses insurers from incorporating the rates of providers in the same specialty; (3) requires insurers to exclude from the rates used to calculate the QPA risk-sharing, bonus, and other incentive-based or retrospective payments, which sometimes form a significant portion of the ultimate amount paid to the physician under the contract; and (4) allows self-insured group health plans, at their option, to calculate QPAs based on the (lower) contracted rates of *other* plans administered by the same entity. Each of these provisions improperly allows payors to manipulate the QPA downward and reimburse for out-of-network services at amounts that are grossly below-market and that ultimately will undermine the emergency medical delivery system.

The July Rule also violates the NSA's disclosure and transparency requirements by failing to require insurers to share with physicians material information regarding the calculation of QPAs. Thus, physicians are unable to make informed decisions in the negotiation process (including the amounts of the offers to submit, or even whether to initiate the IDR process at all) and in the decision whether to submit a complaint to the agencies pursuant to the statutory complaint process. The July Rule thus effectively forecloses review into whether the QPAs

[1] *See* 86 Fed. Reg. 55,980, 55,996 (October 7, 2021) ("[I]t is not the role of the certified IDR entity to determine whether the QPA has been calculated by the [insurer] correctly.").

calculated by insurers comply with the NSA.

Each of these provisions was designed for the exclusive benefit of insurers, without regard to the devastating effect on physicians, their patients, and the healthcare system. The July 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—indeed, significantly below pre-NSA rates. All healthcare physicians have been materially and adversely affected by the July 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.)

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

Key congressional architects of the NSA warned the Departments that their implementation of the NSA "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. 2 at 2.) Indeed, the Departments themselves recognized the perils of physician undercompensation: "[U]ndercompensation could threaten the viability of these providers [and] facilities . . . . This, in turn, could lead to participants, beneficiaries and enrollees not receiving needed medical care, undermining the goals of the No Surprises Act." 86 Fed. Reg. at 56,044.

What members of Congress feared has already come true. 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 Departments' rules as the legal justification for their actions. Absent vacatur of the July Rule, the situation will only deteriorate, with devastating consequences for patients and the emergency physicians who serve them.

ARGUMENT

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

The NSA prohibits balance-billing patients for emergency services in excess of their in-network cost-sharing. *See* 42 U.S.C. § 300gg-111(a)(1)(C)(ii), (b)(1)(A). Accordingly, out-of-network physicians must turn to the patient's insurer for payment of unreimbursed amounts. Under the NSA, insurers are obligated to pay these physicians a reasonable fee, called the "out-of-network rate," less the patient's cost-sharing. *Id.* §§ 300gg-111(a)(1)(C)(iv)(II), (b)(1)(D). The out-of-network rate is defined as (1) the amount determined by an All-Payer Model Agreement under the Social Security Act; or (2) if there is no such Agreement, by a "specified state law"; or (3) if there is no applicable Agreement or state law, by the amount determined through a 30-day open negotiation process culminating, if necessary, in IDR. *Id.* § 300gg-111(a)(3)(K).

Under the NSA, the IDR entity must consider a detailed list of factors in determining the

out-of-network rate, including the QPA; five "additional circumstances," such as the provider's training, experience, and market share; and any information the arbitrator requests or the parties provide. 42 U.S.C. §§ 300gg-111(c)(5)(C)(i)(I)-(II). As this Court held, the October 2021 IFR conflicted with the NSA by treating the QPA as the default reimbursement amount. The Departments' second attempt to regulate IDR did not cure these deficiencies, and is currently the subject of "*TMA II*," *Texas Med. Ass'n v. U.S. Dep't of Health & Human Servs.*, No. 6:22-cv-00372 (E.D. Tex.). Under the new IDR rule, arbitrators must consider the QPA first and may not give weight to any of the other mandated factors unless other criteria are met—once again improperly making the QPA the benchmark for out-of-network rates. *See* 87 Fed. Reg. at 52,652.

Yet even if there were no such presumption in favor of the QPA, the IDR process would still result in out-of-network rates significantly below fair compensation as a result of the July Rule's requirements for calculation of the QPA. The NSA directed the Departments to promulgate rules establishing "the methodology" that insurers "shall use to determine" the QPA. 42 U.S.C. § 300gg-111(a)(2)(B)(i). Congress further charged the Departments with specifying the information that insurers "shall share" with providers when determining the QPA, as well as "a process to receive complaints of violations" of the QPA requirements. *Id.* § 300gg-111(a)(2)(B)(ii), (iv). The July Rule fails to implement the NSA in all these respects.

A. The July Rule's Methodology for Determining the QPA Violates the NSA.

The NSA defines the QPA as "the median of the contracted rates recognized by the plan or issuer . . . as the total maximum payment . . . for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished" as of 2019, adjusted for inflation. *Id.* § 300gg-111(a)(3)(E)(i)(I). If the insurer "does not have sufficient information to calculate the median of

the contracted rates," the QPA must be calculated by reference to an independent database, such as a state all-payor claims database, that reflects "allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region." *Id*. § 300gg-111(a)(3)(E)(iii). Thus, insurers must calculate the QPA based on rates for services that are *actually provided* by physicians in the same specialty and in the same geographic region; if insurers do not have this information, they must calculate the QPA based on an appropriate database. The July Rule violates these clear statutory directives in a series of QPA provisions, each of which alone drives down the QPA, but when combined, result in dramatically insufficient QPAs.

1. Inclusion of "Ghost Rates" and "Zero-Pay" Payments

The July Rule provides that contracted rates are the total amounts that the insurer "has contractually agreed to pay a participating provider." 45 C.F.R. § 149.140(a)(1). Thus, contrary to the NSA requirement that QPAs be based on services *actually provided*, the July Rule allows insurers to include all "contracted" rates, regardless of whether the service was actually provided. *See* 86 Fed. Reg. at 36,889 (NSA "envisions that each contracted rate for a given item or service be treated as a single data point when calculating a median contracted rate . . . *regardless of the number of claims paid at that contracted rate*") (emphasis added).

The July Rule therefore allows for the inclusion of "ghost rates"—rates that are included in contracts, but are for services not actually performed by that provider. Providers who do not perform a particular service have little to no incentive to negotiate a fair and reasonable reimbursement rate for that service. As a result, ghost rates are lower than they would have been had the rates been negotiated by providers who actually performed the service. Indeed, these ghost rates, combined with other disingenuous calculations like zero-pay payments, can be as low as $0.

The Departments recognized that the July Rule allowed for the inclusion of these rates in

the calculation of QPAs. In a series of "FAQs" published in August 2022, the Departments acknowledged that inclusion of these rates "may artificially lower the QPA, as these providers have little incentive to negotiate fair reimbursement rates" for these services and sometimes even accept "$0 as their rate." (Ex. 3 at 16, FAQ 13.) Yet while the Departments stated that "$0 amounts" should not be used in calculating the QPA, they did not prohibit altogether the use of non-negotiated rates, thereby allowing such rates in the amounts of even $1. (*Id.* at 17 n.29, FAQ 14.)

2. Inclusion of Out-of-Specialty Rates

Although the NSA requires that QPAs be calculated according to the rates of providers "in the same or similar specialty," 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I), the July Rule permits insurers to disregard this directive when it is not "consistent with the plan's or issuer's usual business practice." 45 C.F.R. § 149.140(a)(12). The Departments recognized this departure from the clear statutory language, and even considered requiring insurers to "calculate separate median contracted rates for every provider specialty," as provided in the NSA. 86 Fed. Reg. at 36,891. Yet the Departments rejected such a provision based entirely on the convenience of insurers.

The Departments justified this departure from the NSA by asserting the need to provide insurers with "flexibility" to calculate the QPA; to reduce the "burden associated with calculating the QPA"; and to avoid "instances in which the plan or issuer would not have sufficient information to calculate the QPAs using its contracted rates." *Id*. The NSA, however, expressly provides a method for calculating the QPA when the insurer does not have sufficient information: an independent claims database. 42 U.S.C. § 300gg-111(a)(3)(E)(iii). The Departments cited a supposed "statutory goal" of limiting the times an insurer uses this express statutory alternative. 86 Fed. Reg. at 36,888. Nothing in the NSA suggests that this was a "statutory goal."

Including out-of-specialty rates drives QPAs downward. As the Departments themselves

recognized, many insurers "establish contracted rates by offering most providers the same fee schedule for all covered services, and then it is up to the providers to negotiate increases to the rates for the services that they are most likely to bill." (Ex. 3 at 16, FAQ 14.) For example, an insurer may contract with a primary care physician ("PCP") to provide anesthesiology services, even though the PCP does not actually provide such services, and therefore will not attempt to negotiate those rates with the insurer. (In this respect, such non-specialty rates are a species of "ghost rates.") One study found that many PCPs, who significantly outnumber other specialties, "are contracting with insurers for services the providers rarely or never provide"; that most such PCPs do not actively negotiate payment rates for those services; and that the inclusion of such PCP-contracted rates "do[es] not reflect payments typically accepted by in-network providers" of that specialty. (Ex. 4 at 1, 6.) Including such non-specialty rates when determining QPAs is yet another way the July Rule skews QPAs downward and away from market rates for that specialty.

3. Exclusion of Risk-Sharing, Bonus, and Other Retrospective Payments

The July Rule provides that insurers must exclude from rates used to calculate QPAs "risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments." 45 C.F.R. § 149.140(b)(2)(iv). The NSA, however, requires QPAs to be based on the "total maximum payment" recognized by the insurer, 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I), and these incentive and retrospective payments are often critical components of a contracted rate.

Indeed, the Departments recognized that insurers and providers sometimes agree that payments will be "reconciled retrospectively to account for utilization, value adjustments, or other weighting factors that can affect the final payment," and that insurers and providers will sometimes "agree to certain incentive payments during the contracting process." 86 Fed. Reg. at 36,894. In some contracts, risk-sharing amounts can total 10-15% of the total payments. The contracted rates

are then adjusted *downward* to reflect the potential for receiving such bonuses or incentives. But if providers do not believe that they will receive such additional payments, they will demand higher fixed rates for that service. Thus, excluding these payments or payment adjustments from the QPA calculation necessarily will result in a lower QPA. The Departments provided no statutory justification for excluding such payments from the rates used to calculate the QPA. There is none.

4. Using Rates from All Self-Insured Plans Administered by the Same Entity

The July Rule allows a self-insured group health plan, "at the option of the plan sponsor," to calculate its own QPAs using rates from all contracts administered by the same entity, even the contracted rates of a different plan sponsor. 45 C.F.R. § 149.140(a)(8)(iv). The NSA, however, expressly requires that QPAs be "determined with respect to all such plans *of such sponsor*." 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I) (emphasis added). Given the option of using their own rates or those of other plans, plans will certainly chose the lower amount. The July Rule thus again results in lower reimbursement rates than what would have been authorized under the NSA.

B. The July Rule Fails to Require Adequate Disclosure of the Basis for the Insurer's Calculation of the QPA.

The July Rule also fails to implement the NSA's statutory directive that insurers provide meaningful disclosure of how the QPA was calculated. The Departments acknowledged the need for "transparency" in this regard. But again citing their goal of "minimizing administrative burdens on plans and issuers," 86 Fed. Reg. at 36,898, the July Rule requires insurers initially to provide only the most minimal of information: the QPA itself and a statement certifying that the QPA was calculated in accordance with the NSA. 45 C.F.R. § 149.140(d)(1). Only if the provider presses for more information is the insurer obligated to do so, but even then is required to provide only limited additional information. *Id.* The July Rule does not require insurers to disclose critical

information underlying the calculation of the QPA, including the "contracted rates used in determining the median rate; the specialties of the providers who contracted for those rates; whether the insurers used the rates of other plans administered by the same administrator; or the amounts of the incentive-based or retrospective payments the insurers excluded when calculating the QPA. The July Rule therefore leaves physicians entirely in the dark when it comes to assessing whether the QPA is consistent with the NSA.

II. The Departments' Implementation of the NSA Has Resulted in Serious Adverse Consequences for the Delivery of Emergency Care to Patients.

Key congressional architects of the NSA warned of the devastating consequences for this nation's healthcare system of inadequate physician reimbursement rates:

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

(Ex. 5.) The predicted effects have already become reality.

First, the reimbursement rates for physicians have declined dramatically since the Departments' implementation of the NSA. EDPMA has analyzed data from its members to ascertain the effects of the implementation of the NSA on emergency medicine. In a 2022 survey of its members, EDPMA compared pre-NSA (2021) out-of-network allowed amounts to post-NSA (2022) allowed amounts. EDPMA found that post-NSA out-of-network payments *decreased 92% of the time* compared to pre-NSA amounts, with an average decrease of 32% per emergency room visit. (Ex. 6 at 1.)[2] Furthermore, when insurers *do* disclose the QPA, *see infra* pp. 13-14, the QPA

[2] Furthermore, the allowed amounts for emergency medicine services ranged from a weighted average of 126%-145% of Medicare rates. This represents cuts of at *least* 25-65% from pre-NSA average out-of-network reimbursement levels for emergency medicine. (Ex. 6 at 2 n.4.)

is equal to the insurers' allowed amount at least 93% of the time, demonstrating that insurers are using problematic QPAs as the basis for reimbursement, notwithstanding the NSA's intent that the QPA should not be a "benchmark" payment standard. (*Id.* at 2; *see* 87 Fed. Reg. at 52,625 n.29 ("many plans and issuers make initial payments that are equivalent to or are informed by the corresponding QPA for the item or service at issue").)

The fact that QPAs are artificially low—significantly so—is evidenced by the enormous volume of IDR proceedings. The Departments have reported that the number of IDRs initiated by providers in the first five months of the program was more than the government anticipated for an entire year. (Ex. 6 at 2 & nn. 2-3.) Indeed, IDR requests have exceeded CMS's projections by more than 700%. (Exs. 7-8.) This has caused a severe backlog for arbitration and a significant delay in resolutions. These delays in turn have resulted in negative cash flow for physician groups, resulting in layoffs and hospital closures, to the detriment of patients. In addition, insurers' unwillingness to be transparent in their submission of initial payments has resulted in providers being unable to correctly decipher eligible claims to pursue in IDR. This has compounded the backlogs, as IDR entities must now sort through potentially thousands of ineligible claims that would not have been filed in the first place had insurers provided the necessary information.

Because of the dramatic and unexpected reduction in out-of-network reimbursements by commercial payors, previous subsidizing cross-funding that guaranteed a patient's access to emergency care under EMTALA no longer exists. Instead, hospitals—many of which are already in severe financial distress—are now shouldering the brunt of these costs, potentially crippling this country's healthcare safety net. (Ex. 6 at 2.) Moreover, emergency medicine groups are expected

to see a reduction in commercial reimbursement of almost *$1 billion* annually. (*Id.*)[3] If the Departments' implementation of the NSA is upheld, the current understaffing of emergency departments will only grow worse, reducing patient access to emergency care, particularly in underserved and rural communities. (*Id.*)

Second, the Department's implementation of the NSA has left physicians with no meaningful options for challenging—or even ascertaining the basis of—insurers' reimbursements. For example, EDPMA has found that insurers routinely fail to comply with the NSA's QPA disclosure requirements. Insurers often do not indicate that the QPA applies for purposes of determining the cost-sharing amount for out-of-network services (the "recognized amount"). (Ex. 9 at 1-5; Ex. 10 at 3-4, 7-9.) When it is unclear whether the cost-sharing amount included in the remittance notice *is* the recognized amount, physicians are unable to verify whether that amount is accurate, resulting in confusion for both patients and providers, and sometimes resulting in patients being billed for incorrect amounts—putting patients right back into the middle of billing disputes, contrary to one of the key purposes of the NSA. (Ex. 9 at 2-4.)

Furthermore, insurers fail readily to provide the QPA *at all* in 91% of their initial payments or notices of denial, often off-loading it onto separate portals or look-up tools, imposing unnecessary obligations on an already overburdened delivery system. (Ex. 6 at 1.) This dearth of information is particularly problematic in the emergency medicine context. Because of the realities of acute, non-scheduled care, emergency medicine providers often receive little to no information at the time the patient is treated. In fact, because of the unique requirements of EMTALA, emergency medicine groups do not collect billing or cost-sharing information before

[3] At the same time, commercial payors are seeing record earnings. (*See, e.g.*, Ex. 11.)

stabilizing the patient. (Ex. 9 at 1-4.) Instead, emergency medicine practices must wait until after care has been rendered, and then wade through the staggering morass of individual policy benefits, which often requires extensive back-and-forth with the insurer and the patient.

As the Departments themselves acknowledged, prompt and meaningful insurer disclosure of the QPA and the factors that went into calculating it is an essential component of the process. Without it, providers are unable accurately to assess patient responsibility for the charge, whether the allowed amount is subject to the IDR process at all (or if a specified state law applies instead), whether to initiate the IDR process, the type of offers they should submit, and whether to institute a complaint with the Departments. (Exs. 6, 9-10.) To make matters worse, while the Departments are authorized to audit insurers' QPA calculations, 42 U.S.C. § 300gg-111(a)(2), there has been no meaningful agency action on that front.

Third, underpayments to physicians—and the post-NSA amounts are egregiously below market—cause the contraction of provider networks and the narrowing of healthcare choices for patients.[4] 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 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.

Fourth, the Departments' implementation of the NSA already has had the effect of narrowing provider networks and thereby reducing the availability of healthcare to patients.

[4]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. 12.)

Numerous physician practices have received from insurers termination notices 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. 13; *see also* Exs. 14, 15.) The only recourse for physicians who are forced out-of-network is the flawed IDR process, and its even more problematic QPA determinations.

Finally, the Departments' assumption that lower reimbursement rates will translate into lower costs to patients is without any basis. The Departments have stated that the IDR rules 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, however, 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. 16.) In other words, there is no evidence of a relationship between higher insurance premiums and laws that improve emergency physician reimbursement. Continued implementation of the July Rule will 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

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

DATED: January 31, 2023

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CERTIFICATE OF SERVICE

I hereby certify that on January 31, 2023, 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*

Mahshid Abir • *Neema Iyer* • *Alexandria C. Smith* • *Joseph V. Vesely*

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RAND CORPORATION

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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

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

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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 3

FAQS ABOUT AFFORDABLE CARE ACT AND CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION PART 55

August 19, 2022

Set out below are Frequently Asked Questions (FAQs) regarding implementation of certain provisions of the Affordable Care Act and title I (the No Surprises Act)[1] of Division BB of the Consolidated Appropriations Act, 2021. These FAQs have been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs and http://www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html), these FAQs answer questions from stakeholders to help people understand the law and promote compliance.

The No Surprises Act

Sections 102 and 103 of the No Surprises Act added section 9816 to the Internal Revenue Code (Code), section 716 to the Employee Retirement Income Security Act (ERISA), and section 2799A-1 to the Public Health Service Act (PHS Act). Section 104 of the No Surprises Act added sections 2799B-1 and 2799B-2 to the PHS Act. Section 105 of the No Surprises Act added section 9817 to the Code, section 717 to ERISA, and sections 2799A-2 and 2799B-5 to the PHS Act. These provisions provide protections against surprise medical bills for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

Sections 102 and 104 of the No Surprises Act added section 9820(c) to the Code, section 720(c) to ERISA, and sections 2799A-5(c) and 2799B-3 to the PHS Act, generally requiring group health plans, health insurance issuers offering group or individual health insurance coverage, and health care providers and health care facilities to make certain disclosures regarding balance billing protections to the public and to individual participants, beneficiaries, and enrollees.

The Departments issued interim final rules in July 2021 to implement certain of these provisions (July 2021 interim final rules).[2] The July 2021 interim final rules generally prohibit balance billing and limit cost sharing for out-of-network services subject to the surprise billing provisions of the No Surprises Act. Under the No Surprises Act and its implementing regulations, cost-sharing amounts for out-of-network emergency services and applicable non-emergency items and services must be calculated based on the recognized amount, which is:

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[1] The No Surprises Act was enacted as title I of Division BB of the Consolidated Appropriations Act, 2021. Pub. L. 116-260, 134 Stat. 1182 (2020).

[2] 86 FR 36872 (July 13, 2021). The July 2021 interim final rules are generally applicable for plan years (in the individual market, policy years) beginning on or after January 1, 2022. The HHS-only regulations that apply to health care providers, facilities, and providers of air ambulance services are generally applicable with respect to items and services furnished during plan years (in the individual market, policy years) beginning on January 1, 2022.

(1) an amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act (SSA);

(2) if there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law; or

(3) if there is no such applicable All-Payer Model Agreement or specified state law, the lesser of the billed charge or the qualifying payment amount (QPA).

Cost-sharing amounts for out-of-network air ambulance services must be calculated using the lesser of the billed charge or the QPA.

The QPA is generally the median of the contracted rates recognized by the plan or issuer on January 31, 2019, for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the geographic region in which the item or service is furnished, increased for inflation.[3] The median contracted rate is determined with respect to all plans of the plan sponsor (or, if applicable, administering entity) or all coverage offered by the issuer that are offered in the same insurance market. The July 2021 interim final rules establish the methodology for calculating the QPA, including when a plan or issuer lacks sufficient information to calculate a median of contracted rates with participating providers, facilities, or providers of air ambulance services.

Applicability to No-Network and Closed Network Plans

Q1: Do the balance billing prohibitions of the No Surprises Act apply to nonparticipating providers, emergency facilities, and providers of air ambulance services when providing emergency services, certain non-emergency services, or air ambulance services to a participant, beneficiary, or enrollee who is covered under a group health plan or group or individual health insurance coverage that does not have a network of providers, such as a plan that utilizes reference-based pricing?

Yes, with respect to emergency services and air ambulance services. The balance billing prohibitions in sections 2799B-1 and 2799B-5 of the PHS Act, implemented at 45 CFR 149.410 and 149.440, apply to nonparticipating emergency facilities, nonparticipating providers, and nonparticipating providers of air ambulance services, with respect to any participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer who is furnished emergency services or air ambulance services (for which benefits are provided under the plan or coverage). A nonparticipating provider is any physician or other health care provider that does not have a contractual relationship directly or indirectly with a group health plan or group or individual health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage, respectively.

[3] *See* Rev. Proc. 2022-11, 2022-3 IRB 449, available at https://www.irs.gov/pub/irs-drop/rp-22-11.pdf. *See also* Notice 2022-11, 2022-14 IRB 939, available at https://www.irs.gov/pub/irs-drop/n-22-11.pdf.

A nonparticipating emergency facility means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to post-stabilization emergency services), that does not have a contractual relationship directly or indirectly with a group health plan or group or individual health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage, respectively. These definitions[4] and the protections afforded to participants, beneficiaries, or enrollees related to emergency services and air ambulance services are not dependent on whether the group health plan or group or individual health insurance coverage has a network of providers.

In contrast, the provisions that prohibit balance billing for non-emergency services apply only to services provided by a nonparticipating provider with respect to a visit to a participating health care facility. A participating health care facility is any health care facility[5] that has a contractual relationship directly or indirectly with a plan or issuer setting forth the terms and conditions upon which the relevant item or service is furnished to the participant, beneficiary, or enrollee under the plan or coverage.[6] Therefore, as stated in the preamble to the July 2021 interim final rules, the prohibitions on balance billing for non-emergency services provided by nonparticipating providers with respect to a visit to certain participating facilities would never be triggered if a plan or coverage does not have a network of participating facilities.[7]

Q2: Do the surprise billing provisions of the No Surprises Act apply to a group health plan or group or individual health insurance coverage that does not have a network of providers, such as a plan that utilizes reference-based pricing?

Yes, with respect to emergency services and air ambulance services. The provisions that limit cost sharing for out-of-network emergency services apply if a plan or issuer provides or covers any benefits for emergency services and the services are provided by a nonparticipating provider or nonparticipating emergency facility. Similarly, the provisions that limit cost sharing for out-of-network air ambulance services apply if a plan or issuer provides or covers any benefits for air ambulance services and those services are provided by a nonparticipating provider of air ambulance services. As stated in Q1, the definitions of nonparticipating provider or nonparticipating emergency facility and the protections afforded to participants, beneficiaries, or

[4] The implementing regulations define "nonparticipating provider" and "nonparticipating emergency facility" but do not include a separate definition of "nonparticipating provider of air ambulance services." The regulations define "provider of air ambulance services" to mean an entity that is licensed under applicable state and Federal law to provide air ambulance services. 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30. Similar to the definition of "nonparticipating provider," the Departments consider a provider of air ambulance services to be a nonparticipating provider of air ambulance services if the provider of air ambulance services does not have a contractual relationship directly or indirectly with a group health plan or group or individual health insurance coverage offered by a health insurance issuer, with respect to the furnishing of air ambulance services under the plan or coverage, respectively.

[5] Under the July 2021 interim final rules, a health care facility is defined, in the context of non-emergency services, as one of the following: (1) a hospital (as defined in section 1861(e) of the SSA), (2) a hospital outpatient department, (3) a critical access hospital (as defined in section 1861(mm)(1) of the SSA), and (4) an ambulatory surgical center described in section 1833(i)(1)(A) of the SSA.

[6] 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.

[7] 86 FR 36872, 36904 (July 13, 2021).

enrollees related to emergency services and air ambulance services are not dependent on whether the group health plan or group or individual health insurance coverage has a network of providers.[8]

In contrast, as also noted in Q1, the provisions that limit cost sharing for non-emergency services apply only to services provided by a nonparticipating provider with respect to a visit to a participating health care facility. Therefore, as stated in the preamble to the July 2021 interim final rules, the provisions that limit cost sharing for non-emergency services provided by nonparticipating providers with respect to a visit to certain participating facilities would never be triggered if a plan or coverage does not have a network of participating facilities.[9]

Q3: How must a group health plan or group or individual health insurance coverage that does not have a network of providers calculate cost sharing for out-of-network items and services that are subject to the surprise billing provisions of the No Surprises Act?

In general, for emergency services furnished by a nonparticipating provider or a nonparticipating emergency facility, and for non-emergency services furnished by nonparticipating providers with respect to a visit to a participating health care facility, cost sharing is calculated as if the total amount that would have been charged for the services by a participating emergency facility or participating provider were equal to the recognized amount for the services, as defined by the statute and in 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.

If an All-Payer Model Agreement or specified state law applies, the plan or issuer must calculate cost sharing for out-of-network services that are subject to the No Surprises Act (other than out-of-network air ambulance services) based on the amount determined by the All-Payer Model Agreement or specified state law.

If an All-Payer Model Agreement or specified state law does not apply (including for all out-of-network air ambulance services subject to the No Surprises Act), cost sharing is determined based on the lesser of the billed charge or the QPA.

The July 2021 interim final rules establish the methodology for calculating the QPA, including when a plan or issuer lacks sufficient information to calculate a median contracted rate. If a plan or issuer does not have sufficient information to calculate a median contracted rate—including because the plan or issuer does not have a network of participating providers for the item or service involved—the plan or issuer must calculate the QPA using an eligible database, in accordance with the regulations.[10]

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[8] *See* Q4 regarding the calculation of the out-of-network rate for out-of-network items and services that are subject to the surprise billing provisions of the No Surprises Act.

[9] *Id*.

[10] 26 CFR 54.9816-6T(c)(3), 29 CFR 2590.716-6(c)(3), and 45 CFR 149.140(c)(3). Note that when a plan or issuer has sufficient information to calculate the median of its contracted rates, but payments under its contractual agreements are not on a fee-for-service basis (such as bundled or capitation payments), the plan or issuer is required under the July 2021 interim final rules to calculate the QPA using underlying fee schedule rates or derived amounts. The regulations do not permit a plan or issuer to use underlying fee schedules or derived amounts to calculate the QPA in any other circumstance.

Example: Person X is enrolled in a group health plan that does not have a network of providers or facilities. Under the terms of the plan, the plan pays a reference-based amount, based on a fee schedule, for items and services covered under the plan. Participants and beneficiaries generally are responsible for the difference between the provider's or facility's billed charge and the payment amount set under the plan. The plan applies a deductible, after which the plan does not impose cost sharing for covered services. Person X has satisfied the deductible for the current plan year. Person X is taken to a hospital emergency room for emergency services, and the facility sends the plan a bill for $1,200 for CPT code 99282. There is no All-Payer Model Agreement or specified state law that is applicable with respect to the plan. Under the plan's terms, the plan would pay a reference-based amount of $800 for CPT code 99282 after the deductible is satisfied.

Conclusion: Under the No Surprises Act, the emergency facility is prohibited from billing Person X for an amount that exceeds Person X's cost-sharing requirement. Person X's cost-sharing requirement must be calculated as if the total amount that would have been charged for the services by the nonparticipating emergency facility was equal to the recognized amount for the services. Since neither an All-Payer Model Agreement nor a specified state law applies, the plan must calculate the recognized amount using the QPA. Because the plan does not have a network from which to calculate median contracted rates, the QPA is calculated using an eligible database. Using an eligible database, the plan determines the applicable QPA is $900. Because Person X's deductible has been satisfied and the plan does not impose other cost-sharing requirements for emergency services, Person X owes no cost sharing and cannot be billed or held liable for the $400 difference between the amount billed by the facility ($1,200) and the plan's reference-based amount ($800).

Q4: How must a group health plan or group or individual health insurance coverage that does not have a network of providers calculate the out-of-network rate for out-of-network items and services that are subject to the surprise billing provisions of the No Surprises Act?

If an All-Payer Model Agreement or specified state law applies, the plan or issuer must calculate the out-of-network rate for out-of-network services that are subject to the No Surprises Act based on the amount determined by the All-Payer Model Agreement or specified state law, consistent with the definition of "out-of-network rate" set forth in 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.

If an All-Payer Model Agreement or specified state law does not apply, the out-of-network rate is the amount the nonparticipating provider, emergency facility, or provider of air ambulance services and the plan or issuer agree upon as the amount of payment for the item or service (including if the amount agreed upon is the initial payment sent by the plan or issuer or is agreed upon through negotiations with respect to such item or service). However, if the parties enter into the Federal independent dispute resolution (IDR) process and do not agree upon a payment amount before the date on which the certified IDR entity makes a determination with respect to such item or service, then the amount determined by the certified IDR entity is the out-of-

network rate. As a result, a plan or coverage that utilizes a reference-based pricing structure (or a similar network design) and does not have a network of providers may be required to make a total payment that is different than the plan's or issuer's reference-based amount for items and services that are subject to the surprise billing provisions of the No Surprises Act.

Q5: How do the maximum-out-of-pocket requirements of section 2707(b) of the PHS Act apply to items and services subject to the No Surprises Act for a non-grandfathered large group market plan, or self-insured group health plan, that does not have a network of providers?

In October 2014, the Departments issued FAQs Part XXI, which provide guidance on the maximum-out-of-pocket (MOOP) requirements under section 2707(b) of the PHS Act. The FAQs state that the Departments would not consider a non-grandfathered large group market plan or self-insured group health plan that utilizes reference-based pricing (or a similar network design) as failing to comply with the MOOP requirements of section 2707(b) of the PHS Act if the plan treats providers that accept the reference amount as the only in-network providers for purposes of section 2707(b) of the PHS Act, as long as the plan or issuer uses a reasonable method to ensure that it offers adequate access to quality providers at the reference-based price.[11] FAQs Part XXI set forth the specific factors the Departments will consider when evaluating whether such a plan is using a reasonable method. One of those factors is the type of service. Those FAQs state that a plan or issuer that uses reference-based pricing and treats providers that accept the reference amount as the only in-network providers for purposes of the MOOP requirements should apply only to those services for which the period between identification of the need for care and provision of the care is long enough for consumers to make an informed choice of provider. Those FAQs also state that limiting or excluding out-of-pocket spending from counting toward the MOOP with respect to providers that do not accept the reference-based price would not be considered reasonable with respect to emergency services.[12]

Note that the term "emergency services" was previously defined under section 2719A of the PHS Act and its implementing regulations, and that provision was sunset and recodified by the No Surprises Act. "Emergency services" are now defined in 26 CFR 54.9816-4T(c)(2), 29 CFR 2590.716-4(c)(2), and 45 CFR 149.110(c)(2) to include certain items and services furnished after

[11] The Departments previously stated that if a plan includes a network of providers, the plan may, but is not required to, count an individual's out-of-pocket spending for out-of-network items and services toward the plan's annual out-of-pocket maximum. *See* FAQs about Affordable Care Act Implementation (Part XVIII) and Mental Health Parity Implementation, Q4 (Jan. 9, 2014), available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-xviii.pdf and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html; and FAQs about Affordable Care Act Implementation (Part XIX), Q2 (May 2, 2014), available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-xix.pdf and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html.

[12] *See* FAQs about Affordable Care Act Implementation (Part XXI) (Oct. 10, 2014), available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-xxi.pdf and https://www.cms.gov/sites/default/files/repo-new/61/Reference_Pricing_FAQ_10.10.14.pdf. As stated in FAQs Part XXI, compliance with section 2707(b) of the PHS Act is not determinative of compliance with any other provision of law, including section 2713 of the PHS Act (relating to coverage of preventive services). This also applies to sections 9816 and 9817 of the Code, sections 716 and 717 of ERISA, or sections 2799A-1 and 2799A-2 of the PHS Act (relating to surprise billing protections).

the patient is stabilized. Additionally, post-stabilization services are excluded from the definition of "emergency services" under the No Surprises Act if all conditions under 45 CFR 149.410(b) are met.[13] The new definition of "emergency services" reflects that, when patients receive these post-stabilization services, they may not have an opportunity in the time between identification of the need for care and provision of the care to seek a participating provider (and be protected from out-of-network cost sharing and balance billing). Therefore, consistent with the Departments' prior guidance in FAQs Part XXI, limiting or excluding out-of-pocket spending from counting toward the MOOP with respect to providers that do not accept the reference-based price would not be considered reasonable with respect to post-stabilization services that are included in the definition of "emergency services."

Q6: Do the surprise billing provisions of the No Surprises Act apply in the case of a group health plan or group or individual health insurance coverage that generally does not provide out-of-network coverage?

Yes. The No Surprises Act's protections regarding emergency services, non-emergency services furnished by a nonparticipating provider with respect to a visit to a participating facility, and air ambulance services apply if those services are otherwise covered under the plan or coverage, even if the plan or coverage otherwise does not provide coverage for out-of-network items or services.

Note that, under section 9816(a) of the Code, section 716(a) of ERISA, and section 2799A-1(a) of the PHS Act, if a plan or issuer provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department, the plan or issuer must cover emergency services, including on an out-of-network basis, in accordance with the No Surprises Act and its implementing regulations.[14] Similarly, under section 9816(b) of the Code, section 716(b) of ERISA, section 2799A-1(b) of the PHS Act, if a plan or issuer provides or covers benefits with respect to non-emergency items and services, the plan or issuer must cover the items and services furnished to a participant, beneficiary, or enrollee of the plan or coverage by a nonparticipating provider with respect to a visit at a participating health care facility in accordance with requirements set forth in 26 CFR 54.9816-5T(c), 29 CFR 2590.716-5(c), and 45 CFR 149.120(c) related to cost sharing, payment amounts, and procedural requirements related to billing disputes. Finally, under section 9817(a) of the Code, section 717(a) of ERISA, and section 2799A-2(a) of the PHS Act, if a plan or issuer provides or covers any benefits for air ambulance services, the plan or issuer must cover such services from a nonparticipating provider of air ambulance services in accordance with requirements set forth in 26 CFR 54.9817-1T(b), 29 CFR 2590.717-1(b), and 45 CFR 149.130(b) related to cost sharing, payment amounts, and procedural requirements related

[13] Under 45 CFR 149.410(b), post-stabilization services are emergency services unless all of the following conditions are met: (1) the attending emergency physician or treating provider determines that the participant, beneficiary, or enrollee is able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into account the individual's medical condition; (2) the provider or facility furnishing such additional items and services satisfies the notice and consent criteria of 45 CFR 149.420(c) through (g); (3) the participant, beneficiary, or enrollee (or their authorized representative) is in a condition to receive notice and provide consent; and (4) the provider or facility satisfies any additional requirements or prohibitions under state law.

[14] *See* 26 CFR 54.9816-4T, 29 CFR 2590.716-4, and 45 CFR 149.110.

to billing disputes.[15] These requirements may result in a plan or coverage providing benefits for out-of-network items and services subject to the surprise billing provisions, even if the plan or coverage otherwise would not provide coverage for these items or services on an out-of-network basis.

Applicability to Air Ambulance Services

Q7: If a plan or issuer covers air ambulance services only for emergencies, is the plan or issuer required under the No Surprises Act to cover non-emergent air ambulance services (such as non-emergent inter-facility transports) provided by a nonparticipating provider of air ambulance services?

No. Under 26 CFR 54.9817-1T, 29 CFR 2590.717-1, and 45 CFR 149.130, if a plan or issuer provides or covers any benefits for air ambulance services, the plan or issuer must cover "such services" from a nonparticipating provider of air ambulance services in accordance with the implementing regulations. The Departments in this instance interpret "such services" to mean air ambulance services the plan or issuer provides or covers, as opposed to all air ambulance services. Therefore, if non-emergent air ambulance services are not covered under the terms of a plan or coverage, neither the No Surprises Act[16] nor its implementing regulations require the plan or issuer to cover those services or limit the amount a participant, beneficiary, or enrollee may be charged for those services.[17]

Q8: Do the protections against surprise medical bills in the No Surprises Act apply to air ambulance services furnished by a nonparticipating provider of air ambulance services when the point of pick-up is in a jurisdiction outside of the United States?

Yes. The requirements in 26 CFR 54.9817-1T, 29 CFR 2590.717-1, and 45 CFR 149.130 and 45 CFR 149.440 prohibiting surprise medical bills for air ambulance services apply to air ambulance services (for which benefits are available under the plan or coverage) furnished by a nonparticipating provider of air ambulance services that is licensed under applicable state and federal law to provide air ambulance services, and that therefore meets the definition of a provider of air ambulance services set forth in 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30, even if the point of pick-up is in a jurisdiction outside of the United States.

Q9: How should a plan or issuer identify the geographic region used to calculate the QPA for air ambulance services when the point of pick-up is outside of the United States?

Under 26 CFR 54.9816-6T(a)(7)(ii), 29 CFR 2590.716-6(a)(7)(ii), and 45 CFR 149.140(a)(7)(ii), the geographic region in which air ambulance services are furnished is based on the point of pick-up, which is defined under 42 CFR 414.605 as the location of the individual at the time the

[15] *See* Q7 for further detail about the coverage requirements applicable to air ambulance services.
[16] Section 9817 of the Code, section 717 of ERISA, and section 2799A-2 of the PHS Act.
[17] In contrast, and as noted in Q6, if a plan or issuer provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department, the plan or issuer must cover all emergency services, as defined in the No Surprises Act and its implementing regulations. 26 CFR 54.9816-4T, 29 CFR 2590.716-4, and 45 CFR 149.110.

individual is placed on board the ambulance. For air ambulance services, a "geographic region" generally is defined as one region consisting of all metropolitan statistical areas (MSAs) in the state, and one region consisting of all other portions of the state, determined based on the point of pick-up.[18]

If a plan or issuer does not have sufficient information, as defined under 26 CFR 54.9816-6T(a)(15), 29 CFR 2590.716-6(a)(15), and 45 CFR 149.140(a)(15), to calculate the median contracted rate based on this primary definition, the "geographic region" is one region consisting of all MSAs in each Census division and one region consisting of all other portions of the Census division, determined based on the point of pick-up. In cases in which a plan or issuer does not have sufficient information using its own contracted rates to calculate the median contracted rate using either definition, the plan or issuer must determine the QPA using the same definitions of "geographic region" based on data from an eligible database, pursuant to 26 CFR 54.9816-6T(c)(3), 29 CFR 2590.716-6(c)(3), and 45 CFR 149.140(c)(3).

The Departments recognize that the July 2021 interim final rules do not currently provide for geographic regions outside of the United States. Therefore, the methodology for calculating the QPA for air ambulance services, either based on a plan's or issuer's contracted rates or using an eligible database, does not currently account for air ambulance services that are subject to the surprise billing protections of the No Surprises Act when the point of pick-up is outside of the United States.

In future rulemaking, the Departments intend to address the geographic region to be used to calculate the QPA for air ambulance services when the point of pick-up is in a jurisdiction outside of the United States. Until that rulemaking is finalized and effective, plans and issuers are expected to use a reasonable method to determine which geographic region under the interim final regulations applies for purposes of calculating the QPA for air ambulance services for which the point of pick-up is outside of the United States. For example, the Departments will consider a plan or issuer to have used a reasonable method if the plan or issuer identifies the relevant geographic region based on the border point of entry to the United States following patient pick-up.[19]

> *Example:* A nonparticipating provider of air ambulance services is dispatched from Florida to pick up an individual experiencing a medical emergency in the Bahamas, and transports the individual back to a hospital in the United States, entering the United States through the Miami-Fort Lauderdale-West Palm Beach MSA. The nonparticipating provider of air ambulance services submits a claim to the individual's plan or issuer for the services. The plan or issuer determines that the air ambulance services are a covered benefit under the terms of the individual's coverage. The plan or issuer could reasonably

[18] The Departments consulted with the National Association of Insurance Commissioners, as required by the No Surprises Act, to establish the geographic regions to be used in the methodology for calculating the QPA set forth in the July 2021 interim final rules.

[19] This method is generally consistent with the approach used in Medicare for air ambulance transports from areas outside of the United States to the United States for covered claims. *See* Medicare Claims Payment Manual, Chapter 15, Section 20.1.5D (Rev. 11365, 04-28-22), available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf.

calculate the QPA for the air ambulance services using the geographic region that corresponds to the United States border point of entry, which in this case would be the region consisting of all MSAs in Florida, provided the plan or issuer has sufficient information to calculate a median contracted rate for that region.

Applicability to Emergency Services Furnished in a Behavioral Health Crisis Facility

The surprise billing protections set forth in the No Surprises Act and its implementing regulations apply to emergency services[20] (with respect to an emergency medical condition) that are furnished with respect to a visit to a hospital emergency department (defined to include a hospital outpatient department that provides emergency services) or an independent freestanding emergency department,[21] including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, as well as pre- and post-stabilization services (regardless of the department of the hospital in which the services are furnished). The term "emergency medical condition" means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in section 1867(e)(1)(A)(i)-(iii) of the SSA, as added by the Emergency Medical Treatment and Labor Act (EMTALA), referring to placing the health of the individual (or, with respect to a pregnant person, the health of the person or their unborn child) in serious jeopardy, serious impairment to bodily functions, and serious dysfunction of any bodily organ or part.

Under the July 2021 interim final rules, as noted above, the term "emergency department of a hospital" includes a hospital outpatient department that provides emergency services. The July 2021 interim final rules also define "independent freestanding emergency department" to mean a health care facility (not limited to those described in the definition of "health care facility" in the July 2021 interim final rules) that provides emergency services, and is geographically separate and distinct from a hospital and separately licensed as such by a state.[22] The preamble to the July 2021 interim final rules states that the definition of "independent freestanding emergency department" is intended to include any health care facility that is geographically separate and

[20] For the definition of emergency services, see 26 CFR 54.9816-4T(c)(2), 29 CFR 2590.716-4(c)(2), and 45 CFR 149.110(c)(2).
[21] For the definitions of emergency department of a hospital and independent freestanding emergency department, see 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.
[22] 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.

distinct from a hospital, and licensed by a state to provide emergency services (as defined in the July 2021 interim final rules), with respect to an emergency medical condition.[23]

Q10: How do the surprise billing provisions of the No Surprises Act and its implementing regulations apply to emergency services furnished with respect to a visit to a behavioral health crisis facility?

The July 2021 interim final rules made clear that the definition of emergency medical condition includes mental health conditions and substance use disorders that satisfy that definition.[24] The Departments recognize that individuals experiencing behavioral health emergencies may be served most effectively in settings outside of hospital emergency departments and that states, localities, and health care systems are actively exploring alternatives to hospital-based care to respond to behavioral health emergencies, including through services provided in specialized facilities that are staffed by behavioral health providers trained to provide crisis services.

To the extent that services provided in response to a behavioral health crisis meet the definition of "emergency services," and are provided with respect to a visit to a facility that meets the definition of an "emergency department of a hospital" or an "independent freestanding emergency department," as those terms are defined under the July 2021 interim final rules, these services are subject to the surprise billing protections in the No Surprises Act and its implementing regulations applicable to emergency services.[25] This is true regardless of whether the license issued to the facility uses the term "hospital emergency department" or "independent freestanding emergency department" and regardless of whether the license issued to the facility uses the term "emergency services" to describe the services the facility is licensed to provide. For example, if under state licensure laws, a facility that provides behavioral health crisis response services is permitted to provide emergency services as described in 26 CFR 54.9816-4T(c)(2), 29 CFR 2590.716-4(c)(2), and 45 CFR 149.110(c)(2), and is geographically separate and distinct from a hospital, then such a facility would fall within the definition of "independent freestanding emergency department" under the July 2021 interim final regulations, and the surprise billing protections would apply with respect to emergency services provided with respect to a visit to the facility.

General Disclosure for Protections Against Balance Billing

Section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, as added by the No Surprises Act, require plans and issuers to make certain disclosures regarding balance billing protections to participants, beneficiaries, and enrollees that are similar to disclosure requirements applicable to providers and facilities under section 2799B-3 of the PHS Act, as implemented in 45 CFR 149.430.

[23] 86 FR 36872, 36879 (Jul. 13, 2021).
[24] 26 CFR 54.9816–4T(c)(1), 29 CFR 2590.716–4(c)(1), and 45 CFR 149.110(c)(1).
[25] In addition, to the extent that a medical screening examination and stabilizing treatment provided in response to a behavioral health crisis meet the definition of "emergency services," and are provided in an outpatient department of a hospital, these services are also subject to the surprise billing protections applicable to emergency services.

In general, plans and issuers must make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 9816 of the Code, section 716 of ERISA, and section 2799A-1 of the PHS Act apply, information on:

(1) the requirements under those sections, as applicable;

(2) the requirements and prohibitions applied under sections 2799B-1 and 2799B-2 of the PHS Act (relating to the prohibitions against balance billing for emergency and non-emergency services in certain circumstances);

(3) other applicable state laws on out-of-network balance billing; and

(4) contacting appropriate state and Federal agencies if an individual believes the provider or facility has violated the prohibition against balance billing.

These disclosure requirements are applicable for plan years (in the individual market, policy years) beginning on or after January 1, 2022.

To reduce burden and facilitate compliance with these disclosure requirements, the Departments issued a model disclosure notice that may be used to satisfy the disclosure requirements regarding balance billing protections.[26] The Departments consider use of the model notice in accordance with the accompanying instructions to be good faith compliance with the disclosure requirements of section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, if all other applicable requirements are met.

Q11: May a group health plan that does not have its own website satisfy the disclosure requirements of section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, with respect to posting the required information on a public website of the plan, if the plan's service provider posts the required information on its public website on behalf of the group health plan?

Yes. If a group health plan does not have a website, the plan may satisfy the requirements to post on its public website the information required by section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, by entering into a written agreement under which a plan's health insurance issuer or third-party administrator (TPA), as applicable, posts the information on its public website where information is normally made available to participants, beneficiaries, and enrollees, on the plan's behalf. To the extent a health insurance issuer or TPA posts the required information on its public website on behalf of a plan, the plan satisfies the requirements with respect to posting the information on the plan's public website if the health insurance issuer or TPA makes the information available in the required manner. The Departments note this guidance applies in instances in which the plan sponsor (for example, an

[26] *See* Q13, which explains which versions of the standard notice and consent form and model disclosure notice providers, facilities, plans, and issuers may use.

employer) may maintain a public website, but the group health plan sponsored by the employer does not.

Notwithstanding the preceding paragraph, if a plan enters into a written agreement under which a health insurance issuer or TPA agrees to post the required information on its public website on behalf of the plan, and the health insurance issuer or TPA fails to do so, the plan violates the disclosure requirements of section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act.

Q12: Are plans and issuers required under section 9820(c)(1)(B) of the Code, section 720(c)(1)(B) of ERISA, and section 2799A-5(c)(1)(B) of the PHS Act to provide information on all state laws regarding balance billing?

No. The statute requires plans and issuers to provide information only on "applicable" state laws regarding out-of-network balance billing. The Departments will consider a plan or issuer to be in compliance with the requirements in section 9820(c)(1)(B) of the Code, section 720(c)(1)(B) of ERISA, and section 2799A-5(c)(1)(B) of the PHS Act if the plan's or issuer's disclosure includes information on state laws applicable to balance billing that apply with respect to participants, beneficiaries, and enrollees in such coverage.

The Departments do not expect a plan or issuer to provide information on state laws that do not apply to a particular participant, beneficiary, or enrollee that is enrolled in the plan or coverage. The Departments note that many state laws regarding balance billing and other surprise billing protections such as limits on cost sharing do not apply with respect to participants, beneficiaries, and enrollees who are enrolled in coverage provided by a self-insured group health plan or out-of-state issuer.

The Departments note that, prior to the enactment of the No Surprises Act, some states adopted laws that apply to providers and facilities within the state with respect to participants, beneficiaries, and enrollees who are enrolled in coverage over which the state does not have jurisdiction, such as coverage provided by a self-insured ERISA plan (that did not or could not voluntarily opt in to the state law) or by an out-of-state health insurance issuer. These state laws do not establish requirements that apply to self-insured group health plans or, generally, coverage provided by out-of-state health insurance issuers. The Departments will not consider a plan or out-of-state issuer to violate the requirements in section 9820(c)(1)(B) of the Code, section 720(c)(1)(B) of ERISA, and section 2799A-5(c)(1)(B) of the PHS Act if the plan's or issuer's disclosure does not include information on state laws that would not apply to claims arising under the relevant plan or policy regarding out-of-network balance billing. However, if a self-insured plan has voluntarily opted into a state law that provides such protections, the plan is required to disclose information on any such state law.

Standard Notice and Consent Form and Model Disclosure Notice Regarding Patient Protections Against Balance Billing

Section 2799B-2 of the PHS Act, as implemented in 45 CFR 149.410 and 149.420, allows nonparticipating providers and facilities to seek consent from an individual to waive the

individual's balance billing and cost-sharing protections in certain situations. In order to seek that consent, the nonparticipating provider or facility must provide written notice to participants, beneficiaries, or enrollees in accordance with guidance issued by HHS, and in the form and manner specified in guidance. HHS issued standard notice and consent documents that nonparticipating providers and facilities must use in order to meet the requirements of the notice and consent exception. HHS considers use of these documents in accordance with their accompanying instructions to be good faith compliance with the notice and consent requirements of section 2799B-2(d) of the PHS Act, provided that all other requirements are met. To the extent a state develops notice and consent documents that otherwise meet the statutory and regulatory requirements under section 2799B-2(d) of the PHS Act and 45 CFR 149.410 and 149.420, the state-developed documents will meet the Secretary of HHS's specifications regarding the form and manner of the notice and consent documents.

In addition, section 2799B-3 of the PHS Act, as implemented in 45 CFR 149.430, requires certain providers and facilities to provide disclosures regarding patient protections against balance billing to participants, beneficiaries, and enrollees. In general, those providers and facilities must make publicly available, post on a public website of the provider or facility (if applicable), and provide to participants, beneficiaries, and enrollees a one-page notice in clear and understandable language containing information on:

> (1) the requirements and prohibitions applicable to such provider or facility under sections 2799B-1 and 2799B-2 of the PHS Act (relating to prohibitions on balance billing for emergency and non-emergency services in certain circumstances);
>
> (2) any applicable state requirements; and
>
> (3) contacting appropriate state and federal agencies if the individual believes the provider or facility has violated the restrictions against balance billing.

HHS issued a model disclosure notice that may be used to satisfy these disclosure requirements regarding these balance billing protections, and the parallel disclosure requirements on plans and issuers in section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, which are described in more detail in Q11 and Q12. For providers and facilities, HHS considers use of the model notice in accordance with their accompanying instructions to be good faith compliance with the disclosure requirements under section 2799B-3 of the PHS Act, as implemented in 45 CFR 149.430, provided that all other requirements are met. In addition, for plans and issuers, the Departments consider use of the model notice in accordance with the accompanying instructions to be good faith compliance with the disclosure requirements set forth in section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, provided that all other requirements are met.

Q13: Which versions of the standard notice and consent form and model disclosure notice may providers, facilities, plans, and issuers use?

HHS previously published and obtained emergency approval from the Office of Management and Budget (OMB) for a standard notice and consent form that providers and facilities must use

when providing notice and seeking consent from individuals to waive their protections against surprise bills (unless a state develops notice and consent documents that otherwise meet the statutory and regulatory requirements under section 2799B-2(d) of the PHS Act and 45 CFR 149.410 and 149.420) and a model disclosure notice that providers, facilities, plans, and issuers may use to notify individuals of their protections against balance billing.

Based on public comments, HHS has revised these documents and obtained OMB approval for the revised versions.[27]

Providers and facilities may use either the initial version of the standard notice and consent form (Appendix II) or the revised version (Appendix IV) for items and services furnished during calendar year 2022. However, providers and facilities may use only the revised version of the standard notice and consent form (Appendix IV) for items and services furnished on or after January 1, 2023. Providers and facilities may use either the initial version of the model disclosure notice (Appendix I) or the revised version (Appendix III) for making disclosures during calendar year 2022. However, HHS will consider providers' and facilities' use of only the revised version of the model disclosure notice (Appendix III) to be good faith compliance for disclosures made on or after January 1, 2023.

Similarly, the Departments will consider plans' and issuers' use of either the initial (Appendix I) or revised (Appendix III) version of the model disclosure notice in accordance with its accompanying instructions to be good faith compliance for making disclosures with respect to plan or policy years beginning on or after January 1, 2022, and before January 1, 2023. However, the Departments will consider plans' and issuers' use of only the revised version of the model disclosure notice (Appendix IV) to be good faith compliance for disclosures with respect to plan or policy years beginning on or after January 1, 2023.

Methodology for Calculating Qualifying Payment Amounts

In general, under section 9816(a)(3)(E) of the Code, section 716(a)(3)(E) of ERISA, and section 2799A-1(a)(3)(E) of the PHS Act, for a given item or service, the QPA is the median of the contracted rates recognized by the plan or issuer on January 31, 2019, for the same or similar item or service that is provided by a provider in the same or similar specialty and provided in a geographic region in which the item or service is furnished, increased for inflation. The median contracted rate is determined with respect to all group health plans of the plan sponsor, or all group or individual health insurance coverage offered by the health insurance issuer in the same insurance market. The No Surprises Act and the July 2021 interim final rules establish the

[27] The initial and revised versions of the model disclosure notice and standard notice and consent form are available at https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets. The information collection is approved under OMB control number 0938-1401 (CMS-10780, Requirements Related to Surprise Billing: Qualifying Payment Amount, Notice and Consent, Disclosure on Patient Protections Against Balance Billing, and State Law Opt-in), and currently has an expiration date of May 31, 2025.

methodology that plans and issuers must use to calculate the median of contracted rates to determine the QPA.

After the July 2021 interim final rules were issued, stakeholders brought to the Departments' attention certain contractual arrangements in which providers accept contracted rates established by plans or issuers for service codes that they are not likely to bill or that are not utilized by their specific provider specialty. Stakeholders raised concerns that the inclusion of these rates in the calculation of QPAs may artificially lower the QPA, as these providers have little incentive to negotiate fair reimbursement rates for these service codes, with some even accepting $0 as their rate for codes they do not utilize.

The No Surprises Act and its implementing regulations place the responsibility for monitoring the accuracy of plans' and issuers' QPA calculation methodologies with the Departments (and applicable state authorities) by requiring audits of plans' and issuers' QPA calculation methodologies.[28] It is not the responsibility of a provider, facility, provider of air ambulance services, or certified IDR entity to verify a QPA's accuracy, and plans and issuers are not obligated to demonstrate that a QPA was calculated in accordance with the requirements of 26 CFR 54.9816-6T(c), 29 CFR 2590.716-6(c), and 45 CFR 149.140(c) unless required to do so by an applicable regulator. Providers, facilities, and providers of air ambulance services with concerns about a plan's or issuer's compliance with the requirements of 26 CFR 54.9816-6T, 26 CFR 54.9816-6, 29 CFR 2590.716-6, and 45 CFR 149.140 may contact the No Surprises Help Desk at 1-800-985-3059, submit a complaint at https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint, or contact the applicable state authority.

Q14: Under the No Surprises Act and its implementing regulations, are plans and issuers required to calculate a median contracted rate separately for each provider specialty, if the plan's or issuer's contracted rates for service codes vary based on provider specialty (as a result of the plan's or issuer's contracting process)?

Yes. Under 26 CFR 54.9816-6T(b)(3), 29 CFR 2590.716-6(b)(3), and 45 CFR 149.140(b)(3), if a plan or issuer has contracted rates that vary based on provider specialty for a service code, the median contracted rate (and consequently the QPA) must be calculated separately for each provider specialty, as applicable. Plans and issuers are required to calculate separate median contracted rates by provider specialty both in instances where their contracting process purposefully sets different rates for different specialties and in instances where the contracting process otherwise results in different rates for different specialties.

The Departments have been informed that some plans and issuers establish contracted rates by offering most providers the same fee schedule for all covered services, and then it is up to the providers to negotiate increases to the rates for the services that they are most likely to bill. After the negotiation process, the entire fee schedule may be included in the provider contract, with contracted rate modifications made only to certain service codes based on the negotiations. For example, an anesthesiologist's contract may include rates for anesthesia services that are a result of negotiations between the plan or issuer and the provider and that are materially different from

[28] 86 FR 36872, 36899 (July 13, 2021).

the contracted rates the plan or issuer has for the same anesthesia services with other providers in specialties that do not bill for those services. Similarly, an anesthesiologist's contract may also include contracted rates for other services the anesthesiologist does not provide (for example, dermatology services) that are identical to the contracted rates the plan or issuer has with other providers in specialties who similarly do not bill for those services.[29]

To the extent contracted rates for a service code vary based on only certain provider specialty types, the plan or issuer must calculate a separate median contracted rate for each provider specialty for which the rates differ. For example, if a plan's or issuer's contracted rates for a given anesthesia service are clustered at one rate for anesthesiologists and at another rate for all other provider specialties because those providers do not provide and bill for anesthesia services, the plan or issuer must calculate one median contracted rate for the anesthesia service code for anesthesiologists, and one separate median contracted rate for the same anesthesia service code for all other provider specialties. In this example, the plan or issuer would not be expected to calculate separate median contracted rates for the anesthesia service code for each of the other specialties, such as psychiatry or cardiology, because the plan or issuer does not have contracted rates for anesthesia services that vary based on those provider specialties.

The Departments understand that some natural variation in contracted rates is likely to occur as part of the contracting process. A plan or issuer may have established contracted rates for service codes that vary across providers for reasons that are not based on provider specialty. For the purpose of identifying provider specialties for which QPAs must be separately calculated, a plan's or issuer's contracted rates for an item or service are considered to vary based on provider specialty if there is a material difference in the median contracted rates for a service code between providers of different specialties, after accounting for variables other than provider specialty. Plans and issuers whose median contracted rates for a service code are not materially different between providers of different specialties are not required to calculate median contracted rates separately for each provider specialty when determining the QPA. For this purpose, whether a material difference exists depends on all the relevant facts and circumstances.

The Departments recognize that plans and issuers (reasonably and in good faith) may have not understood the July 2021 interim final rules to require the calculation of separate median contracted rates when the plan's or issuer's contracting process unintentionally results in contracted rates that vary based on provider specialty. Accordingly, the Departments will not require a plan or issuer (to the extent not already in compliance) to calculate a QPA as described in this guidance with respect to items and services furnished prior to the date that is 90 days after publication of these FAQs. HHS encourages states to take a similar approach to enforcement and will not consider a state to be failing to substantially enforce the requirements relating to the calculation of a QPA because the state takes such an approach. The Departments will monitor plans' and issuers' compliance with the July 2021 interim final rules, as interpreted in this guidance, and are continuing to monitor contracting practices that affect the calculation of the QPA, to determine whether additional guidance is needed.

[29] The Departments have been informed that some plans and issuers enter $0 in their fee schedule for covered items and services that a provider or facility is not equipped to furnish. In the Departments' view, $0 does not represent a contracted rate in these cases. Therefore, plans and issuers should not include $0 amounts in calculating median contracted rates.

Q15: How may a self-insured group health plan calculate a QPA if it offers multiple benefit package options administered by different TPAs?

Under 26 CFR 54.9816-6T(b), 29 CFR 2590.716-6(b), and 45 CFR 149.140(b), the median contracted rate used to determine the QPA for an item or service is determined with respect to all group health plans of the plan sponsor or all coverage offered by a health insurance issuer that are offered in the same insurance market. In the case of a self-insured group health plan, an "insurance market" generally means all self-insured group health plans (other than account-based plans and plans that consist solely of excepted benefits) of the plan sponsor. However, to reduce burden on self-insured group health plans, the July 2021 interim final rules provide that sponsors of self-insured group health plans may allow their TPAs to determine the QPA on behalf of the sponsor by calculating the median contracted rate using the contracted rates recognized by all self-insured group health plans administered by the TPA, as opposed to only those of the particular plan sponsor.

Consistent with the approach set forth in the July 2021 interim final rules, if a single self-insured group health plan offers multiple benefit package options administered by different TPAs, the plan may allow each TPA acting on behalf of the plan to calculate a median contracted rate separately for those benefit package options administered by the TPA. In other words, contracted rates would not have to be aggregated across multiple mutually-exclusive benefit package options administered by different TPAs to calculate a median contracted rate. Instead, the relevant QPA in a particular case would be the QPA specific to the particular item or service under the benefit package option elected by the participant or beneficiary.

For example, if a self-insured plan offers participants a choice of two benefit packages, Option A administered by TPA "A" and Option B administered by TPA "B," the QPA for an item or service may be calculated separately for Option A and Option B, determined with respect to all self-insured group health plans administered by the same TPA (including from other plan sponsors). In this case, if a participant is enrolled in coverage under Option A, the plan would use the QPA for Option A for claims arising under that participant's coverage, as calculated by TPA "A" for all self-insured group health plans administered by TPA "A."

Requirements for Initial Payments or Notices of Denial of Payment, Related Disclosures, and Initiation of Open Negotiation Periods and Federal IDR Process

The No Surprises Act and its implementing regulations, including the July 2021 interim final rules, a second set of interim final rules issued in October 2021 (October 2021 interim final rules),[30] and the final rules issued concurrently with these FAQs establish requirements to help ensure that billing disputes related to items and services subject to the balance billing protections in the No Surprises Act are resolved in a timely fashion. Among other requirements, these include timeframes within which a plan or issuer must make an initial payment or send a notice

[30] 86 FR 55980 (Oct. 7, 2021).

of denial of payment for items and services subject to surprise billing protections;[31] disclosures a plan or issuer must furnish to a provider, facility, or provider of air ambulance services with an initial payment or notice of denial of payment;[32] and a process for initiating an open negotiation period that must precede any initiation of the Federal IDR process.[33]

Q16: Under the No Surprises Act and its implementing regulations, when must a plan or issuer send an initial payment or notice of denial of payment to a nonparticipating provider, facility, or provider of air ambulance services for items and services subject to the surprise billing protections?

Sections 9816(a)(1)(C)(iv)(I) and 9817(a)(3)(A) of the Code, sections 716(a)(1)(C)(iv)(I) and 717(a)(3)(A) of ERISA, and sections 2799A-1(a)(1)(C)(iv)(I) and 2799A-2(a)(3)(A) of the PHS Act, as added by the No Surprises Act, require plans and issuers to send an initial payment or notice of denial of payment[34] not later than 30 calendar days after a nonparticipating provider, facility, or provider of air ambulance services submits a bill related to the items and services that fall within the scope of the surprise billing protections for emergency services, non-emergency services performed by nonparticipating providers related to a visit to a participating facility, and air ambulance services furnished by nonparticipating providers of air ambulance services. The 30-calendar-day period begins on the date the plan or issuer receives the information necessary to decide a claim for payment for such services, commonly known as a "clean claim."[35]

The Departments will generally enforce the applicable provisions of the No Surprises Act in conjunction with states where applicable. Providers, facilities, and providers of air ambulance services with concerns about a plan's or issuer's compliance with the 30-calendar-day requirement to send an initial payment or notice of denial of payment may contact the No Surprises Help Desk at 1-800-985-3059 or submit a complaint at https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint.

Q17: May a provider, facility, or provider of air ambulance services initiate open negotiation prior to receiving an initial payment or notice of denial of payment for items and services subject to the surprise billing protections?

No. In general, providers, facilities, and providers of air ambulance services have 30 business days from the day they receive an initial payment or a notice of denial of payment from the plan

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[31] 26 CFR 54.9816-4T(b)(3)(iv)(A), 29 CFR 2590.716-4(b)(3)(iv)(A), and 45 CFR 149.110(b)(3)(iv)(A); 26 CFR 54.9816-5T(c)(3), 29 CFR 2590.716-5(c)(3), and 45 CFR 149.120(c)(3); and 26 CFR 54.9817-1T(b)(4)(i), 29 CFR 2590.717-1(b)(4)(i), and 45 CFR 149.130(b)(4)(i).

[32] 26 CFR 54.9816-6T(d)(1), 26 CFR 54.9816-6(d)(1), 29 CFR 2590.716-6(d)(1), and 45 CFR 149.140(d)(1).

[33] 26 CFR 54.9816-8T(b)(1), 29 CFR 2590.716-8(b)(1), and 45 CFR 149.510(b)(1).

[34] The Departments note that a plan or issuer must send an initial payment or notice of denial of payment directly to the provider, facility, or provider of air ambulance services, as applicable. 26 CFR 54.9816-4T(b)(3)(iv)(A), 54.9816-5T(c)(3), and 54.9817(b)(4)(i); 29 CFR 2590.716-4(b)(3)(iv)(A), 2590.716-5(c)(3), and 2590.717-1(b)(4)(i); or 45 CFR 149.110(b)(3)(iv)(A), 149.120(c)(3), and 149.130(b)(4)(i). A plan or issuer does not satisfy its obligation under the statute and regulations if the plan or issuer sends an initial payment or notice of denial of payment to a participant, beneficiary, or enrollee that was furnished items or services by a nonparticipating provider, facility, or provider of air ambulance services.

[35] 86 FR 36872, 36900 (July 13, 2021).

or issuer regarding an item or service that falls within the scope of the surprise billing provisions to initiate open negotiation with respect to that item or service. If a plan or issuer fails to send an initial payment or notice of denial of payment not later than 30 calendar days after the plan or issuer receives a bill related to such an item or service from a nonparticipating provider, facility, or provider of air ambulance services that includes the information necessary to decide a claim for payment (*i.e.*, a "clean claim"), the 30-business-day timeline to initiate open negotiations will not begin until an initial payment or notice of denial of payment is made.

Providers, facilities, and providers of air ambulance services with concerns about a plan's or issuer's compliance with the requirements to timely make an initial payment or provide notice of denial of payment may contact the No Surprises Help Desk at 1-800-985-3059 or submit a complaint at https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint. The Departments will generally enforce the applicable provisions of the No Surprises Act, in conjunction with states where applicable.

Q18: Under the No Surprises Act and its implementing regulations, what constitutes an "initial payment" or a "notice of denial of payment" to a nonparticipating provider, facility, or provider of air ambulance services for items and services that are subject to the surprise billing protections?

As stated in the preamble to the July 2021 interim final rules, the initial payment should be an amount that the plan or issuer reasonably intends to be payment in full based on the relevant facts and circumstances and as required under the terms of the plan or coverage, prior to the beginning of any open negotiation period or initiation of the Federal IDR process.[36] The initial payment is not required to be equivalent to the QPA (or the QPA less the individual's cost-sharing amount), but as noted in Q19, the plan or issuer must include the QPA for each item or service with the initial payment or notice of denial of payment, as well as a statement certifying that the QPA applies for the purposes of the recognized amount, among other required information.

A notice of denial of payment means, with respect to an item or service for which benefits subject to the surprise billing protections are provided or covered, a written notice from the plan or issuer to the provider, facility, or provider of air ambulance services that states that payment for the item or service will not be made by the plan or coverage and explains the reason for denial.[37] For example, a notice of denial of payment could be provided if the item or service is covered but is subject to a deductible greater than the recognized amount.

The term "notice of denial of payment" does not include a notice of benefit denial due to an "adverse benefit determination" as defined in 29 CFR 2560.503-1(m)(4), as explained in the July 2021 interim final rules. There is a significant distinction between an adverse benefit determination, which may be disputed through a plan's or issuer's claims and appeals process, and a notice of denial of payment or an initial payment that is less than the billed amount under the July 2021 interim final rules, which may be disputed through open negotiation and, after that,

[36] *Id.*
[37] 26 CFR 54.9816-3T, 29 CFR 2590.716-3, and 45 CFR 149.30.

through the Federal IDR process. In general, when adjudication of a claim results in a participant, beneficiary, or enrollee being personally liable for payment to a provider or facility, this determination may be an adverse benefit determination that can be disputed through a plan's or issuer's typical claims and appeals process. Conversely, when: (1) the adjudication of a claim results in a decision that does not affect the amount the participant, beneficiary, or enrollee owes; (2) the dispute involves only payment amounts due from the plan or issuer to the provider, facility, or provider of air ambulance services; and (3) the provider, facility, or provider of air ambulance services has no recourse against the participant, beneficiary, or enrollee, the decision is not an adverse benefit determination and the payment dispute may be resolved through open negotiation and, if necessary, the Federal IDR process.

Q19: A plan or issuer receives a claim for emergency services from a nonparticipating provider, under which the recognized amount with respect to the item or service furnished by the nonparticipating provider is the QPA. After reviewing the claim, the plan or issuer provides an initial payment with an explanation of benefits that includes only a general statement that the claim was processed according to applicable state or Federal law and directs the nonparticipating provider to a website for more information. Does this satisfy the requirements of the regulations with respect to the information to be shared with an initial payment or notice of denial of payment?

No. Under 26 CFR 54.9816-6T(d)(1), 26 CFR 54.9816-6(d)(1), 29 CFR 2590.716-6(d)(1), and 45 CFR 149.140(d)(1), in cases in which the recognized amount (or, in the case of air ambulance services, the amount on which cost sharing is based) with respect to an item or service furnished by the provider or facility is the QPA, plans and issuers are required to provide in writing, in paper or electronic form, certain information to nonparticipating providers, nonparticipating emergency facilities, and nonparticipating providers of air ambulance services regarding the QPA and how to dispute an initial payment or notice of denial of payment.

Specifically, when the recognized amount is the QPA, plans and issuers must provide the following information with an initial payment or notice of denial of payment:

> (1) the QPA for each item or service involved;
>
> (2) if the QPA is based on a downcoded service code or modifier, a statement from the plan or issuer explaining that the service code or modifier billed by the provider, facility, or provider or air ambulance services was downcoded; an explanation of why the claim was downcoded, including a description of which service codes or modifiers were altered, added, or removed, if any; and the amount that would have been the QPA had the service code or modifier not been downcoded;[38]
>
> (3) a statement to certify that the plan or issuer has determined that the QPA applies for the purposes of the recognized amount (or, in the case of air ambulance services, for

[38] These requirements related to downcoding were finalized in final rules issued concurrently with these FAQs and are applicable with respect to items or services provided or furnished on or after the date that is 60 days after the date of publication of the final rules in the Federal Register for plan years (in the individual market, policy years) beginning on or after January 1, 2022.

> calculating the participant's, beneficiary's, or enrollee's cost sharing), and that each QPA was determined in compliance with the methodology established in the July 2021 interim final rules
>
> (4) a statement that if the provider or facility, as applicable, wishes to initiate a 30-business-day open negotiation period for purposes of determining the amount of total payment, the provider or facility may contact the appropriate person or office to initiate open negotiation, and that if the 30-business-day open negotiation period does not result in a determination, generally, the provider or facility may initiate the Federal IDR process within 4 days after the end of the open negotiation period; and
>
> (5) contact information, including a telephone number and email address, for the appropriate person or office to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service.[39]

In this case, because the plan or issuer provides an explanation of benefits with only a general statement about the processing of the claim and directs the provider to a website for more information, the plan or issuer has failed to provide all the information required to be provided when making an initial payment or sending a notice of denial of payment and has therefore failed to satisfy the requirements of the July 2021 interim final rules.[40]

It is important to note that plans and issuers are not required to provide a QPA in all circumstances. For example, plans and issuers are not required to provide the QPA when the recognized amount for the item or service is calculated based on an amount determined by an All-Payer Model Agreement or under a specified state law, or when the item or service is not covered under the terms of the plan or coverage.

The Departments recognize that the requirements related to when a plan or issuer must provide a QPA, particularly in instances in which a plan or issuer has provided a recognized amount that is not the QPA, have caused confusion for some providers and facilities as to whether claims for which no QPA is provided are being properly processed by plans and issuers. Remittance Advice Remark Codes (RARCs) related to the No Surprises Act were approved and made effective as of March 1, 2022.[41] Although plans and issuers are not required to use the RARCs under the No Surprises Act and its implementing regulations, the Departments strongly encourage plans and issuers to use the RARCs, subject to state law, as these codes can facilitate communication with providers and facilities regarding how claims subject to the No Surprises Act were calculated. For example, in certain instances in which the recognized amount is not the QPA, a plan or

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[39] Certain additional information must be provided in a timely manner upon request from a nonparticipating provider, facility, or provider of air ambulance services. *See* 26 CFR 54.9816-6T(d)(2), 29 CFR 2590.716-6(d)(2), and 45 CFR 149.140(d)(2).

[40] Although plans and issuers are not required to include the requisite information on an explanation of benefits, the July 2021 interim final rules require disclosure of the information and assume that issuers and TPAs will automate the process of preparing and providing the information in a format similar to an explanation of benefits. *See* 86 FR 36872, 36933.

[41] *See* Remittance Advice Remark Codes Related to the No Surprises Act (March 1, 2022), available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA-NSA-RARC-Codes.pdf.

issuer can use RARC N867 to communicate that cost sharing was calculated based on a specified state law, in accordance with the No Surprises Act.

Q20: If a plan or issuer has failed to disclose the information it is required to provide when making an initial payment or sending a notice of denial of payment, may a provider, facility, or provider of air ambulance services initiate an open negotiation period and then proceed to the Federal IDR process?

Yes. In general, providers, facilities, and providers of air ambulance services have 30 business days from the day they receive an initial payment or a notice of denial of payment from the plan or issuer regarding an item or service to initiate open negotiation with respect to that item or service, including in cases in which information required to be provided is missing. However, a plan's or issuer's failure to satisfy the disclosure requirements in 26 CFR 54.9816-6T(d)(1) or (2), 26 CFR 54.9816-6(d)(1), 29 CFR 2590.716-6(d)(1) or (2), and 45 CFR 149.140(d)(1) or (2) could adversely affect a provider's, facility's, or provider of air ambulance services' ability to meaningfully participate in negotiations during the open negotiation period and Federal IDR process.

In these cases, when a plan or issuer fails to comply with the disclosure requirements in 26 CFR 54.9816-6T(d)(1) or (2), 26 CFR 54.9816-6(d)(1), 29 CFR 2590.716-6(d)(1) or (2), and 45 CFR 149.140(d)(1) or (2), providers, facilities, or providers of air ambulance services retain the right to initiate the open negotiation period within 30 business days of receiving the initial payment or notice of denial of payment. In initiating the open negotiation period, the provider, facility, or provider of air ambulance services, must provide the standard open negotiation notice[42] to the plan or issuer, as required in 26 CFR 54.9816-8T(b), 29 CFR 2590.716-8(b), and 45 CFR 149.140(b).[43, 44] After the 30-business-day open negotiation period has lapsed, the provider, facility, or provider of air ambulance services may initiate the Federal IDR process in accordance with the normal timelines.

Alternatively, in cases in which a plan or issuer fails to comply with the disclosure requirements in 26 CFR 54.9816-6T(d)(1) or (2), 26 CFR 54.9816-6(d)(1), 29 CFR 2590.716-6(d)(1) or (2), and 45 CFR 149.140(d)(1) or (2), providers, facilities, or providers of air ambulance services may request an extension to initiate the Federal IDR process,[45] and provide applicable attestations, by emailing a request for extension due to extenuating circumstances to

[42] https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-2.pdf.

[43] Note that plans and issuers are prohibited from initiating open negotiation periods or the Federal IDR process before satisfying the requirements in 26 CFR 54.9816-6T(d)(1) and (2), 26 CFR 54.9816-6(d)(1), 29 CFR 2590.716-6(d)(1) and (2), and 45 CFR 149.140(d)(1) and (2), as applicable.

[44] The Departments expect that a party initiating open negotiation will be able to demonstrate the steps it has taken to comply with the notice requirements. Examples of steps taken to comply with the notice requirement include emailing or otherwise submitting the standard open negotiation notice to the contact or web portal address based on information provided with the initial payment or notice of denial of payment, or any contact associated with the plan or issuer if (and only if) contact information was not included with the initial payment or notice of denial of payment.

[45] 26 CFR 54.9816-8T(g); 29 CFR 2590.716-8(g); 45 CFR 149.510(g).

FederalIDRQuestions@cms.hhs.gov, including the time period(s) for which they are seeking an extension.

Failure by either party to supply information that is required to be submitted to the certified IDR entity (for example, failure to provide the QPA) may lead to a finding by the certified IDR entity that does not take into consideration the absent information, or may lead to the certified IDR entity drawing an inference about the absent information that is adverse to that party.

Providers, facilities, and providers of air ambulance services with concerns about a plan's or issuer's compliance with the requirements of 26 CFR 54.9816-6T(d)(1), 26 CFR 54.9816-6(d)(1), 29 CFR 2590.716-6(d)(1), and 45 CFR 149.140(d)(1), including concerns that a plan or issuer is not acting in good faith with respect to this requirement, may contact the No Surprises Help Desk at 1-800-985-3059 or submit a complaint at https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint. The Departments will generally enforce the applicable provisions of the No Surprises Act, in conjunction with states where applicable.

Q21: A plan or issuer establishes an online portal for nonparticipating providers, facilities, and providers of air ambulance services to submit the information necessary to initiate the open negotiation period. However, the portal does not accept uploads of the standard open negotiation form issued by the Departments, and the plan or issuer does not otherwise accept delivery of the standard open negotiation form. Instead, the plan or issuer requires that nonparticipating providers, facilities, and providers of air ambulance services manually enter information for each claim separately in a manner prescribed by the plan or issuer through the portal before the plan or issuer will engage in any open negotiation with the nonparticipating provider. Is this permissible?

No. The October 2021 interim final rules at 26 CFR 54.9816-8T(b)(1)(ii)(B), 29 CFR 2590.716-8(b)(1)(ii)(B), and 45 CFR 149.510(b)(1)(ii)(B) state that the initiating party may initiate the open negotiation period by sending an open negotiation notice to the other party electronically (such as by email) if the following conditions are satisfied:

> (1) the initiating party has a good faith belief that the electronic method is readily accessible by the other party; and
>
> (2) the notice is provided in paper form free of charge upon request.

The Departments have developed a standard open negotiation form[46] that an initiating party must use to initiate the open negotiation period. The October 2021 interim final rules do not prohibit a plan or issuer from encouraging the use of an online portal for nonparticipating providers, facilities, and providers of air ambulance services to submit the information necessary to initiate the open negotiation period, or from seeking additional information to inform good faith open negotiations, such as through use of a supplemental open negotiation form. However, because

[46] *See* Open Negotiation Notice and Instructions, available at: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-2.pdf.

the initiating party (in this case, a nonparticipating provider) is required to use the standard open negotiation form, the other party must accept the standard open negotiation form sent by the initiating party to the contact information provided by the non-initiating party even when the initiating party does not use the plan's or issuer's portal or supplemental form, provided that the notice was sent in a manner that complies with the delivery requirements discussed above.

The October 2021 interim final rules permit the initiating party to send the open negotiation notice to the opposing party electronically if the party sending the notice has a good faith belief that the electronic method is readily accessible to the other party. For example, if a provider sends an open negotiation notice to the email address identified by the plan or issuer with the initial payment or notice of denial of payment, this electronic delivery would satisfy the delivery requirements of the October 2021 interim final rules (so long as the provider also provides the notice in paper form free of charge upon request).[47] Conversely, if a plan or issuer is in compliance with the requirement to disclose contact information with the initial payment or notice of denial of payment,[48] a provider, facility, or provider of air ambulance services generally would not have a good faith belief that sending an open negotiation notice to a general email address (that was not identified with the initial payment or notice of denial of payment) of the plan or issuer is a readily accessible electronic method under the October 2021 interim final rules.

In the preamble to the October 2021 interim final rules, the Departments encouraged plans, issuers, providers, facilities, and providers of air ambulance services to engage in good faith open negotiations. The Departments are aware of instances in which plans and issuers are not responding to or not acknowledging receipt of the notice of initiation of open negotiation, as well as instances in which providers are failing to provide information to plans and issuers in addition to what is included on the standard notice of initiation of open negotiation form, to assist the plan or issuer in identifying the claim under dispute. The Departments are of the view that these actions may hinder a party's ability to meaningfully participate in an open negotiation. The Departments consider good faith negotiations to include a dialogue between parties; at minimum, during the open negotiation period, parties should communicate to identify the claims under dispute, the type of plan or coverage responsible for the claims, and other information to help identify whether the claims qualify for the Federal IDR process. If a plan, issuer, provider, facility, or provider of air ambulance services timely sends the notice of initiation of open negotiation, and the other party does not respond during the 30-business-day open negotiation period, the initiating party may initiate the Federal IDR process during the 4-business-day period beginning on the 31st business day after the start of the open negotiation period if the item or service is a qualified IDR item or service.[49]

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[47] 86 FR 55980, 55990 (Oct. 7, 2021).

[48] Plans and issuers are required to provide contact information, including a telephone number and email address, for the appropriate person or office to initiate open negotiations. 26 CFR 54.9816-6T(d)(1)(v), 29 CFR 2590.716-6(d)(1)(v), and 45 CFR 149.140(d)(1)(v).

[49] For the definition of qualified IDR item or service, see 26 CFR 54.9816-8T(a)(2)(xii), 29 CFR 2590.716-8(a)(2)(xii), and 45 CFR 149.510(a)(2)(xii).

The Departments will continue to monitor whether and how the parties to a payment dispute interact during the open negotiation period and will consider whether additional guidance is needed.

Transparency in Coverage Machine-Readable Files

The Transparency in Coverage Final Rules (the TiC Final Rules) require non-grandfathered plans and issuers offering non-grandfathered coverage in the group and individual markets to disclose, on a public website, information regarding in-network rates for covered items and services, out-of-network allowed amounts and billed charges for covered items and services, and negotiated rates and historical net prices for covered prescription drugs in separate machine-readable files.[50]

The machine-readable file requirements of the TiC Final Rules are applicable for plan years (in the individual market, policy years) beginning on or after January 1, 2022. The Departments previously announced that they will defer enforcement of the requirements related to machine-readable files disclosing in-network and out-of-network data until July 1, 2022.[51] The Departments also previously announced that they will defer enforcement of the requirement that plans and issuers publish a machine-readable file related to prescription drugs while the Departments consider, through notice-and-comment rulemaking, whether this requirement remains appropriate.[52]

Additionally, the TiC Final Rules require plans and issuers to make price comparison information available to participants, beneficiaries, and enrollees through an internet-based self-service tool and in paper form, upon request.[53] This information must be available for plan years (in the individual market, policy years) beginning on or after January 1, 2023, with respect to the 500 items and services identified by the Departments in Table 1 in the preamble to the TiC Final Rules,[54] and with respect to all covered items and services, for plan or policy years beginning on or after January 1, 2024.[55]

Q22: May a group health plan that does not have its own website satisfy the requirements of the TiC Final Rules with respect to posting the machine-readable files on a public website, if the plan's service provider posts the machine-readable files on its public website on behalf of the group health plan?

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[50] 26 CFR 54.9815-2715A3; 29 CFR 2590.715-2715A3; and 45 CFR 147.212; 85 FR 72158 (Nov. 12, 2020).
[51] *See* FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49, Q2 (Aug. 20, 2021), available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf. For 2022 plan years and policy years beginning after July 1, 2022, plans and issuers should post the machine-readable files beginning in the month in which the plan year (in the individual market, policy year) begins, consistent with the applicability provision of the TiC Final Rules.
[52] *See* id. at Q1.
[53] 26 CFR 54.9815-2715A2(b); 29 CFR 2590.715-2715A2(b); and 45 CFR 147.211(b).
[54] 85 FR 72158, 72182 (Nov. 12, 2020).
[55] 26 CFR 54.9815-2715A2(c)(1); 29 CFR 2590.715-2715A2(c)(1); and 45 CFR 147.211(c)(1).

Yes. If a group health plan does not have its own public website, nothing in the TiC Final Rules requires the plan to create its own website for the purposes of providing a link to a location where the machine-readable files are publicly available. The Departments note this guidance applies in instances in which the plan sponsor (for example, the employer) maintains a public website, but the group health plan sponsored by the employer does not.

Instead, a plan may satisfy the requirements of 26 CFR 54.9815-2715A3(b), 29 CFR 2590.715-2715A3(b), and 45 CFR 147.212(b) by entering into a written agreement under which a service provider (such as a TPA) posts the machine-readable files on its public website on behalf of the plan.

To the extent a service provider posts the required information on its public website on behalf of a plan, the plan satisfies the requirements with respect to posting the information on a public website if the service provider makes the information available in the required manner, regardless of whether the group health plan has a public website.[56] In the case of aggregated Allowed Amounts files, however, the plan must post a link to the file hosted by the service provider on the plan's own website, if the plan maintains a public website, per the requirements of 26 CFR 54.9815-2715A3(b)(4)(iii), 29 CFR 2590.715-2715A3(b)(4)(iii), and 45 CFR 147.212(b)(4)(iii).

Notwithstanding the preceding paragraph, if a plan enters into an agreement under which a service provider agrees to post the machine-readable files on its public website on behalf of the plan, and the service provider fails to do so, the plan violates the disclosure requirements of 26 CFR 54.9815-2715A3(b), 29 CFR 2590.715-2715A3(b), and 45 CFR 147.212(b).

Q23: With regard to the internet-based self-service tool as required by the TiC Final Rules, will the list of codes for the 500 items and services required in the self-service tool for plan years (in the individual market, policy years) beginning on or after January 1, 2023 be updated when an item or service code is no longer valid?

The list of 500 items and services that must be included in the first phase of implementation of the internet-based self-service tool can be found on the TiC Website at www.cms.gov/healthplan-price-transparency/resources/500-items-services. The Departments will update this list quarterly to reflect the retirement of any codes that were included in Table 1 in the preamble to the TiC Final Rules list and will provide a reasonable period of time for plans and issuers to update their internet-based self-service tools to reflect the current codes. Plans and issuers should refer to this webpage for the most up-to-date list of codes to comply with the requirements regarding the self-service tool for plan years (in the individual market, policy years) beginning on or after January 1, 2023 and prior to January 1, 2024.

[56] 26 CFR 54.9815-2715A3(b)(4)(ii); 29 CFR 2590.715-2715A3(b)(4)(ii); and 45 CFR 147.212(b)(4)(ii).

APPENDICES:

Initial forms

Appendix I: Model Disclosure Notice Regarding Patient Protections Against Surprise Billing: for use by providers and facilities under section 2799B-3 of the PHS Act for disclosures during calendar year 2022, and for use by group health plans and health insurance issuers under section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act for disclosures with respect to plan years beginning on or after January 1, 2022, and before January 1, 2023

Available at: https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf (see "Version 1")

Appendix II: Standard Notice and Consent Documents Under the No Surprises Act: for use by nonparticipating providers and nonparticipating emergency facilities under section 2799B-2 of the PHS Act for items and services furnished during calendar year 2022 only

Available at: https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf (see "Version 1")

Revised forms

Appendix III: Model Disclosure Notice Regarding Patient Protections Against Surprise Billing: for use by providers and facilities under section 2799B-3 of the PHS Act for disclosures during calendar year 2022 and on or after January 1, 2023, and for use by group health plans and health insurance issuers under section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act for disclosures with respect to plan years beginning on or after January 1, 2022

Available at: https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf (see "Version 2")

Appendix IV: Standard Notice and Consent Documents Under the No Surprises Act: for use by nonparticipating providers and nonparticipating emergency facilities under section 2799B-2 of the PHS Act for items and services furnished during calendar year 2022 and on or after January 1, 2023

Available at: https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf (see "Version 2")

EXHIBIT 4

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

Avalere Health | 08.2.2022

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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

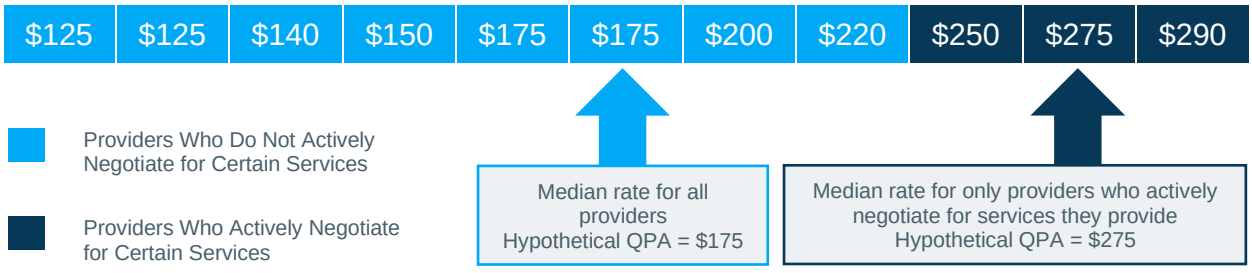
PCPs outnumber anesthesiologists, emergency physicians, and radiologists (Figure 1). The existence of PCP contract rates for services rarely or never provided may cause the QPA to reflect an inaccurate view of the rates commonly paid for in-network services. The inclusion of rates that are not actively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

EDPMA 25 YEARS

Data Analysis

Qualifying Payment Amounts and Health Plan Compliance Under the No Surprises Act

The Emergency Department Practice Management Association (EDPMA) is a trade association focused on the sustainable delivery of high-quality, cost-effective patient care in emergency departments. Our members deliver or directly support health care for approximately half of the 146 million patients that annually visit U.S. emergency departments.

The Study

EDPMA surveyed its membership to report on issues related to the implementation of the No Surprises Act (NSA) since January 1, 2022. Specifically, EDPMA analyzed the out-of-network allowed amounts commercial health plans reimbursed for services and whether the Qualified Payment Amount (QPA) was disclosed to the provider as required by law. EDPMA also reviewed members' experiences of the Independent Dispute Resolution (IDR) process. We then conducted a subsequent survey to compare out-of-network allowable amounts in 2021 prior to the NSA to 2022 allowable amounts, after the NSA was implemented. The surveys found nearly universal payer non-compliance with even basic statutory requirements, payer-calculated QPAs that were inconsistent with actual in-network payments, and a clear regulatory failure to effectively enforce the law. This is a high-level summary of initial findings; additional details are forthcoming.

The Numbers

14,500 claims from 35 States
Date range: January – May 2022
59 local, regional, and national practices
Antitrust Safe Harbor status maintained[1]

The Findings

Health Plans routinely fail to comply with the NSA's statutory and regulatory QPA disclosure requirements.

91% of claims surveyed did NOT include an identified QPA as specifically required by law. There is no known enforcement related to this pervasive health plan non-compliance.

Post-NSA Out-of-Network Payments decreased 92% of the time, compared to Pre-NSA. The average decrease is 32% per ER visit.

EDPMA studied 2021 out-of-network data in nine states. Allowed amounts for Level 4 and Level 5 claims (which make up most ED visits) decreased 92% of the time. Of these claims, there was a 32% decrease in reimbursement levels for clinically identical services pre-NSA. This abrupt and dramatic reduction significantly risks how EDs deliver emergency care. Emergency Departments are relied upon to deliver half of the care for the uninsured and 30% of the care to Medicaid patients.

[1] Redacted data must be at least 3 months old; at least 5 data contributors per published dataset; no group contributing more than 25% of a data set; raw data only reviewed by a third-party independent consultant.

EDPMA 25 YEARS

Data Analysis

Qualifying Payment Amounts and Health Plan Compliance Under the No Surprises Act

The Independent Dispute Resolution volumes are driven by artificially low QPAs, payer intransigence, failure of Open Negotiation, health plan termination of in-network agreements, and CMS' refusal to implement common-sense recommendations.

Certified IDR Entities are attempting to process disputes at a much higher volume than estimated. The balanced law passed by Congress was significantly skewed by the NSA regulations, resulting in dramatically lower payments and more out-of-network claims. The QPA survey results suggest artificially low QPA calculations that are not reflective of a market-based payment rate. This could be due to the regulations establishing the QPA calculation methodology or due to health plans improperly applying the QPA methodology. These unsustainably low initial payments have created significant and unanticipated volumes of IDR initiations. The Tri-Departments reported in the first five months that providers initiated five times more disputes than the government anticipated for a full year.[2][3] Significant delays in resolutions (up to 6 months) drive substantial negative cash flow for emergency physician groups and result in additional threats to patient access to care.

When reported, the QPA consistently equals the allowed amount for provider payments.

While the statute avoided setting an initial payment benchmark and instituted no requirement that the paid amount equal the QPA, results find that health plans are commonly paying at a rate that equals the QPA at least 93% of the time. This finding highlights that health plans are misapplying the presumed credibility of QPAs as a payment standard, despite evidence that they do not accurately reflect in-network rates when the NSA specifically avoided the inclusion of a benchmark payment standard.[4]

EMTALA is now minimally funded, jeopardizing the Emergency Department Safety Net.

Poorly written rules and inattentive regulators have emboldened commercial payers to slash both in-and-out-of-network reimbursement for emergency care. These decisions have begun to erode funding for patients' guaranteed access to emergency care under EMTALA. This unsustainable model now heavily relies on hospitals that are also in distress. Without intervention, HHS' implementation of the No Surprises Act threatens to cripple our healthcare safety net.

Emergency Department staffing is in jeopardy.

Since the No Surprises Act, emergency medical groups are expected to lose almost $1 billion annually. If the current NSA implementation goes unchecked, this model will cripple emergency departments, risking access to emergency care. Emergency departments serving rural and underrepresented communities are especially at risk.

The Solutions

To ensure a sustainable healthcare safety net, emergency physicians must be fairly compensated in a timely manner for services already delivered, especially if those services are required under the federal EMTALA law, which provides both a guaranteed network for health plans and a safety net for patients.

Congressional Involvement

Congress should ensure that the bipartisan No Surprises Act not only keeps patients out of the middle of payment disputes but is implemented as intended. This includes aligned implementation policies for health plans and providers, efficient and cost-effective dispute resolution, appropriate transparency, and effective enforcement processes. Congress' continued assistance and involvement is key to achieving the agreed-upon goals of this landmark legislation.

[2] https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/federal-independent-dispute-resolution-process-status-update.pdf
[3] https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf
[4] The allowed amounts for emergency medicine services range from a weighted average of 126% to 145% of 2022 Medicare rates. These levels represent cuts of at LEAST 25% - 65% from pre-NSA average out-of-network reimbursement levels for emergency medicine.

EDPMA 25 YEARS

Data Analysis

Qualifying Payment Amounts and Health Plan Compliance Under the No Surprises Act

Rapid and Effective Enforcement

The Tri-Departments must uphold the NSA statute and ensure that ALL eligible claims clearly disclose the required QPA. Non-compliance with this and other provisions must be quickly and effectively enforced. EDPMA calls on the Tri-Departments to immediately begin robust audits of the QPAs and correct health plan non-compliance issues, including failing to report the QPA, and provide stakeholders with transparency into enforcement processes and results in real-time.

Accurate QPAs

The Tri-Departments must ensure QPAs are calculated as intended by law to reflect the patient's out-of-network financial responsibility and not the provider's out-of-network reimbursement. Audits should examine not just the payer's strict adherence to the methodology developed by the Departments, but whether the methodology itself results in QPAs that deviate materially from the true median of in-network reimbursement. Audits should be made public as they are completed; to arbitrarily withhold audit results until an "end of year report" during the first crucial years of implementation would be a significant dereliction of regulatory responsibility.

Require RARC Codes

Without RARC information from health plans, emergency medicine physicians cannot effectively navigate resolution processes when they receive inadequate or inappropriate payments for clinical services. EDPMA calls on the Tri-Departments to immediately mandate, not just "strongly recommend," that the most specific available RARC codes be communicated by the health plans at the time of initial payment in the mandated ANSI 835 remittance advice sent to physicians and hospitals.

Clarify RARC Codes

NSA-specific RARC codes are rarely communicated. When a RARC specific to the NSA is communicated, N830 is used in 93% of claims. This code informs the provider that the claim was processed EITHER under the federal OR a state balance billing law. In states with a Specified State Law, this code does NOT identify ERISA/non-ERISA claims or other characteristics that could place the claim under federal or state jurisdiction. To reduce the volume of unnecessary IDR claims, the Tri-Departments must require health plans to use the most specific NSA RARC from the list CMS developed earlier this year and a clear ERISA identifier in the ANSI 835. By mandating the use of an ERISA identifier and the most specific available RARC codes, the Tri-Departments will expedite the IDR process and reduce the unintentional submission of ineligible claims.

EMTALA Must Now Be Funded

Since 1987, the federal law EMTALA has required hospitals to provide clinical care to all patients without regard for their ability to pay. This requirement is significant and applies to almost all emergency care provided in US hospitals. However beneficial, EMTALA was never funded. Now, with commercial reimbursement plummeting due to the manner of implementation of the NSA, the previous equilibrium is significantly disrupted. EMTALA-required care, stand-by costs, uninsured care, and underinsured care have no offset in a system that requires care for all patients without a corresponding requirement of fair reimbursement. We must now step up to ensure that the healthcare safety net is sustainable and that patients can reliably receive emergency medical care. Without solutions, the patients we serve will be at a very real risk.

Contact **Cathey Wise** 703-506-3282 cathey.wise@edpma.org edpma.org

EXHIBIT 7

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
200 Independence Avenue SW, Mail Stop 739H
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 8

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 9

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

January 19, 2023

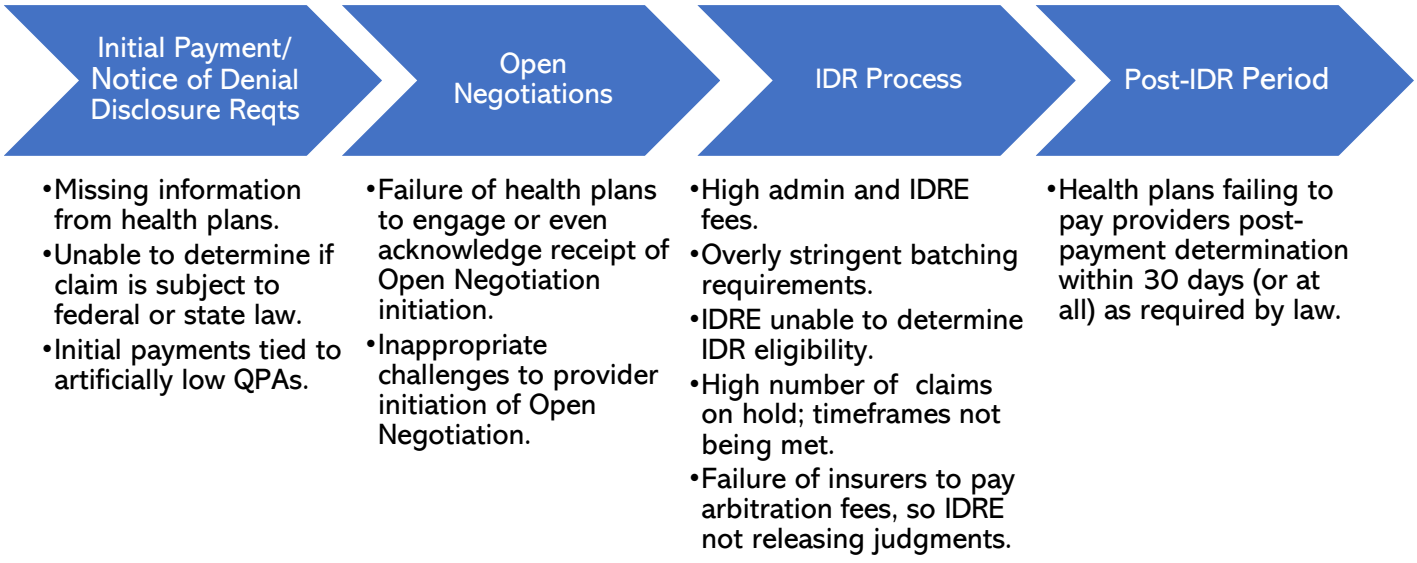
The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

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

Dear Secretaries Becerra, Walsh, and Yellen:

On behalf of our members, the American College of Emergency Physicians (ACEP) and the Emergency Department Practice Management Association (EDPMA) would like to thank the Departments of Health and Human Services (HHS), Labor, and Treasury (the Departments) for the opportunity to meet with members of their staff and other stakeholders on January 5, 2023 to discuss issues related to the implementation of the *No Surprises Act* and discuss potential solutions to the challenges our members are experiencing with the federal dispute resolution process. We found the discussion to be very productive, and we hope that we can continue to work collaboratively with the Departments and other stakeholders to find mutually beneficial ways to improve the process.

The figure below presents a high-level summary of the key issues that were discussed during the meeting.



As a follow-up, we are now providing additional input on some of these issues and more detailed recommendations for addressing them. ACEP and EDPMA's specific recommendations are broken out by the distinct phases of the dispute resolution process.

Before discussing our recommendations, we would like to first note that some of the difficulties with the process have been exacerbated by the unique aspects of how patient care billing works in emergency medicine. Despite the fact that these are universal realities in emergency care, we find they are often confused with the realities of scheduled, non-emergency care.

There is a great deal of variability in the amount of information that emergency medicine groups receive about an individual's insurance coverage at the time of treatment. Because of the dynamics and realities of acute, unscheduled patient care, emergency medicine providers often only receive limited information (or none at all) at the time they treat the patient in the emergency department (ED). This phenomenon is amplified by an important difference between scheduled care and emergency care due to the Emergency Medical Treatment & Labor Act (EMTALA). Emergency medicine groups do not collect billing or cost-sharing information prior to stabilizing the patient in accordance with the long-standing law, first enacted in the late 1980s.

In addition, in contrast to emergency care, insurance verification for pre-scheduled health care involves far more than the name of the insurance plan. With respect to scheduled health care, administrative staff not only verify first-level insurance information, but they also drill down to the patient's individual health plan type before the patient enters the exam room or treatment space. This type of information is critical and necessary not only for the payment process, but also for the federal dispute resolution process under the *No Surprises Act*. Administrative staff also pre-identify the correct co-pays, deductibles, and other pertinent benefit information, and, often, will require pre-payment of some or all patient-responsibility amounts, **all before health care is delivered**.

Emergency medicine practices, on the other hand, must wait until *after* the episode of care has occurred, and then wade through the morass of individual policy benefits, relying on costly and time-consuming administrative back-and-forth that may again involve the patient for more clarification (who often, will not know a sufficient level of detail, and must go back to the insurance plan, who *does* have the information). Therefore, requiring key information exchange between health insurers and providers proactively reduces administrative cost and keeps patients out of the middle.

The following table provides more detail and articulates a basis for ACEP and EDPMA's recommendations below, particularly around proactively communicating the health plan type and the *No Surprises Act* Remittance Advice Remark Codes (RARCs) and making accurate insurance information readily available to both providers and patients.

Step in the Emergency Encounter	Accompanying Data
1. A person presents to an emergency department (ED) believing they have an emergency medical condition (EMC). The hospital collects enough information from the patient so that care can be initiated. As mandated by the federal Emergency Medical Treatment and Labor Act (EMTALA) statute, a clinician performs a medical screening exam (MSE) – which may or may not include testing – to determine if an EMC exists.	Name, date of birth, allergies, etc. *This basic information is sufficient to initiate treatment, but insufficient for billing purposes.*

2. If the clinician reasonably believes an EMC exists, stabilizing treatment must be rendered to the patient. If the EMC can be stabilized and treated in the ED, the patient is discharged from the ED once that is complete (and, if necessary, any post-stabilization care will be addressed as appropriate). The hospital will collect more in-depth information from the patient prior to discharge from the ED.	Insurance coverage (if any), detailed contact information, demographics, employer, etc. *Note that patients often have outdated or inaccurate insurance cards or no information in hand at the time of their emergency, so emergency physician groups and billing companies may never have access to the patient's actual insurance card.* *In addition, certain health plan coverages in effect may not apply to this emergency (for example, auto insurance or workers' compensation is actually the payor for the claim). Due to EMTALA restrictions, the patient and the provider cannot definitively determine the health plan that is responsible for payment, the deductible amount, or co-insurance at the time care is rendered.*
3. If the patient requires further care to stabilize the EMC, the patient may be admitted to the hospital or transferred– in compliance with EMTALA mandates.	*Comprehensive billing information is gathered if the patient is admitted from the ED to the hospital but may <u>not</u> be gathered if the patient is transferred to another hospital (a higher level of care). These patients are often unstable. Financial discussions are inappropriate at the time of transfer; information must be obtained later.*
4. Following the patient's visit, the hospital shares patient information with the emergency physician group and/or billing company as part of a regular data transfer—usually daily.	*The physician group usually receives billing information routinely from the hospital, but its accuracy and thoroughness for ED patients is highly variable. This requires additional or more accurate data to supplement the initial data feed. Hospitals are subject to EMTALA and have the same limitations in their ability to gather data at the time of care as noted above.*
5. The physician group or billing company submits a claim to the patient's insurance company for the encounter.	*The physician group or billing company determines whether to submit a claim based on the best information available. The patient is re-contacted or directly billed if there is no information or if the information is inaccurate or incomplete.*
6. The insurance company responds to the physician or its billing group with an initial payment or denial, and an accompanying remittance.	*The health plan is responsible to remit timely payment under the* No Surprises Act*'s provisions. In order to do that, it must receive, evaluate, and process the claim, and remit timely payment. In doing so, it must also be able to identify the health plan type and other critical information. In service of reducing administrative burden, keeping patients out of the middle, reducing cost, and reducing reliance on IDR, EDPMA and ACEP strongly advocate for requiring and enforcing transparency and communication at the time of initial payment, including health plan type, RARCs, and claim adjustment reason codes (CARCs).*
7. If the patient's insurance coverage has a deductible that has not yet been met, the physician group or billing company sends a bill to the patient for their cost-sharing responsibility.	*Patient responsibility amounts are determined by the Qualifying Payment Amount (QPA) as set forth in the* No Surprises Act. *It is important that the QPA be identified (as required) at the time of initial payment.*

Overall, this process demonstrates how emergency care is substantially different due to EMTALA's requirements for provision of a medical assessment and stabilizing care without prior review of the patient's ability to pay (or health insurer's willingness to pay). As a result, the emergency care system has significant and unique dependency on payment and billing processes *after* care has been rendered.

With that context in mind, here are our additional recommendations related to the federal dispute resolution process:

Initial Payment and Notice of Denial Phase

Information Disclosures

As discussed in the meeting, in many cases, the provider does not receive all the information required to be disclosed by health insurers at the time of the initial payment or notice of denial. In some cases, the qualifying payment amount (QPA) for the item or service billed is not being clearly identified, and a certifying statement that affirms that the QPA was calculated properly and that it serves as the recognized amount for the purposes of calculating patient cost-sharing is missing. This lack of information makes it difficult for providers and eventually for certified IDR entities to determine whether a claim is eligible for the federal IDR process.

We have previously made recommendations about how to address the lack of information that providers are receiving from health insurers both during the initial payment and notice denial phase, and during the rest of the dispute resolution process. These recommendations were made with the intention of reducing the frequency on IDR, reducing administrative cost, and providing time- and cost-saving interventions early in the process. While our key recommendations are found below, we have also included a table in the ***Appendix*** that provides an overview of how our recommendations align with the major regulatory requirements of the dispute resolution process.

Recommendations

- **Mandate Plan Type Disclosure:** The Departments should require that the plan type be disclosed at the time of the initial payment or notice of denial, as this information is not available on a patient's insurance ID card (if that is even obtainable). Without knowing the type of plan early in the dispute resolution process, it will be extremely difficult for the provider to know whether the plan is a fully insured or self-insured plan, and whether it is therefore subject to the federal or state dispute resolution process.

- **Mandate Use of RARCs:** The Departments should require health insurer and issuer use of the Remittance Advice Remark Codes (RARCs) when providing the disclosures that regulation requires accompany the initial payment or notice of denial. Ensuring the use of the RARCs for all claims will also give providers the necessary information to assess patient responsibility amounts, keep patients out of the middle of the process, and reduce the need to initiate payment disputes for out-of-network services. Further, the RARCs will provide certified IDR entities with dispositive information about whether a particular claim is eligible for the federal IDR process.

QPAs and Initial Payments Being Artificially Low

During the January 5 meeting, ACEP and EDPMA emphasized some key points about the QPA and the initial payments:

- The QPA methodology finalized by the Departments is leading to artificially low QPAs that do not reflect market-rates. It was designed to limit cost-sharing liabilities and is not a market-based indicator of appropriate payment for an item or service.

- We are also hearing complaints that health insurers are miscalculating the QPA, leading to QPAs **even lower** than what proper adherence to the methodology would dictate. This combination of the QPA methodology *and* the miscalculations has led to QPAs that "don't even pass the laugh test"—those that are so low that they are even significantly below Medicare and Medicaid payment rates.

Recommendations

- **Increase Transparency Around Calculation of the QPA:** It is essential that the Departments require health insurers to disclose the methodology used to calculate the QPA for an out-of-network claim, so that providers are ensured it is calculated correctly and in line with the regulatory requirements. Currently, there is little to no recourse for providers who believe that the QPA is miscalculated. While they can submit a complaint, the initial payment they receive for that service is still, in most cases, based on an incorrectly calculated QPA. Currently, providers are restricted from requesting from health insurers specific information on how the QPA was calculated (i.e., to "check their math"), so requiring more transparency is the ONLY way to ensure that health insurers actually adhere to the methodology.

- **Scale up and Publicize Auditing of the QPA:** ACEP and EDPMA understand that the Departments have begun with their statutorily required audits of the QPA calculations. However, to enhance transparency, the Departments should scale up and publicly report on the results of these audits. That way, health insurers will be able to better understand the common mistakes that are being made when calculating the QPA and, hopefully, the number of miscalculations will decrease over time.

- **Modify the QPA Methodology to Ensure that the QPA Reflects Market Rates:** Our organizations have requested numerous modifications to the QPA methodology in previous comments. We continue to be especially concerned about the decision to use each contracted rate as a single data point when calculating a median contracted rate. The rate negotiated under a contract constitutes a single contracted rate regardless of the number of claims paid at that contracted rate**.** We request that the Departments base the rate on the total number of actual payments issued to individually contracted physicians. By basing the contract on claims rather than contracts, the QPA would more accurately reflect the actual negotiated rates between payors and providers. ***Health insurers should also be reminded that they are not required to tie the initial payment to the artificially low and potentially miscalculated QPA. The initial payment is supposed to represent a reasonable payment in full for the service that was delivered—and in many cases, the QPA, which was designed to keep patient cost-sharing low, does not reflect a reasonable payment.***

Open Negotiations Phase

There was ample discussion during the meeting about the lack of active negotiations during the Open Negotiations phase of the dispute resolution process. Our physician groups report that health insurers are sometimes not acknowledging receipt of the notice to initiate Open Negotiations and/or are not actively engaging in negotiations at any point during the 30-day period. The lack of engagement by health insurers to come to a resolution before

the IDR process is initiated is counter to the overall intent of the *No Surprises Act* to use the IDR process as a last resort-- and is a significant contributing factor toward the high number of disputes that advance to Federal IDR.

Some stakeholders did note that part of the reason why there may not be much engagement during this part of the dispute resolution process is the fact that both the statute and the regulations do not lay out a particular structure to Open Negotiations nor do they articulate any goals or parameters of the negotiations. Health insurers also reported that the notice of Open Negotiations was frequently going to the wrong contact person, so they had no way of tracking which claims had entered into the Open Negotiations Process.

Recommendation

- **Include the Open Negotiations Process in the IDR Portal:** The Departments should consider incorporating the Open Negotiations Process into the IDR portal. Doing so could help both health insurers and providers better track what claims are entering the dispute resolution process and when the 30-day Open Negotiations Process begins. There could also be a way to assign an identification number to specific items or services under dispute to better track them through the process. The updated portal could also clearly include the contact information, including the email addresses, for all the key contacts involved in the dispute. Finally, it would formalize the Open Negotiations Process and provide a more structured way for health insurers and providers to share information and try to resolve disputes before the IDR process. Therefore, it could track the level of engagement by both health insurers and providers and provide more data to the Departments about the level of compliance among the disputing parties to the statutory and regulatory requirements.

  If the Departments were to move in this direction, they must take the following into account:
  - *Administrative Complexity:* It is important that such a change is done in a manner that *reduces* administrative burden and does not create even more complexity.
  - *Terms of Open Negotiations NOT a Factor in the IDR Process:* If disputes go to the IDR phase of the dispute resolution process, the certified IDR entity should not be privy to the specific discussions that took place during Open Negotiations, including the amounts of any offers or counteroffers exchanged between the parties. The ONLY factor the certified IDR entity should take into account (or perhaps even be privy to) from Open Negotiations is the ***level of engagement*** of each party during that phase of the process.
  - *Batching Flexibility:* There are different rules around how claims can go through the Open Negotiations Process versus how they can be batched during the IDR process. If Open Negotiation is moved into the portal, we want to ensure that providers would continue to have the flexibility to decide how they want to batch certain claims at the beginning of the *IDR* process, rather than having to already make that decision at the start of Open Negotiations. Yet this could also offer providers an incentive and mechanism to enter some groups of claims into Open Negotiation organized according to the batching criteria, which could ease throughput pressure on certified IDR entities.

IDR Process and Beyond

Accessibility, Transparency, and Enforcement

Participants in the meeting discussed the results of the Department's first report on the IDR process that included data from the initial reporting period, April 15 to September 30, 2022. There was particular interest in understanding the geographic variation among the total number of initiated IDR claims and the number of claims determined to be ineligible for the IDR process—as most of the disputes were concentrated in a select few states.

Further, ACEP and EDPMA pointed out that the reason the majority of the initiating parties were large practice management companies, medical practices, or revenue management companies representing hundreds of individual groups was that many smaller groups simply did not have the resources or administrative capability to engage in the complex and administratively burdensome (and often fruitless) process. In fact, because of the high cost of the process and the fact that many IDR claims are currently on hold, some billing companies are instructing smaller groups not to use the process at all.

Finally, provider groups in the meeting noted the extremely concerning trend related to health insurers' failure to pay what they owe to the provider if a certified IDR entity finds in favor of the provider. ***Many health insurers are simply not paying the amount owed within the required 30-day period, if at all***, despite numerous attempts by providers to collect the payment they are entitled to under the terms of the arbitration. One group noted during the meeting that it has not received the amount owed to it in ***over 90 percent*** of the cases in which the certified IDR entity ruled in its favor (the eligibility rate and win rate was also over 90 percent, demonstrating a high level of reasonableness and good faith in utilizing the IDR process).

Recommendations

- **Reduce the IDR Fees in 2023:** The Departments should immediately rescind the significant increases in both the administrative fee and the fees that certified IDR entities can charge. These fees already create a financial barrier that prevents physician practices from participating, especially smaller and rural practices. These increases will further limit what types of claims go through the IDR process.

- **Make Enforcement and Auditing More Transparent:** The primary mechanism for addressing non-compliance with the *No Surprises Act* is on a case-by-case basis through the submission and resolution of individual complaints.

  We therefore recommend that the Departments release aggregated information about these cases, including:
  - The total number of cases
  - The total number of cases that are resolved
  - The total number of cases that are unresolved
  - The most common issues raised and how these issues were addressed
  - Best practices to avoid issues that are commonly leading to complaints

  This information should also be broken out by state to help provide more granular data and potentially answer some of the questions posed during the meeting about the possible reasons for geographic variation among IDR cases.

  Releasing all of this information will reduce the overall number of complaints and increase compliance of all *No Surprises Act* requirements. Further, analysis of these complaints could help determine which health insurers need to be audited. **Auditing is critical to ensuring that health insurers have an incentive to comply with the statutory and regulatory requirements.** The Departments should therefore publicly report auditing results, as well as best practices.

- **Enforce Required Payments:** Health insurers who are not paying what they owe to a provider after the IDR process is completed ***must be penalized and forced to compensate the provider the total amount owed plus interest.***

Batching Issues

During the meeting, multiple participants stated that the rules and requirements around batching are leading to significant confusion as well as an *increase* in the number of claims going through the IDR process (rather than the decrease batching was intended for). One of the major batching issues relates to "the same group health plan or health insurance issuer." This policy alone has created so much confusion that some providers are simply not even trying to batch self-insured claims. Further, these criteria require providers to know the employer of a product. This information is frankly not readily available to out-of-network providers, thus injecting a batching criterion that has thrown the entire system into disarray.

We believe that the statute was clear that all disputes (that otherwise met the batching requirements) from the same group health plan (or health insurance issuer) could be batched. The statute did *not* state that batching was limited to individual insurance products offered by a group health plan. Moreover, it is unworkable from the provider's perspective because in order for it to work, it relies on out-of-network providers organizing disputes based on information that they simply do not have.

Not having the plan type (as described earlier with regard to eligibility for IDR) also creates issues with batching, as providers do not know whether the health plan is a self-insured plan or the employer corresponding to the plan. Requiring health plans to provide the plan type at the time of the initial payment or notice of denial (one of our previous recommendations) would therefore also help reduce some of the errors in batching.

Having to put small batches through the IDR process has become even more concerning given the significant increase in IDR fees in 2023. Not only did the Departments announce a 40 percent increase to the maximum amounts that certified IDR entity fees could charge in 2023, but the Departments also just recently announced a 600 percent increase in the administrative (non-refundable) IDR fee that the Departments charge—from $50 to $350. With these increases, the financial burden of entering the IDR process will become even more cost-prohibitive for many physician groups who have limited infrastructure or resources. The high administrative fee of $350 specifically creates an artificial threshold for the IDR process—**a barrier that Congress explicitly omitted from the statute despite several proposals for thresholds offered along the way**. If claims are less than $350 and cannot be batched together to exceed this threshold, it is actually more expensive to enter the IDR process than to adjudicate a low payment to a claim, thereby limiting what types of claims can go through the IDR process, and unfairly providing insurers with further advantages in the process.

Recommendations

- **Modify Batching Rules to Have Fewer, Larger Batches Rather than More, Smaller Batches or Individual Disputes**: The Departments should take a careful look at all their batching requirements and ensure that they are 1) simple and easy to understand; and 2) do not require providers to have access to information that they do not have. This should at least include a modification to how batching is conducted for self-insured claims. In the alternative, the Departments must require that health insurers provide all information necessary to correctly batch claims in tandem with delivery of the initial payment.

Collection and Exchange of IDR Fees

Some stakeholders during the meeting raised the issue that it was difficult to transfer both the IDR administrative fee and the certified IDR entity fee to the certified IDR entity, as required. If the certified IDR entity does not receive the fees for both parties, the entity cannot render a decision—and this has contributed to some delays in the IDR process. One provider group said that certified IDR entities have different systems in place to electronically collect the fees (and noted that at the be process, one entity actually at one point had even required the use of PayPal to receive the fees).

Recommendation

- **Require Electronic Payment Uniformity Among Certified IDR Entities:** Certified IDR entities should have a uniform process in place to electronically collect all the IDR fees and refund the winning party the certified IDR entity fee. By creating a streamlined process of exchanging fees associated with the IDR process, there would be less interruptions to process and more adherence to the statutorily required timeframes.

Conclusion and Summary

We hope our letter sufficiently summarizes the major issues that providers are experiencing and provides more detail about the recommendations we discussed during the meeting. Overall, as stated throughout the letter, we recommend that the Departments ***immediately*** take the following steps:

Initial Payment and Notice of Denial Phase

- **Mandate Plan Type to Be Disclosed:** The Departments should require that the plan type be disclosed at the time of the initial payment or notice of denial.

- **Mandate Use of the RARCs:** The Departments should require health insurer use of the Remittance Advice Remark Codes (RARCs) when providing the disclosures that are required along with the initial payment or notice of denial

- **Increase Transparency around the Calculation of the QPA:** The Departments should require that health insurers demonstrate to providers that they are following the methodology outline in regulation and ensuring that QPAs are calculated correctly.

- **Scale up and Publicize Auditing of the QPA:** The Departments should scale up and publicly post the results of the ongoing QPA audits.

- **Modify the QPA methodology to ensure that the QPA reflects market-rates:** The Departments should modify the QPA methodology by basing the median contracted rate on the total number of actual payments issued to individually contracted physicians.

Open Negotiations Phase

- **Include the Open Negotiations Process in the IDR Portal:** The Departments should consider incorporating the Open Negotiations Process into the IDR portal. If the Department do pursue this

approach, there are a number of factors that ACEP and EDPMA believe the Departments must take into account when doing so.

IDR Process and Beyond

- **Reduce the IDR Fees in 2023:** The Departments should immediately rescind the significant increases in both the administrative fee and the fees that certified IDR entities can charge.

- **Make Enforcement and Auditing More Transparent:** The Departments should release information about the complaints they receive—broken out by state. Auditing is also critical to ensuring that health insurers have an incentive to comply with the statutory and regulatory requirements. The Departments should therefore publicly report auditing results, as well as best practices.

- **Enforce Required Payments:** Health insurers who are not paying what they owe to a provider after the IDR process is completed must be penalized and forced to compensate the provider the total amount owed plus interest.

- **Modify Batching Rules So That There Will be fewer LARGER Batches Rather Than More SMALLER Batches or Individual Disputes**: The Departments should take a careful look at all their batching requirements and ensure that they are 1) simple and easy to understand; and 2) do not require providers to have access to information that they do not have.

- **Require Electronic Payment Uniformity Among Certified IDR Entities:** Certified IDR entities should have a uniform process in place to collect all the IDR fees and refund the winning party the certified IDR entity fee.

We appreciate the opportunity to lay out our concerns and provide potential solutions to help improve the implementation of the *No Surprises Act*. If you have any questions, please contact Laura Wooster, ACEP's Senior Vice President of Advocacy and Practice Affairs at lwooster@acep.org, or Cathey Wise, EDPMA's Executive Director at cathey.wise@edpma.org.

Sincerely,

Christopher S. Kang, MD, FACEP
ACEP President

Don Powell, DO
Chair of the Board, EDPMA

Appendix: Information Needed for Federal Dispute Resolution Process

Major Regulatory Requirement	Regulatory Citation	Are Health Insurers Complying?	Recommendations
Disclosures Required at the time of the Initial Payment/Notice of Denial			
Qualified Payment Amount (QPA)	45 CFR § 149.140(d)(1)(i)	Rarely	• Mandate RARCs. • Publish audits of the QPA. • Require insurers to display the methodology used to calculate QPA. Information could include: ○ Number of contracts used to calculate the QPA; ○ Whether QPA was calculated using contracts with clinicians in same or similar specialty; ○ Geography used to calculate the QPA (i.e., Single MSA, all MSAs in a state, Census Division); ○ Percentage of total claims covered by contracts used to calculate QPA (in-network percentage); ○ Percentage of in-network claims attributable to each contract; ○ Whether plan or issuer's QPA calculations have had an audit result of anything other than "clean" within the last 3 years; ○ If the plan or issuer uses a standard fee schedule, the amount for the service as it

			appears on the fee schedule for the specific market; and ○ If plan or issuer uses contracts from a plan year other than January 31, 2019 to calculate the QPA.
Statement that the QPA is Calculated Accurately and Can be Used for Cost-Sharing: Statement certifying that, based on the determination of the plan or issuer: (1) the QPA applies for purposes of the recognized amount each QPA; and (2) the QPA shared with the provider or facility was determined in compliance with the methodology outlined in these interim final rules.	45 CFR § 149.140(d)(1)(iii)	Rarely	• Mandate RARCs. • Require health insurers to disclose the plan type.
Statement Regarding Initiation of Open Negotiations: A statement that if the provider wishes to initiate a 30-day open negotiation period for purposes of determining the amount of total payment, the provider may contact the appropriate person or office to initiate open negotiation, and that if the 30-day negotiation period does not result in a determination, generally, the provider or facility may initiate the independent dispute resolution process within 4 days after the end of the open negotiation period. The plan or issuer must provide contact	45 CFR § 149.140(d)(1)(iv); 45 CFR §149.140(d)(1)(v)	Rarely	• Better enforcement of this requirement. • Include contact information as an element in combined Open Negotiations and IDR Portal.

information, including a telephone number and email address, for the appropriate office or person to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service.			
Information about Contracted Rates not Based on FFS: Upon request of the provider, information about whether the QPA includes contracted rates that were not set on a fee-for-service basis.	45 CFR § 149.140(d)(2)(i)	Sometimes	• Better enforcement of this requirement.
Information about Cost-sharing Rates including Incentive Payments: Upon request, a statement that the plan's or issuer's contracted rates include risk-sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments for the items and services involved that were excluded for purposes of calculating the QPA.	45 CFR § 149.140(d)(2)(iv)	Sometimes	• Better enforcement of this requirement.
Downcoding: If the QPA is based on a downcoded service code or modifier: • a statement that the service code or modifier billed by the provider or facility was downcoded;	45 CFR § 149.140(d)(1)(ii)	Sometimes	• Better enforcement of this requirement.

• An explanation of why the claim was downcoded, including a description of which service codes or modifiers were altered, added, or removed, if any; and • The amount that would have been the QPA had the service code or modifier not been downcoded.			
Open Negotiations			
Notice to Initiate Open Negotiations: To initiate the open negotiation period, a party must send a notice to the other party (open negotiation notice) that includes information outlined in 45 CFR § 149.510(b)(1)(ii).	45 CFR § 149.510(b)(1)	Rarely acknowledging receipt of the Open Negotiations notice or actively engaged in negotiations.	• Consider combining the Open Negotiations and IDR Portal in order to make sure Open Negotiations Process can be better tracked and actually help facilitate negotiations prior to the IDR process.
IDR Process and Beyond			
Notice of IDR Initiation: To initiate the Federal IDR process, a party must submit a written notice of IDR initiation to the other party and to the Secretary, using the standard form developed by the Secretary, during the 4-business-day period beginning on the 31st	45 CFR § 149.510(b)(2)	Since health insurers rarely provide this information at the time of initial payment or notice of denial, it is difficult for initiating parties (providers) to include all the required information.	• Better enforcement of previous requirement for health insurers to provide certain disclosures at the time of the initial payment/notice of denial.

business day after the start of the open negotiation period. The notice must include information outlined in 45 CFR § 149.510(b)(2)(iii).			
Batched items and services: Batched items and services may be submitted and considered jointly as part of one payment determination by a certified IDR entity only if the batched items and services meet the requirements listed in 45 CFR § 149.510(c)(3)(i).	45 CFR § 149.510(c)(3)(i)	The batching rules are difficult to adhere to and result in more, not less, batches.	• Modify batching rules so that there will be fewer larger batches rather than more smaller batches or individual disputes.
IDR Offer: Not later than 10 business days after the selection of the certified IDR entity, the plan or issuer and the provider, facility, or provider of air ambulance services must each submit to the certified IDR entity: an offer of an out-of-network rate expressed as both a dollar amount and the corresponding percentage of the qualifying payment amount represented by that dollar amount; information requested by the certified IDR entity relating to the offer; and additional information listed in 45 CFR § 149.510(c)(4)(i)(3).	45 CFR § 149.510(c)(4)(i)	In many cases, the offer submitted by the health insurer is close to the initial payment, which mirrors the QPA. It is difficult for providers to develop a counteroffer when there is limited transparency over how the QPA is calculated.	• Remind health insurers that the initial payment does not need to be based on the QPA. • Publicize audits of the QPA. • Require more transparency over how the QPA is calculated.

Payment Determination and Notification: Not later than 30 business days after the selection of the certified IDR entity, the certified IDR entity must select as the out-of-network rate for the qualified IDR item or service one of the offers as the out-of-network rate.	45 CFR § 149.510(c)(4)(ii)	Certified IDR entities rarely meet this 30-business-day timeline for making a payment determination.	• Reduce the backlog of claims and enforce the 30-day requirement.
Written Decision: The certified IDR entity must explain its determination in a written decision submitted to the parties and the Secretary that includes specific information outlined in 45 CFR § 149.510(c)(4)(vi)(B).	45 CFR § 149.510(c)(4)(vi)	Certified IDR entities meet this requirement, but sometimes do not fully explain how they came to their decision.	• Better transparency around how certified IDR entities render their decisions.
Payment by Losing Party: If applicable, the amount of the offer selected by the certified IDR entity (less the sum of the initial payment and any cost sharing paid or owed by the participant or beneficiary) must be paid directly to the provider, facility, or provider of air ambulance services not later than 30 calendar days after the determination by the certified IDR entity.	45 CFR § 149.510(c)(4)(ix)	Insurers rarely pay within 30-day period in cases where certified IDREs select the provider's offer.	• Penalize health insurers not paying what they owe to a provider after the IDR process is completed. • Compel health insurers to compensate the provider the total amount owed plus interest.
Costs of IDR Process: Each party must pay the predetermined certified IDR entity fee charged by the certified IDR entity to the	45 CFR § 149.510(d)	Sometimes Certified IDREs do not receive the IDR fees from health insurers.	• Certified IDR entities should have a uniform process in place to collect all the IDR fees and refund the winning party the certified IDR entity fee.

certified IDR entity at the time the parties submit their offers. Each party must, at the time the certified IDR entity is selected, pay to the certified IDR entity a non-refundable administrative fee due to the Secretary for participating in the Federal IDR process.		The high IDR fees are making it cost-prohibitive for many physician groups to participate in the IDR process.	• The Departments should immediately rescind the significant increases in both the administrative fee and the fees that certified IDR entities can charge.
Extension of Time Periods for Extenuating Circumstances: The time periods for the IDR may be extended in extenuating circumstances at the Secretary's discretion if certain conditions, found in 45 CFR § 149.510(g)(1).	45 CFR § 149.510(g)	The timelines are being extended routinely even in the absence of a formal extension request.	• Reduce the backlog of claims. • Enforce timelines mandated by statute and regulation.

EXHIBIT 10

April 25, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
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

RE: ***Feedback on the Independent Dispute Resolution (IDR) Portal***

Dear Secretaries Becerra, Walsh, and Yellen:

On behalf of our members, the American College of Emergency Physicians (ACEP) and the Emergency Department Practice Management Association (EDPMA) would like to lay out some issues emergency physicians have had obtaining the required information from plans and issuers as articulated under the *Requirements Related to Surprise Billing; Part I Interim Final Rule* (First IFR).[1] All of the information listed in the regulation is absolutely necessary for providers in order to accurately assess the patient responsibility amounts, keep patients out of the middle of easily

[1] Requirements Related to Surprise Billing; Part I. 86 FR. 36898-36899 (July 13, 2021).

addressable issues, sustain clinical practices, and eventually resolve any payment disputes for out-of-network services with efficiency for all parties involved.

As background, ACEP is the national medical society representing emergency medicine. Through continuing education, research, public education and advocacy, ACEP advances emergency care on behalf of its 40,000 emergency physician members, and the nearly 150 million Americans we treat on an annual basis. EDPMA is the nation's largest professional physician trade association focused on the sustainable delivery of high-quality, cost-effective care in the emergency department (ED), and its members handle over half of the visits to U.S. emergency departments each year. Together, ACEP and EDPMA members provide a large majority of emergency care in our country, including rural and urban settings, in all fifty states and the District of Columbia.

Overview of Regulatory Requirement

In the First IFR implementing the *No Surprises Act*, the Departments require that "plans and issuers make certain disclosures with each initial payment or notice of denial of payment, and that plans and issuers must provide additional information upon request of the provider or facility. This information must be provided in writing, either on paper or electronically, to a nonparticipating provider, emergency facility, or provider of air ambulance services, as applicable, when the QPA serves as the recognized amount."[2]

These required disclosures, which are specifically found in the First IFR[3], include the following:

- First, a plan or issuer must provide the Qualifying Payment Amount (QPA) for each item or service involved.

- Second, a plan or issuer must provide a statement certifying that, based on the determination of the plan or issuer: (1) the QPA applies for purposes of the recognized amount (or, in the case of air ambulance services, for calculating the participant's, beneficiary's, or enrollee's cost sharing), and (2) each QPA shared with the provider or facility was determined in compliance with the methodology outlined in these interim final rules.
    - The First IFR also requires a statement from the plan or issuer that the QPA applies for purposes of the recognized amount so that providers and facilities will understand that the plan or issuer has determined that neither an All-Payer Model Agreement nor a specified state law applies for purposes of calculating a participant's, beneficiary's, or enrollee's cost-sharing liability, but rather that cost sharing liability has been calculated using the QPA. The Departments expect that in most if not all cases where the QPA serves as the basis for determining the recognized amount, the federal IDR process will govern any dispute over payment instead of a specified state law or process. Therefore, this notice will also serve to

[2] 86 FR. 36898 (July 13, 2021).
[3] 86 FR. 36898-36899 (July 13, 2021).

direct providers or facilities to the federal IDR process if the parties cannot agree on an out-of-network rate.

- Third, a plan or issuer must provide a statement that if the provider or facility, as applicable, wishes to initiate a 30-day open negotiation period for purposes of determining the amount of total payment, the provider or facility may contact the appropriate person or office to initiate open negotiation, and that if the 30-day open negotiation period does not result in a determination, generally, the provider or facility may initiate the IDR process within 4 days after the end of the open negotiation period. The plan or issuer must also provide contact information, including a telephone number and email address, for the appropriate office or person to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service.

- In addition, upon request of the provider or facility, a plan or issuer must provide, in a timely manner, information about whether the QPA includes contracted rates that were not set on a fee-for-service basis for the specific items and services at issue and whether the QPA for those items and services was determined using underlying fee schedule rates or a derived amount. If a related service code was used to determine the QPA for a new service code, a plan or issuer must provide information to identify which related service code was used. Similarly, if an eligible database was used to determine the QPA, a plan or issuer must provide information to identify which database was used to determine the QPA.

- Finally, if applicable upon request, a plan or issuer must provide a statement that the plan's or issuer's contracted rates include risk-sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments for the items and services involved that were excluded for purposes of calculating the QPA. Having information about whether the median contracted rate excludes these types of payment adjustments will better inform the open negotiation and IDR process.

Examples of Incomplete information

ACEP and EDPMA are extremely concerned that although these requirements have been very clearly spelled out for months in the First IFR, they are already not being met and therefore threaten the objectives of the *No Surprises Act.* As seen in the examples provided in Appendix 1, some issuers are not providing all the required information directly to providers with each initial payment or notice of denial of payment. Here are some overall issues our members are experiencing:

- **Issuers do not indicate that the QPA applies for purposes of the recognized amount**: As required by the *No Surprises Act*, when a state law or all-payer model does not apply, the cost-sharing amount for out-of-network services (called the "recognized amount"), should be based on the QPA. However, as seen from the Appendix 1 examples labelled "Unclear if patient responsibility tied to QPA," there is no statement or any other notification from the issuer that the QPA applies for purposes of the recognized amount. Since it is unclear whether the cost-sharing amount included in the remittance notice *is* the

recognized amount, our members are unable to verify whether that amount is accurate. **This lack of information can cause confusion for both providers and patients and can easily result in patients being billed the incorrect amount—which consequentially puts patients back in the middle of billing disputes.**

While the Centers for Medicare & Medicaid Services (CMS) recently released guidance for *No Surprises Act* Remittance Advice Remark Codes (RARCs) that would note that the cost-sharing amounts are calculated in concordance with the *No Surprises Act* requirements, the RARC codes are not mandatory and are not always being used. There are also RARC codes that identify whether the claim is subject to the federal process, but these also are not being included on remittance notices. The omission of the RARC codes is reflected in the Appendix 1 examples that are labelled "No Code (RARC) to notify claim is subject to the federal process**." Thus, without the RARC codes, and without a statement that the QPA applies for purposes of the recognized amount, it is also impossible to know whether the federal dispute resolution process applies to the claim instead of a specified state law or process.**

- **The QPA is NOT provided along with each initial payment or notice of denial.** The initial payment or denial, along with other information about the claim, are usually provided on an electronic remittance advice (ERA) or paper-based remittance notice. However, many issuers are not including the QPA on the ERA or paper-based remittance notice. We include such examples in Appendix 1 (labelled "No QPA"). Omission of the QPA from these remittance notices violates the regulatory requirement for the issuer to provide the QPA to the provider with each initial payment or notice of denial.

- **Most issuers are not providing contact information, including an email address, for the appropriate office or person with which to initiate open negotiations.** This information in many cases is not located on ERAs or paper-based remittance notices, and often cannot even be provided by issuers when our members contact them and specifically request it. Examples of missing contact information are included in Appendix 1 (labelled "No Email Contact for Initiation of Open Negotiation"). On the occasions that a phone number is at least included, without an email address, initiating open negotiation becomes administratively inefficient for all parties, adding costs to the system. Unlike a phone number, an email address also ensures a documented paper trail that will provide all parties with appropriate protection to demonstrate that the *No Surprises Act*'s many required timelines for open negotiation and the IDR process were adhered to.

Specific Requests

ACEP and EDPMA believe that the Departments should take the following actions to ensure that issuers are complying with the regulatory requirements around information sharing.

1. **Require Issuers to Include All Information in One Place: The Departments should require issuers to include all the required information listed in the First IFR in one place at the time of the initial payment or notice of denial—specifically in the ERAs or paper-based remittance notices.** Currently, there is no requirement for issuers to provide the information in a specific format or in a specific document. Creating and enforcing such a requirement may help address some of the issues we are experiencing and reduce administrative complexity.

2. **Require Information to Be Displayed in a Standardized Format:** In addition to requiring issuers to display all the information in one place**, the Departments should require the use of a standardized template in which to relay the information. The Departments could create such a standard template which includes all the required information in a clear and easily understood format.** Issuers then could then incorporate the standardized template into their ERAs or paper-based remittance notices to ensure that all required information is accurately transmitted to providers at the time of the initial payment or notice of denial.

3. **Require the use of the *No Surprises Act* RARCs**: As referenced above, CMS recently finalized new RARCs that are now optional for issuers to use to communicate information about claims to providers and facilities, subject to state law. **As part of the standardized template, the Departments should require the use of the RARCs.**

ACEP and EDPMA strongly believe that adopting these recommendations would help achieve many noteworthy goals that we both share: ensuring that patients are billed accurately and kept out of the middle of payment disputes; reducing administrative complexity and burden; and eliminating unnecessary costs in the health care system as both issuers and providers reduce the number of billing errors and the overall time it takes to properly review and adjudicate claims. Finally, having all the required information could help improve negotiations between the disputing parties, which potentially could help avoid having to rely on the IDR process to resolve disputes. We therefore respectfully request that the Departments duly and carefully consider our requests.

Lastly, ACEP and EDPMA would like to reiterate our previous request that the following information be made available in addition to the information already required to be disclosed by the First IFR:

- The type of plan that covers each claim and the dates that each plan has opted into and out of any state laws;
- The resolution pathway that each item or service lives under (i.e., "Specified State Law" or federal IDR process);
- The QPA(s) for the items and services *as billed by the provider* in cases where the initial payment or recognized amount is based off of a different service or level of service that the provider initially billed;

- The patient's copay, deductible, and coinsurance for each claim;
- Additional information that helps with the valuation of payment amounts should be routinely supplied in an easily accessible, machine-readable, downloadable format, including how the QPA(s) was calculated. Specific information includes:
    - The number of contracts used to calculate the QPA;
    - Whether the QPA was calculated using contracts with clinicians in the same or similar specialty;
    - The geography used to calculate the QPA (i.e., Single MSA, all MSAs in a state, Census Division);
    - Percentage of total claims covered by contracts used to calculate QPA (in-network percentage);
    - Percentage of in-network claims attributable to each contract;
    - Whether the plan or issuer's QPA calculations have had an audit result of anything other than "clean" within the last 3 years;
    - If the plan or issuer uses a standard fee schedule, the amount for the service as it appears on the fee schedule for the specific market; and,
    - If the plan or issuer uses contracts from a plan year other than January 31, 2019 to calculate the QPA.

By requiring issuers to provide this information in the initial response to the providers' claim—in addition to all the disclosures that the First IFR required—the Departments will facilitate clearer insight into how the QPA was calculated and reduce the potential for billing errors even further.

Thank you for the opportunity to provide our input on some of the issues our members are experiencing when it comes to receiving all the required information related to the QPA. If you have any questions, please contact Laura Wooster, ACEP's Senior Vice President of Advocacy and Practice Affairs at lwooster@acep.org, or Cathey Wise, EDPMA's Executive Director at cathey.wise@edpma.org.

Sincerely,

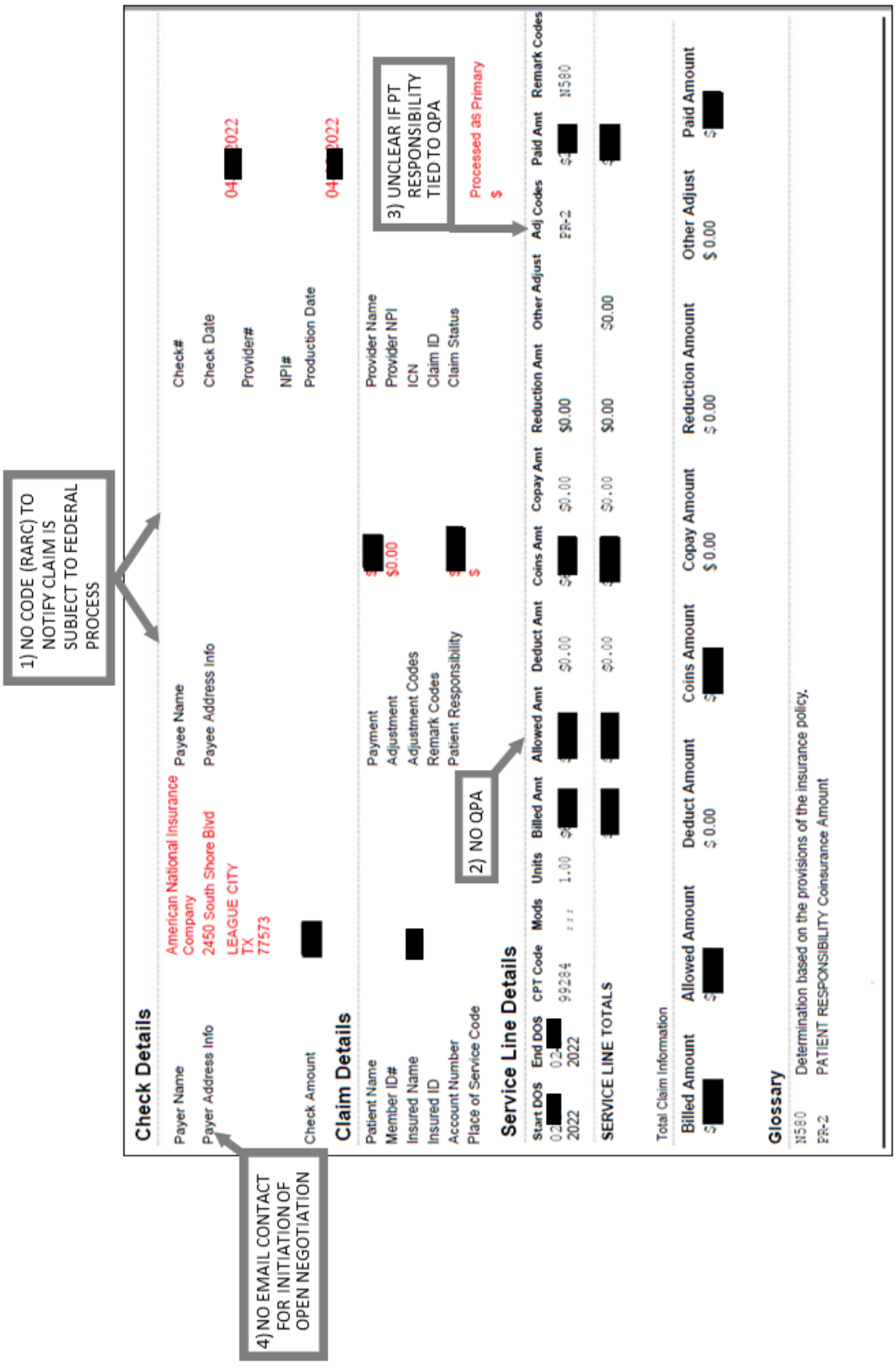
Gillian Schmitz, MD, FACEP

Gillian R. Schmitz, MD, FACEP
ACEP President

Don A Powell, DO

Don Powell, DO
Chair of the Board, EDPMA

Appendix 1


1) NO CODE (RARC) TO NOTIFY CLAIM IS SUBJECT TO FEDERAL PROCESS
4) NO EMAIL CONTACT FOR INITIATION OF OPEN NEGOTIATION
2) NO QPA
3) UNCLEAR IF PT RESPONSIBILITY TIED TO QPA
Check Details
Payer Name
American National Insurance Company
Payee Name
Check#
Payer Address Info
2450 South Shore Blvd
LEAGUE CITY
TX
77573
Payee Address Info
Check Date
Provider#
NPI#
Production Date
Check Amount
Claim Details
Patient Name
Member ID#
Insured Name
Insured ID
Account Number
Place of Service Code
Payment
Adjustment
Adjustment Codes
Remark Codes
Patient Responsibility
$0.00
Provider Name
Provider NPI
ICN
Claim ID
Claim Status
Processed as Primary
Service Line Details
Start DOS
End DOS
CPT Code
Mods
Units
Billed Amt
Allowed Amt
Deduct Amt
Coins Amt
Copay Amt
Reduction Amt
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Paid Amt
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$0.00
$0.00
PR-2
N580
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$0.00
$0.00
Total Claim Information
Billed Amount
Allowed Amount
Deduct Amount
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Coins Amount
Copay Amount
$ 0.00
Reduction Amount
$ 0.00
Other Adjust
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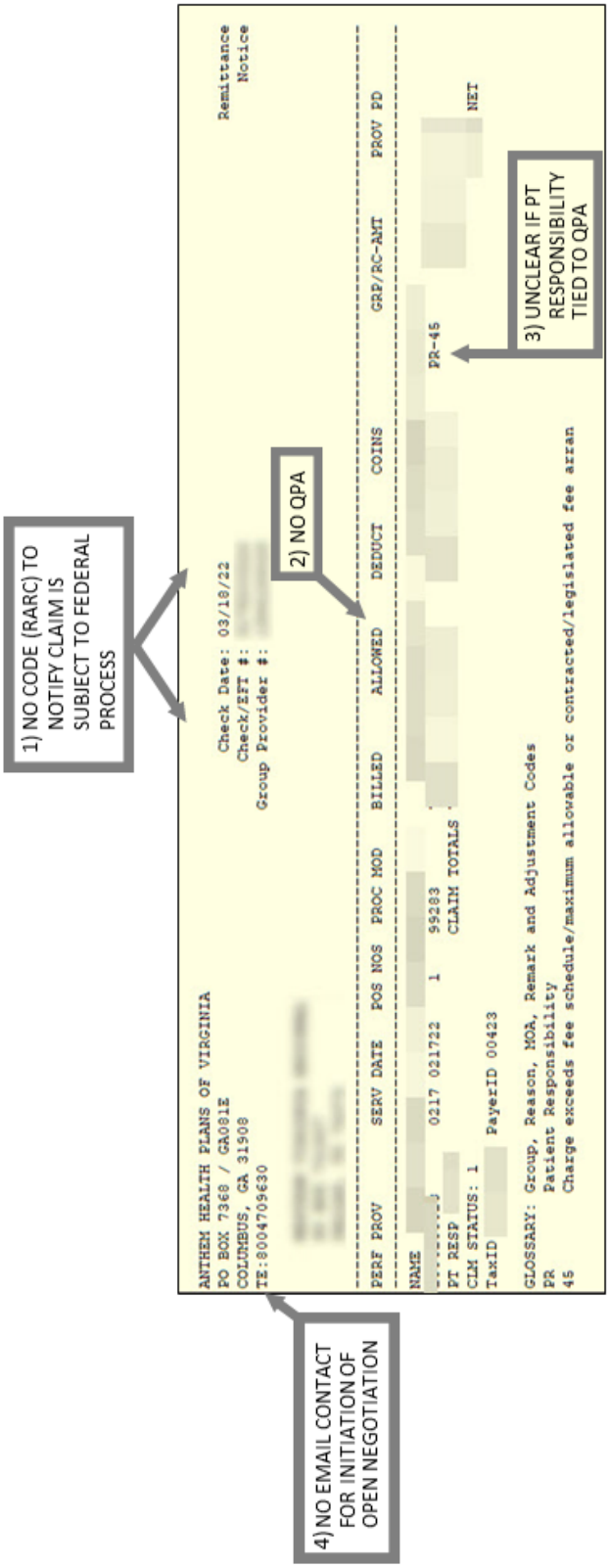
Paid Amount
Glossary
N580 Determination based on the provisions of the insurance policy.
PR-2 PATIENT RESPONSIBILITY Coinsurance Amount


1) NO CODE (RARC) TO NOTIFY CLAIM IS SUBJECT TO FEDERAL PROCESS
2) NO QPA
3) UNCLEAR IF PT RESPONSIBILITY TIED TO QPA
4) NO EMAIL CONTACT FOR INITIATION OF OPEN NEGOTIATION
ANTHEM HEALTH PLANS OF VIRGINIA
PO BOX 7368 / GA081E
COLUMBUS, GA 31908
TE:8004709630
Remittance Notice
Check Date: 03/18/22
Check/EFT #:
Group Provider #:
PERF PROV SERV DATE POS NOS PROC MOD BILLED ALLOWED DEDUCT COINS GRP/RC-AMT PROV PD
NAME
0217 021722 1 99283
CLAIM TOTALS
PR-45
PT RESP
CLM STATUS: 1
NET
TaxID PayerID 00423
GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes
PR Patient Responsibility
45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arran

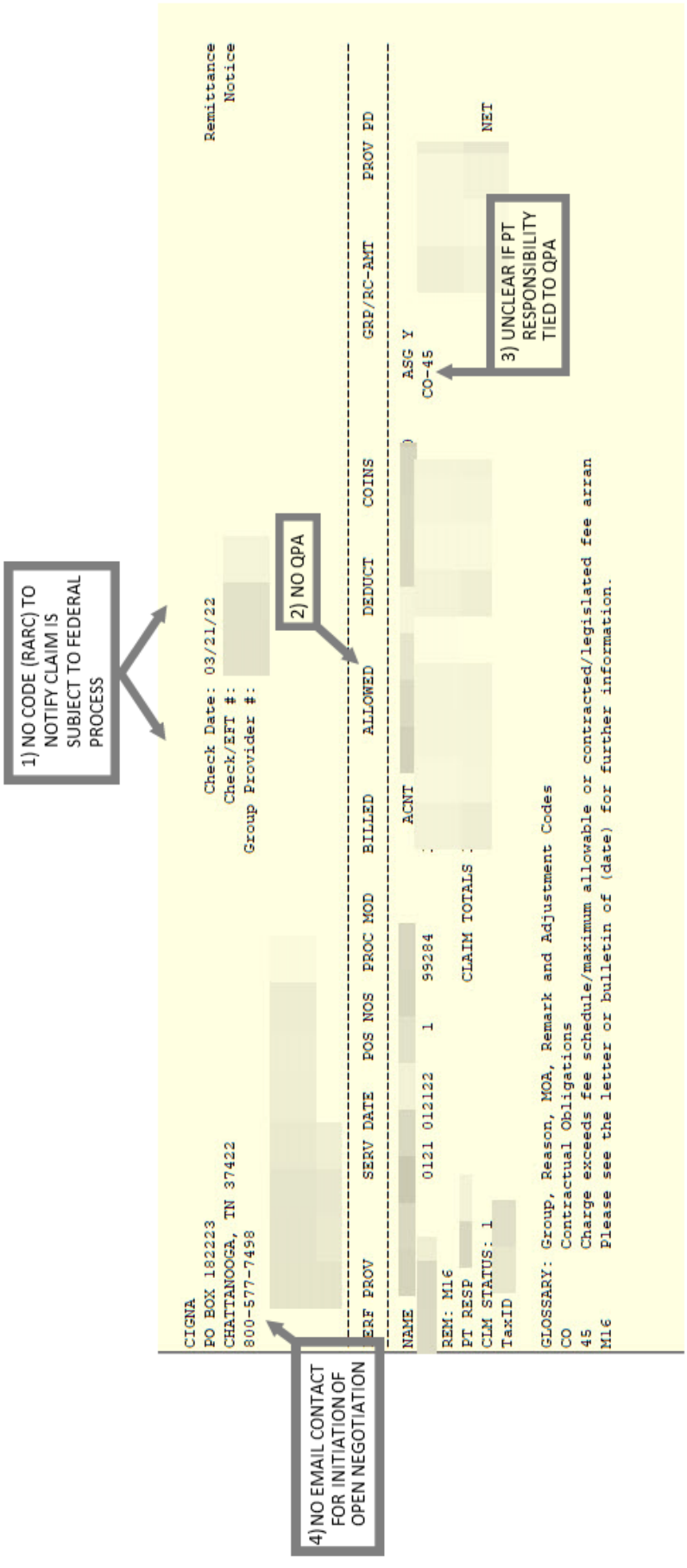

1) NO CODE (RARC) TO NOTIFY CLAIM IS SUBJECT TO FEDERAL PROCESS
2) NO QPA
3) UNCLEAR IF PT RESPONSIBILITY TIED TO QPA
4) NO EMAIL CONTACT FOR INITIATION OF OPEN NEGOTIATION
CIGNA
PO BOX 182223
CHATTANOOGA, TN 37422
800-577-7498
Remittance Notice
Check Date: 03/21/22
Check/EFT #:
Group Provider #:
ERF PROV SERV DATE POS NOS PROC MOD BILLED ALLOWED DEDUCT COINS GRP/RC-AMT PROV PD
NAME ACNT
0121 012122 1 99284
CLAIM TOTALS
REM: M16
PT RESP
CLM STATUS: 1
TaxID
ASG Y
CO-45
NET
GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes
CO Contractual Obligations
45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arran
M16 Please see the letter or bulletin of (date) for further information.

EXHIBIT 11

UNITEDHEALTH GROUP

UnitedHealth Group Reports 2022 Results

- ***Revenues of $324.2 Billion Grew 13% Year-Over-Year, with Double-Digit Growth at both Optum and UnitedHealthcare***
- ***Cash Flows from Operations were $26.2 Billion or 1.3x Net Income***
- ***Full Year and Fourth Quarter Net Earnings were $21.18 and $5.03 Per Share***
- ***Full Year and Fourth Quarter Adjusted Net Earnings were $22.19 and $5.34 Per Share***

MINNETONKA, Minn. (January 13, 2023) – UnitedHealth Group (NYSE: UNH) reported full year and fourth quarter 2022 results reflecting broad-based growth at Optum and UnitedHealthcare.

“We expect the efforts by the people of our company that led to strong performance in 2022 will define 2023 as well, especially delivering balanced growth enterprise-wide, improving support for consumers and care providers, and investing to make high-quality care simpler, more accessible and affordable for everyone,” said Andrew Witty, chief executive officer of UnitedHealth Group.

UnitedHealth Group affirmed the 2023 growth and performance objectives established at its November 29th Investor Conference, including revenues of $357 billion to $360 billion, net earnings of $23.15 to $23.65 per share, adjusted net earnings of $24.40 to $24.90 per share and cash flows from operations of $27 billion to $28 billion.

UNITEDHEALTH GROUP

Quarterly and Annual Financial Performance

	Three Months Ended			Year Ended	
	December 31, 2022	**December 31, 2021**	**September 30, 2022**	**December 31, 2022**	**December 31, 2021**
Revenues	$82.8 billion	$73.7 billion	$80.9 billion	$324.2 billion	$287.6 billion
Earnings from Operations	$6.9 billion	$5.5 billion	$7.5 billion	$28.4 billion	$24.0 billion
Net Margin	5.8%	5.5%	6.5%	6.2%	6.0%

- UnitedHealth Group's 2022 revenues grew $36.6 billion or 13% year-over-year to $324.2 billion with double digit growth at both Optum and UnitedHealthcare, driven primarily by serving more people and by serving them more comprehensively.

- Full year 2022 earnings from operations were $28.4 billion, an increase of 19%, with strong contributions from Optum and UnitedHealthcare. Earnings per share grew 17% compared to last year.

- The medical care ratio at 82.0% for full year 2022 and 82.8% for the fourth quarter was consistent with the company's recent Investor Conference outlook. Days claims payable were 49.9 in the fourth quarter compared to 46.8 a year ago and 50.8 in third quarter 2022. Favorable medical reserve development was $620 million in the quarter.

- The full year 2022 operating cost ratio of 14.7% compared to 14.8% in 2021, with ongoing productivity gains offset by business mix and continued investments in growth initiatives.

- Cash flows from operations for the full year were $26.2 billion or 1.3-times net income. During 2022, the company returned approximately $13 billion to shareholders through dividends and share repurchases. Return on equity of 27.2% in 2022 reflected the company's strong overall growth and efficient capital structure.

UnitedHealthcare

UnitedHealthcare provides health care benefits globally, serving individuals and employers, and Medicare and Medicaid beneficiaries. UnitedHealthcare is dedicated to improving the value customers and consumers receive by improving health and wellness, enhancing the quality of care received, simplifying the health care experience and reducing the total cost of care.

Quarterly and Annual Financial Performance

	Three Months Ended			Year Ended	
	December 31, 2022	**December 31, 2021**	**September 30, 2022**	**December 31, 2022**	**December 31, 2021**
Revenues	$63.0 billion	$56.4 billion	$62.0 billion	$249.7 billion	$222.9 billion
Earnings from Operations	$2.9 billion	$2.1 billion	$3.8 billion	$14.4 billion	$12.0 billion
Operating Margin	4.7%	3.8%	6.1%	5.8%	5.4%

- UnitedHealthcare full year revenues of $249.7 billion grew $26.8 billion or 12% year-over-year, reflecting growth in the number of people served.

- Full year operating earnings were $14.4 billion compared to $12.0 billion last year, reflecting growth in people served and continued strong medical and operating cost management.

- People served domestically by UnitedHealthcare grew by over 1.2 million in 2022, led by the company's community-based and senior offerings. The number of consumers served with domestic commercial benefit offerings grew by 275,000 over the past nine months.

Optum

Optum's health services businesses serve the global health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers. Using market-leading information, analytics and technology to yield clinical insights, Optum helps improve overall health system performance: optimizing care quality, reducing care costs and improving the consumer experience.

Quarterly and Annual Financial Performance

	Three Months Ended			Year Ended	
	December 31, 2022	**December 31, 2021**	**September 30, 2022**	**December 31, 2022**	**December 31, 2021**
Revenues	$47.9 billion	$41.1 billion	$46.6 billion	$182.8 billion	$155.6 billion
Earnings from Operations	$4.0 billion	$3.4 billion	$3.7 billion	$14.1 billion	$12.0 billion
Operating Margin	8.3%	8.3%	7.9%	7.7%	7.7%

- Optum full year revenues of $182.8 billion grew $27.2 billion or 17% year-over-year, led by Optum Health, and full year operating earnings increased to $14.1 billion compared to $12.0 billion last year.

- Optum Health revenue per consumer served increased by 29% in 2022, driven by growth in patients served under value-based arrangements; expansion of care delivery services, including in-home, clinic-based, ambulatory surgery, behavioral and digital; and overall increasing acuity levels of the care that can be offered.

- Optum Insight's revenue backlog increased by $7.6 billion in 2022 to $30 billion, driven by the addition of Change Healthcare and growth in comprehensive managed services. In order to speed improved system performance and experiences for patients and care providers, Optum Insight is advancing its investment initiatives.

- Optum Rx revenue growth of 9% in 2022 reflects continued expansion of its pharmacy care services, adding clinical value to medications, including specialty and community-based pharmacies. Adjusted scripts grew to 1.44 billion compared to 1.37 billion last year.

About UnitedHealth Group

UnitedHealth Group (NYSE: UNH) is a health care and well-being company with a mission to help people live healthier lives and help make the health system work better for everyone through two distinct and complementary businesses. Optum delivers care aided by technology and data, empowering people, partners and providers with the guidance and tools they need to achieve better health. UnitedHealthcare offers a full range of health benefits, enabling affordable coverage, simplifying the health care experience and delivering access to high-quality care. Visit UnitedHealth Group at www.unitedhealthgroup.com and follow @UnitedHealthGrp on Twitter.

Earnings Conference Call

As previously announced, UnitedHealth Group will discuss the company's results, strategy and future outlook on a conference call with investors at 8:45 a.m. Eastern Time today. UnitedHealth Group will host a live webcast of this conference call from the Investor Relations page of the company's website (www.unitedhealthgroup.com). Following the call, a webcast replay will be on the Investor Relations page and at https://uhg.com/Replay through January 27, 2023. This earnings release and the Form 8-K dated January 13, 2023, can also be accessed from the Investor Relations page of the company's website.

Non-GAAP Financial Information

This news release presents non-GAAP financial information provided as a complement to the results provided in accordance with accounting principles generally accepted in the United States of America ("GAAP"). A reconciliation of the non-GAAP financial information to the most directly comparable GAAP financial measure is provided in the accompanying tables found at the end of this release.

Forward-Looking Statements

The statements, estimates, projections, guidance or outlook contained in this document include "forward-looking" statements which are intended to take advantage of the "safe harbor" provisions of the federal securities law. The words "believe," "expect," "intend," "estimate," "anticipate," "forecast," "outlook," "plan," "project," "should" and similar expressions identify forward-looking statements. These statements may contain information about financial prospects, economic conditions and trends and involve risks and uncertainties. Actual results could differ materially from those that management expects, depending on the outcome of certain factors including: risks associated with public health crises, large-scale medical emergencies and pandemics; our ability to effectively estimate, price for and manage medical costs; new or changes in existing health care laws or regulations, or their

enforcement or application; the DOJ's legal action relating to the risk adjustment submission matter; our ability to maintain and achieve improvement in quality scores impacting revenue; reductions in revenue or delays to cash flows received under government programs; changes in Medicare, the CMS star ratings program or the application of risk adjustment data validation audits; failure to maintain effective and efficient information systems or if our technology products do not operate as intended; cyberattacks, other privacy/data security incidents, or our failure to comply with related regulations; failure to protect proprietary rights to our databases, software and related products; risks and uncertainties associated with our businesses providing pharmacy care services; competitive pressures, including our ability to develop and deliver innovative products to health care payers and expand access to virtual care; changes in or challenges to our public sector contract awards; failure to develop and maintain satisfactory relationships with health care payers, physicians, hospitals and other service providers; failure to attract, develop, retain, and manage the succession of key employees and executives; the impact of potential changes in tax laws and regulations (including any increase in the U.S. income tax rate applicable to corporations); failure to achieve targeted operating cost productivity improvements; increases in costs and other liabilities associated with litigation, government investigations, audits or reviews; failure to manage successfully our strategic alliances or complete or receive anticipated benefits of strategic transactions; fluctuations in foreign currency exchange rates; downgrades in our credit ratings; our investment portfolio performance; impairment of our goodwill and intangible assets; and our ability to obtain sufficient funds from our regulated subsidiaries or from external financings to fund our obligations, maintain our debt to total capital ratio at targeted levels, maintain our quarterly dividend payment cycle, or continue repurchasing shares of our common stock. This above list is not exhaustive. We discuss these matters, and certain risks that may affect our business operations, financial condition and results of operations more fully in our filings with the SEC, including our reports on Forms 10-K, 10-Q and 8-K. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify. Actual results may vary materially from expectations expressed or implied in this document or any of our prior communications. You should not place undue reliance on forward-looking statements, which speak only as of the date they are made. We do not undertake to update or revise any forward-looking statements, except as required by law.

# # #

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UNITEDHEALTH GROUP
Earnings Release Schedules and Supplementary Information
Year Ended December 31, 2022

- Condensed Consolidated Statements of Operations
- Condensed Consolidated Balance Sheets
- Condensed Consolidated Statements of Cash Flows
- Supplemental Financial Information - Businesses
- Supplemental Financial Information - Business Metrics
- Reconciliation of Non-GAAP Financial Measure

UNITEDHEALTH GROUP
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS
(in millions, except per share data)
(unaudited)

	Three Months Ended December 31,		Year Ended December 31,	
	2022	**2021**	**2022**	**2021**
Revenues				
Premiums	$64,700	$57,547	$257,157	$226,233
Products	9,398	8,961	37,424	34,437
Services	7,834	6,422	27,551	24,603
Investment and other income	855	813	2,030	2,324
Total revenues	82,787	73,743	324,162	287,597
Operating costs				
Medical costs	53,591	48,159	210,842	186,911
Operating costs	13,009	11,272	47,782	42,579
Cost of products sold	8,314	8,000	33,703	31,034
Depreciation and amortization	982	771	3,400	3,103
Total operating costs	75,896	68,202	295,727	263,627
Earnings from operations	6,891	5,541	28,435	23,970
Interest expense	(676)	(431)	(2,092)	(1,660)
Earnings before income taxes	6,215	5,110	26,343	22,310
Provision for income taxes	(1,307)	(919)	(5,704)	(4,578)
Net earnings	4,908	4,191	20,639	17,732
Earnings attributable to noncontrolling interests	(147)	(120)	(519)	(447)
Net earnings attributable to UnitedHealth Group common shareholders	$4,761	$4,071	$20,120	$17,285
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$5.03	$4.26	$21.18	$18.08
Adjusted earnings per share attributable to UnitedHealth Group common shareholders (a)	$5.34	$4.48	$22.19	$19.02
Diluted weighted-average common shares outstanding	947	955	950	956

(a) See page 6 for a reconciliation of the non-GAAP measure

UNITEDHEALTH GROUP
CONDENSED CONSOLIDATED BALANCE SHEETS
(in millions)
(unaudited)

	December 31, 2022	December 31, 2021
Assets		
Cash and short-term investments	$27,911	$23,907
Accounts receivable, net	17,681	14,216
Other current assets	23,477	23,635
Total current assets	69,069	61,758
Long-term investments	43,728	43,114
Other long-term assets	132,908	107,334
Total assets	$245,705	$212,206
Liabilities, redeemable noncontrolling interests and equity		
Medical costs payable	$29,056	$24,483
Short-term borrowings and current maturities of long-term debt	3,110	3,620
Other current liabilities	57,071	50,189
Total current liabilities	89,237	78,292
Long-term debt, less current maturities	54,513	42,383
Other long-term liabilities	15,608	15,052
Redeemable noncontrolling interests	4,897	1,434
Equity	81,450	75,045
Total liabilities, redeemable noncontrolling interests and equity	$245,705	$212,206

UNITEDHEALTH GROUP
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(in millions)
(unaudited)

	Year Ended December 31,	
	2022	**2021**
Operating Activities		
Net earnings	$20,639	$17,732
Noncash items:		
Depreciation and amortization	3,400	3,103
Deferred income taxes and other	(1,004)	(814)
Share-based compensation	925	800
Net changes in operating assets and liabilities	2,246	1,522
Cash flows from operating activities	26,206	22,343
Investing Activities		
Purchases of investments, net of sales and maturities	(6,837)	(1,843)
Purchases of property, equipment and capitalized software	(2,802)	(2,454)
Cash paid for acquisitions, net	(21,458)	(4,821)
Other, net	2,621	(1,254)
Cash flows used for investing activities	(28,476)	(10,372)
Financing Activities		
Common share repurchases	(7,000)	(5,000)
Dividends paid	(5,991)	(5,280)
Net change in short-term borrowings and long-term debt	12,536	2,481
Other, net	4,681	344
Cash flows from (used for) financing activities	4,226	(7,455)
Effect of exchange rate changes on cash and cash equivalents	34	(62)
Increase in cash and cash equivalents	1,990	4,454
Cash and cash equivalents, beginning of period	21,375	16,921
Cash and cash equivalents, end of period	$23,365	$21,375

UNITEDHEALTH GROUP
SUPPLEMENTAL FINANCIAL INFORMATION - BUSINESSES
(in millions, except percentages)
(unaudited)

	Three Months Ended December 31,		Year Ended December 31,	
	2022	**2021**	**2022**	**2021**
Revenues				
UnitedHealthcare	$63,046	$56,384	$249,741	$222,899
Optum	47,868	41,093	182,768	155,565
Eliminations	(28,127)	(23,734)	(108,347)	(90,867)
Total consolidated revenues	$82,787	$73,743	$324,162	$287,597
Earnings from Operations				
UnitedHealthcare	$2,932	$2,121	$14,379	$11,975
Optum (a)	3,959	3,420	14,056	11,995
Total consolidated earnings from operations	$6,891	$5,541	$28,435	$23,970
Operating Margin				
UnitedHealthcare	4.7%	3.8%	5.8%	5.4%
Optum	8.3%	8.3%	7.7%	7.7%
Consolidated operating margin	8.3%	7.5%	8.8%	8.3%
Revenues				
UnitedHealthcare Employer & Individual - Domestic	$16,281	$15,355	$63,599	$60,023
UnitedHealthcare Employer & Individual - Global	2,168	2,053	8,668	8,345
UnitedHealthcare Employer & Individual - Total	18,449	17,408	72,267	68,368
UnitedHealthcare Medicare & Retirement	28,051	24,843	113,671	100,552
UnitedHealthcare Community & State	16,546	14,133	63,803	53,979
Optum Health	$18,446	$14,550	$71,174	$54,065
Optum Insight	4,387	3,251	14,581	12,199
Optum Rx	25,854	23,849	99,773	91,314
Optum eliminations	(819)	(557)	(2,760)	(2,013)

(a) Earnings from operations for Optum for the three months and year ended December 31, 2022 included $1,692 and $6,032 for Optum Health; $895 and $3,588 for Optum Insight; and $1,372 and $4,436 for Optum Rx, respectively. Earnings from operations for Optum for the three months and year ended December 31, 2021 included $1,229 and $4,462 for Optum Health; $951 and $3,398 for Optum Insight; and $1,240 and $4,135 for Optum Rx, respectively.

UNITEDHEALTH GROUP
SUPPLEMENTAL FINANCIAL INFORMATION - BUSINESS METRICS

UNITEDHEALTHCARE CUSTOMER PROFILE
(in thousands)

People Served	December 31, 2022	September 30, 2022	December 31, 2021
Commercial - Domestic:			
Risk-based	8,045	8,055	7,985
Fee-based	18,640	18,500	18,595
Total Commercial - Domestic	26,685	26,555	26,580
Medicare Advantage	7,105	7,035	6,490
Medicaid	8,170	8,005	7,655
Medicare Supplement (Standardized)	4,375	4,370	4,395
Total Community and Senior	19,650	19,410	18,540
Total UnitedHealthcare - Domestic Medical	46,335	45,965	45,120
Commerical - Global	5,360	5,360	5,510
Total UnitedHealthcare - Medical	51,695	51,325	50,630
Supplemental Data			
Medicare Part D stand-alone	3,295	3,310	3,700

OPTUM PERFORMANCE METRICS

	December 31, 2022	September 30, 2022	December 31, 2021
Optum Health Consumers Served (in millions)	102	101	100
Optum Insight Contract Backlog (in billions)	$30.0	$24.1	$22.4
Optum Rx Quarterly Adjusted Scripts (in millions)	370	359	353

Note: UnitedHealth Group served 151 million unique individuals across all businesses at December 31, 2022.

UNITEDHEALTH GROUP
RECONCILIATION OF NON-GAAP FINANCIAL MEASURE
(in millions, except per share data)
(unaudited)

ADJUSTED NET EARNINGS PER SHARE[a]

	Three Months Ended December 31,		Year Ended December 31,		Projected Year Ended December 31,
	2022	2021	2022	2021	2023
GAAP net earnings attributable to UnitedHealth Group common shareholders	$4,761	$4,071	$20,120	$17,285	$21,700 - $22,300
Intangible amortization	396	280	1,292	1,184	~1,540
Tax effect of intangible amortization	(98)	(68)	(331)	(288)	~(380)
Adjusted net earnings attributable to UnitedHealth Group common shareholders	$5,059	$4,283	$21,081	$18,181	$22,850 - $23,450
GAAP diluted earnings per share	$5.03	$4.26	$21.18	$18.08	$23.15 - $23.65
Intangible amortization per share	0.42	0.29	1.36	1.24	~1.65
Tax effect per share of intangible amortization	(0.11)	(0.07)	(0.35)	(0.30)	~(0.40)
Adjusted diluted earnings per share	$5.34	$4.48	$22.19	$19.02	$24.40 - $24.90

(a) Adjusted net earnings per share is a non-GAAP financial measure. Non-GAAP financial measures should be considered in addition to, but not as a substitute for, or superior to, financial measures prepared in accordance with GAAP.

Adjusted net earnings per share excludes from the relevant GAAP metric, as applicable, intangible amortization and other items, if any, that do not relate to the Company's underlying business performance. Management believes that the use of adjusted net earnings per share provides investors and management useful information about the earnings impact of acquisition-related intangible asset amortization. As amortization fluctuates based on the size and timing of the Company's acquisition activity, management believes this exclusion provides a more useful comparison of the Company's underlying business performance and trends from period to period. While intangible assets contribute to the Company's revenue generation, the intangible amortization is not directly related. Therefore, the related revenues are included in adjusted earnings per share.

EXHIBIT 12

CMA Surprise Billing Survey Results

Physicians Decry Unintended Consequences of California's Surprise Billing Laws

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

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

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

Summary of the Survey Results

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

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

FOR SPECIFIC PHYSICIAN STORIES AND COMMENTS, SEE APPENDIX 1.

Background: California Surprise Billing Law

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

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

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

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

California Physician Survey Results

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

SURVEY OVERVIEW

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

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

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

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

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

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

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

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

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

Appendix 1

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

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

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

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

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

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

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

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

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

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

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

STAFF CONTACT:
Anthony York
Vice President of Strategic Communications
(916) 551-2860
ayork@cmadocs.org

EXHIBIT 13

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 14

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 15

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.

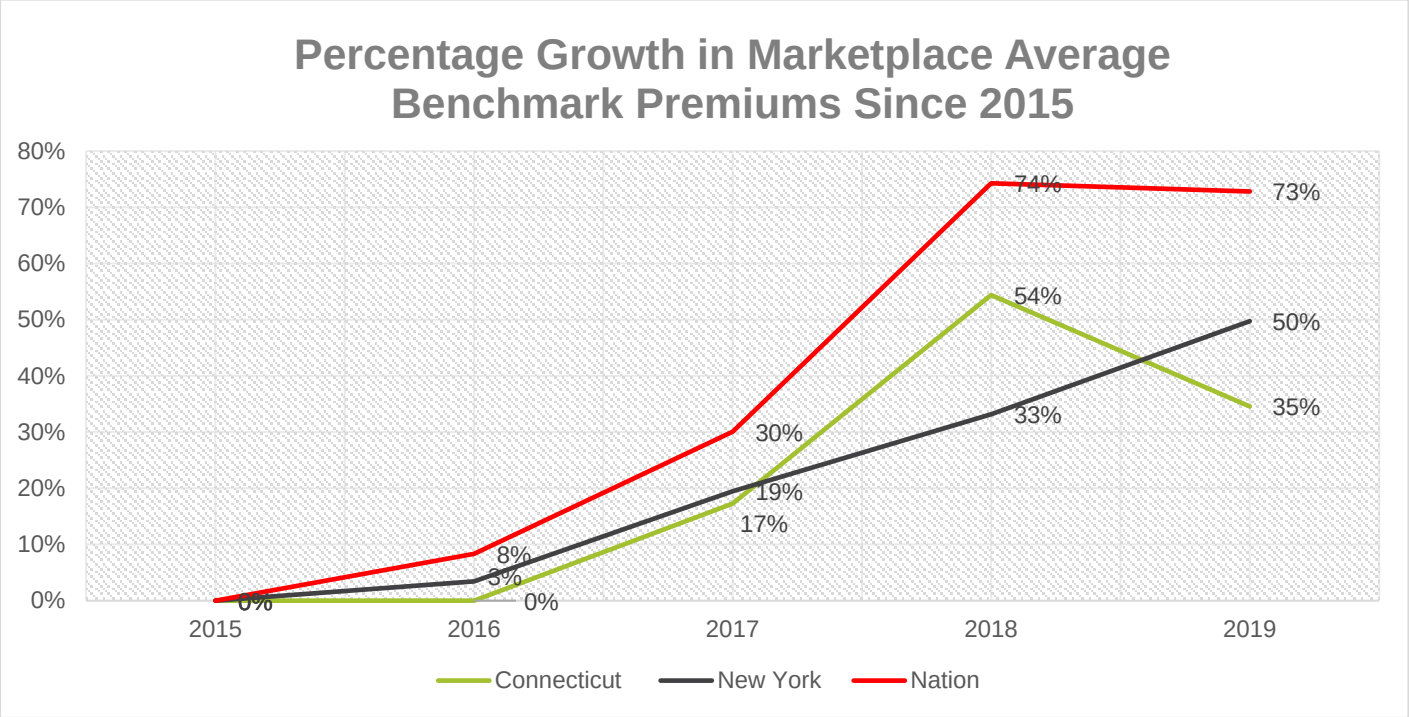
Sincerely,

Greg Lipson

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

cc: Arizona Network Management
Arizona Medical Management

EXHIBIT 16



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