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

TEXAS MEDICAL ASSOCIATION, et al.,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

Civil Action No.: 6:22-cv-00450-JDK

Lead Consolidated Case

BRIEF OF AMERICAN SOCIETY OF ANESTHESIOLOGISTS, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, AND AMERICAN COLLEGE OF RADIOLOGY, AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS' MOTIONS FOR SUMMARY JUDGMENT

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INTERESTS OF AMICI CURIAE

The American Society of Anesthesiologists ("ASA"), the American College of Emergency Physicians ("ACEP"), and the American College of Radiology ("ACR") (collectively, "*Amici*") are voluntary, national professional associations that advocate for the interests of their respective members, including on matters concerning adequate and fair reimbursement for physician services provided out-of-network. ASA is a professional association comprised of approximately 56,000 physician anesthesiologists and others involved in the medical specialty of anesthesiology, critical care, and pain medicine. ACEP is a professional association comprised of more than 40,000 emergency physicians, residents, and medical students. ACR is a professional association comprised of approximately 40,000 diagnostic radiologists, radiation oncologists, interventional radiologists, nuclear medicine physicians, and medical physicists. *Amici* submit this brief on behalf of their members who provide items and services that are impacted by the No Surprises Act ("NSA").

INTRODUCTION

Amici support Plaintiffs' motions for summary judgment, ECF Nos. 25-26, to declare unlawful and vacate specific provisions of the interim final rules ("July 2021 IFR") jointly published by the United States Department of Health and Human Services ("HHS"), the United States Department of Labor, the United States Department of the Treasury, and the United States Office of Personnel Management (collectively, "Departments") implementing the NSA, Pub. L. No. 116-260, div. BB, tit. I, 134 Stat. 2757-890 (2020). Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36,872 (July 13, 2021). *Amici* submit this brief to explain to the Court how the July 2021 IFR improperly calculates the qualifying payment amount ("QPA") and unlawfully empowers insurers to dictate both in-network and out-of-network rates for physician services, which will force many physician practices to consolidate and will harm patient care by

narrowing provider networks, particularly in underserved communities.

The NSA addresses two interrelated problems with the private health insurance market: 1) insurers demand unreasonably low payment rates as a condition of physicians participating in their networks, thus forcing many physicians to stay out-of-network to remain economically viable; and 2) patients who unknowingly receive certain care from out-of-network providers are responsible for amounts not paid by their insurance companies, which is known as "surprise billing." NSA, Pub. L. No. 116-260, div. BB, tit. I, 134 Stat. 2757-890 (2020) (codified at 42 U.S.C. §§ 300gg-111, 300gg-131 to 132; 29 U.S.C. § 1185e; 26 U.S.C. § 9816).[1] *Amici* support Congress's reforms, which, if properly implemented, will ensure fair reimbursement to providers and facilities and reasonable cost sharing by patients.

Unfortunately, the Departments have turned these reforms upside down and transformed an act intended to protect patients and their doctors into a giveaway to private insurers that will harm patients and providers. The Departments flout Congress's carefully crafted calculation for determining the QPA by improperly (1) establishing each contracted rate as a single data point, instead of appropriately weighting rates within contracts based on the number of claims paid at the rate under each contract, (2) excluding incentive-based and retrospective payments to providers, (3) including rates for providers in different specialties, thus allowing for the inclusion of "ghost rates"—contracted rates for services not provided by the contracting healthcare provider, and (4) allowing third-party administrators to determine the QPA based on contracted rates recognized by all self-insured group health plans administered by the third-party

[1] The NSA enacted materially identical amendments to the Public Health Service Act ("PHS"), 42 U.S.C. § 300gg-111(c), the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1185e(c), and the Internal Revenue Code ("IRC"), 26 U.S.C. § 9816(c). To avoid triplicate citations, this brief cites to the PHS provisions of the NSA.

administrator. The July 2021 IFR's manipulated methodology for calculating the QPA results in a deflated QPA that does not reflect the true market value of services. The July 2021 IFR QPA calculation—coupled with the Departments' August 26, 2022 final rule ("August Final Rule"), which unlawfully slants independent dispute resolution ("IDR") decisions toward the QPA—drives down payments for the out-of-network services of *Amici's* members, incentivizing insurers to lower in-network rates, which, in turn, will reduce out-of-network rates. The inevitable result will be narrower provider networks and consolidation of physician practices, which will lead to fewer services in rural and other underserved communities. For these reasons, and the reasons stated in Plaintiffs' summary judgment briefs, the Court should invalidate the provisions of the July 2021 IFR that unlawfully miscalculate the QPA.

BACKGROUND

Amici refer the Court to Plaintiffs' thorough descriptions of the NSA and the Departments' implementing regulations and provide a brief summary here. *See generally* Pl.'s Mot. Summ. J. and Supp. Mem. 2-14, *Texas Med. Ass'n v. HHS*, No. 6:22-cv-00450 (E.D. Tex. Jan. 17, 2023), ECF No. 25.

I. The No Surprises Act

The NSA establishes protections for participants, beneficiaries, and enrollees (collectively, "patients") in group health plans and group and individual health insurance coverage (collectively, "insurers") from surprise billing when patients receive (1) emergency services provided by an out-of-network provider or out-of-network emergency facility, or (2) non-emergency services from an out-of-network provider furnished during a visit at an in-network health care facility. 42 U.S.C. §§ 300gg-111, 300gg-131 to 132. The NSA also creates a framework for determining fair payment for the provision of certain out-of-network items and services. 42 U.S.C. § 300gg-111(c). The NSA mandates that insurers reimburse out-of-network

providers at an "out-of-network rate," minus the cost-sharing requirements of the patients. *Id.* § 300gg-111(a)(1)(C)(iv)(II), (b)(1)(D).[2] If the provider disagrees with the insurer's initial payment determination, the provider can initiate a 30-day open negotiation with the insurer to determine the amount of payment for the out-of-network item or service. *Id.* § 300gg-111(a)(1)(C)(iv)(I), (a)(3)(K)(ii), (c)(1)(A). If the parties cannot agree on the amount for the out-of-network item or service, either party may initiate an IDR process. *Id.* § 300gg-111(c)(1)(B).

The NSA establishes an IDR process, which requires an independent arbitrator—referred to as the IDR entity—to determine appropriate payment amounts for out-of-network health care items and services. *Id.* § 300gg-111(c)(5). Congress delineated factors that the IDR entity "shall consider" when identifying the appropriate payment amount: 1) the QPA for the item or service; and 2) "information on any circumstance described in clause (ii), such information as requested [by the IDR entity relating to the party's offer], and any additional information [submitted by a party relating to such offer of either party]." *Id.* § 300gg-111(c)(5)(C)(I)–(II). In "clause (ii)," Congress identified five additional factors that the IDR entity "shall consider."[3]

Congress carefully established the methodology for calculating the QPA to ensure that the QPA "is a market-based price" and "reflects negotiations between providers and insurers in a local health care market." H.R. REP. NO. 116-615, pt. 1, at 57 (2020). Congress defined the QPA for an item or service furnished during 2022 as:

> [T]he median of the contracted rates recognized by the plan or issuer, respectively (*determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same insurance market* …) as the *total maximum payment* (including the cost-sharing amount imposed for such item

[2] This process for determining the "out-of-network rate" does not apply if there is an applicable All-Payer Model Agreement under section 1115A of the Social Security Act, or if no such agreement exists, a "specified state law." *Id.* § 300gg-111(a)(3)(K)(iii).

[3] Congress also specified other factors that the IDR entity "shall not consider." *Id.* § 300gg-111(c)(5)(D).

> or service and the amount to be paid by the plan or issuer, respectively) *under such plans or coverage*, respectively, on January 31, 2019, 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 adjusted by inflation].

42 U.S.C. § 300gg-111(a)(3)(E)(i)(I) (emphasis added).

II. Departments' Interim Final Rules and Guidance on the Calculation of the QPA

On July 13, 2021, the Departments published interim final rules implementing certain provisions of the NSA, including the methodology for calculating the QPA.[4] 86 Fed. Reg. 36,872. In general, to calculate the QPA for items or services furnished in 2022 or later, an insurer must increase the "median contracted rate" for "the same or similar item or service under such plans or coverage, respectively, on January 31, 2019" adjusted for inflation. 45 C.F.R. § 149.140(c)(1)(i)–(ii).[5]

The "median contracted rate" for an item or service is determined by "arranging in order from least to greatest the contracted rates of all group health plans of the plan sponsor … or all group or individual health insurance coverage offered by the issuer in the same insurance market for the same or similar item or service" that is provided in the geographic region in which the service is furnished by a provider in the same or similar specialty and selecting the middle number. *Id*. § 149.140(b)(1). In general, the amount negotiated under each contract is treated as a separate amount in calculating the median contracted rate. 86 Fed. Reg. at 39,676.[6]

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[4] The Departments established a specific QPA methodology for anesthesia services. *Id*. § 149.140(c)(1). The aspects of the QPA calculation at issue in this case also apply to the methodology for determining the QPA for anesthesia services. The July 2021 IFR also establishes a methodology for calculating the QPA for air ambulance services, which is not addressed in this brief. 86 Fed. Reg. at 36,965-66.

[5] The Departments have stated that providers and IDR entities are not responsible for verifying a QPA's accuracy, but the Departments have failed to audit insurers' QPA calculation methodologies.

[6] "A single case agreement, letter of agreement, or other similar arrangement" between a

The contracted rate is defined as the total amount (including cost sharing) that an insurer "has contractually agreed to pay a participating" provider/facility for covered items and services, whether directly or indirectly. 45 C.F.R. § 149.140(a)(1). To calculate the median contracted rate, each contracted rate for an item or service is "treated as a single data point … regardless of the number of claims paid at that contracted rate." 86 Fed. Reg. at 36,889. Under the Departments' definition of "contracted rates," rates within a large contract with thousands of claims would be weighted the same as rates within a small contract with just a few claims.

Under certain circumstances, "payers and providers may agree to certain incentive payments during the contracting process," and "providers' payments may be reconciled retrospectively to account for utilization, value adjustments, or other weighting factors that can affect the final payment to a provider." *Id.* at 36,894. However, the July 2021 IFR directs insurers to exclude risk sharing, bonus, or penalty, and other incentive-based and retrospective payments or adjustments in the calculation of the median contracted rate. *Id*.

The July 2021 IFR also creates an exception to the NSA's directive to calculate the QPA based on the median of the contracted rates for the same or a similar item or service that is "provided by a provider in the same or similar specialty." 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I). Under the July 2021 IFR, a "[p]rovider in the same or similar specialty means the practice specialty of a provider, as identified by the plan or issuer consistent with the plan's or issuer's usual business practice." 45 C.F.R. § 149.140(a)(12). The July 2021 IFR asserts that insurers "should be required to calculate median contracted rates separately by provider specialty *only* where the plan or issuer otherwise varies its contracted rates based on provider specialty." 86

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provider/facility and an insurer to supplement the network of the plan or coverage for a specific patient in unique circumstances does not constitute a contract. 45 C.F.R. § 149.140(a)(1).

Fed. Reg. at 36,891 (emphasis added).

This methodology allows for the inclusion of "ghost rates" into the calculation of the QPA. Under this practice, which was illuminated by an August 2022 study jointly commissioned by *Amici*, insurers are including rates for certain specialty services in the contracts of different specialists who rarely or never bill for the service. Avalere Health, *PCP Contracting Practices and Qualified Payment Amount Calculation Under the No Surprises Act* (Aug. 2, 2020).[7] Because these specialists rarely or never bill for the service, they often do not negotiate the out-of-specialty rate in their contracts; instead, they simply accept the low rate offered by the insurer. Because the Departments do not require insurers always to calculate separate QPAs for services provided by different specialties, as the law requires, they may include ghost rates in the calculation of a QPA that applies to the service.

The Departments tried to address this issue in a "Frequently Asked Questions" guidance document. Dept's, *FAQs About Affordable Care Act and Consolidated Appropriations Act*, *2021 Implementation Part 55*, at 17 (Aug. 19, 2022) [hereinafter "FAQ"].[8] The Departments clarified that they would not require insurers to calculate "separate median contracted rates " "when the plan's or issuer's contracting process unintentionally results in contracted rates that vary based on provider specialty." *Id.* at 17. The FAQ states, "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." *Id*. (emphasis added).[9]

[7] https://www.emergencyphysicians.org/globalassets/emphysicians/all-pdfs/2022-8-15-avalere-qpa-whitepaper_final.pdf.
[8] https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-55.pdf.
[9] The Departments provided no further guidance on what constitutes a "material" difference.

Lastly, the July 2021 IFR unlawfully authorizes self-insured group health plans to "allow their third-party administrators to determine the QPA for the sponsor by calculating the median contracted rate using the contracted rates recognized by *all* self-insured group health plans administered by the third-party administrator (*not only those of the particular plan sponsor*)." 86 Fed. Reg. at 36,890 (emphasis added).

III. Departments' Interim Final Rules/Final Rules on the IDR Process

On October 7, 2021, the Departments promulgated interim final rules improperly giving presumptive weight to one statutory factor in the IDR process—the QPA—over all other statutory factors unless the party satisfied additional requirements that are not stated in the NSA. Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980, 56,104, 56,116, 56,128 (Oct. 7, 2021) [hereinafter "October 2021 IFR"]. On February 23, 2022, this Court vacated the October 2021 IFR's rebuttable presumption in favor of the QPA, holding that the rebuttable presumption conflicted with the unambiguous statute and that the Departments promulgated the October 2021 IFR in violation of the Administrative Procedure Act. *Texas Med. Ass'n v. HHS*, 587 F. Supp. 3d 528 (E.D. Tex. 2022) ("*TMA I*").

After this Court's decision in *TMA I*, the Departments published the August Final Rule establishing new requirements that once again improperly tilt IDR decisions in favor of the QPA by prohibiting the IDR entity from considering the non-QPA statutory factors under several circumstances. Requirements Related to Surprise Billing, 87 Fed. Reg. 52,618, 52,620-21, 52,631, 52,634 (Aug. 26, 2022). These provisions are currently challenged in a separate action. *Texas Med. Ass'n v. HHS* ("*TMA II*"), No. 6:22-cv-00372 (E.D. Tex. Sept. 22, 2022).

ARGUMENT

The July 2021 IFR artificially deflates the QPA by (1) establishing each contracted rate as a single data point, (2) excluding incentive-based and retrospective payments, (3) including

rates for providers in different specialties, and (4) allowing third-party administrators to determine the QPA based on contracted rates recognized by all self-insured group health plans administered by the third-party administrator. This distorted calculation results in a QPA that is not reflective of the fair market value of items and services furnished by out-of-network providers in the marketplace. The Departments' faulty method for calculating the QPA undermines the ability of providers to obtain adequate reimbursement for out-of-network items and services. Further, the inaccurately calculated QPA compounds the defects of the biased IDR process under the August Final Rule, which favors the QPA and thus empowers insurers to reduce their in-network rates significantly or terminate in-network agreements altogether. The July 2021 IFR hinders the ability of providers to engage in fair contracting negotiations with insurers. If more providers are forced out-of-network due to the July 2021 IFR, patients will lose access to in-network care. Moreover, depressed QPAs will impose serious financial pressures on all providers, which will, in turn, threaten their ability to operate in the marketplace. If this occurs, small, independent providers may have no other choice but to consolidate or to cease operating. Patients will lose access to care, particularly in underserved areas.

I. The QPA Does Not Reflect the Fair Market Value of Out-of-Network Services

Despite Congress's intent for the QPA to reflect "a market-based price" informed by "negotiations between providers and insurers in a local health care market," H.R. Rep. No. 116-615, pt. 1, at 57 (2020), the Departments did not ensure that the QPA would be an accurate representation of prevailing market rates for specific clinical services.

First, the Departments' overly broad definition of "contracted rates" is contrary to the NSA and does not reflect the actual fair market value of the out-of-network services. Because the July 2021 IFR calculates the QPA based on each contracted rate rather than on the rates paid for each individual claim, the Departments have failed to ensure that the QPA "is a market-based

price" that "reflects negotiations between providers and insurers in a local health care market." H.R. Rep. No. 116-615, pt. 1, at 57 (2020); *see also* Letter from ACEP et al. to Xavier Becerra et al. 14-15 (Aug. 31, 2021) ("ACEP Comment Letter");[10] Letter from ASA to Xavier Becerra et al. 3 (Sept. 7, 2021) ("ASA Comment Letter");[11] Letter from ACR to Chiquita Brooks-LaSure, Adm'r, CMS 2 (Sept. 7, 2021) ("ACR Comment Letter").[12]

Second, in calculating the median contracted rate, the July 2021 IFR directs insurers to exclude risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments. 45 C.F.R. § 149.140(b)(2)(iv). Providers negotiate these payments, which are included in the ultimate rate paid to the contracting provider. The exclusion of these payments decreases the QPA and misrepresents the fair market value of these services.

Third, the July 2021 IFR improperly includes out-of-specialty rates in the calculation of the QPA. Providers in different specialties do not have an incentive to negotiate out-of-specialty rates meaningfully because these rates are not a significant source of their revenue. Providers in different specialties are more likely to accept lower contracted rates for these low-volume services, compared to specialists who frequently provide such services. Inclusion of out-of-specialty rates, which includes "ghost rates," artificially lowers the QPA. Although the Departments' FAQ acknowledged that $0 ghost rates should not be included in QPA calculations, the Departments failed to direct insurers to exclude all contractual rates for items or services that are never provided (e.g., $.01+ ghost rates). The Departments' calculation of the QPA, which wholly ignores the frequency of use or applicability of those in-network contracts in the market, misrepresents the true market value of the out-of-network item or service.

[10] https://www.regulations.gov/comment/CMS-2021-0117-5695.
[11] https://www.regulations.gov/comment/CMS-2021-0117-7410.
[12] https://www.regulations.gov/comment/CMS-2021-0117-7239.

Fourth, the July 2021 IFR unlawfully authorizes self-insured group health plans to allow their third-party administrators to determine their QPAs by using rates recognized by all self-insured group health plans administered by the third-party administrator. Self-insured group health plans have the option of selecting their third-party administrator's QPA calculation if it will ***lower*** the self-insured group health plan's QPA. This cherry-picking undermines the value of items and services in the local health care market.

The QPA simply does not reflect actual market conditions. *See* Decl. of Dr. Nicola; Decl. of Dr. Young; Decl. of Dr. Raley. Attachments A–C. For these reasons, the QPA does not represent the true market value of items or services provided out-of-network.

II. The July 2021 IFR Incentivizes Insurers to Lower In-Network Rates, Ultimately Narrowing Provider Networks

Because the July 2021 IFR QPA calculations do not reflect the true market rate of the items and services and because the August Final Rule skews the IDR process in favor of the insurer-calculated QPA, providers will not be fairly reimbursed for their out-of-network services. The July 2021 IFR's flawed QPA calculation, along with the biased IDR process, empowers insurers to reduce their in-network rates significantly or terminate in-network agreements altogether. As a result, the July 2021 IFR significantly diminishes providers' negotiating position with insurers who do not have an incentive to enter into network agreements.

Indeed, when the Departments began implementing the NSA, 152 members of Congress expressed concerns that the Departments' implementation "could incentivize insurance companies to set artificially low payment rates," resulting in improperly depressed rates. Letter from Members of Congress to Xavier Becerra, Janet Yellen, and Martin Walsh, Dep't Sec'ys 2 (Nov. 5, 2021) [hereinafter "November Letter"].[13] These Congressmembers stressed that tying

[13] https://www.acep.org/globalassets/new-pdfs/advocacy/2021.11.05-no-surprises-act-letter.pdf.

out-of-network payments to the QPA could result in "narrow provider networks … jeopardize[ing] patient access to care—the exact opposite of the goal of the [NSA]." *Id*. at 2.

The concerns expressed by these Congressmembers, unfortunately, materialized. For instance, Blue Cross Blue Shield of North Carolina ("BCBSNC") sent letters to providers demanding a reduction in contracted rates as a direct result of the Departments' October 2021 IFR. Decl. of Dr. Nicola (BCBSNC's "letter cites" the IFR "as justification to 'warrant a significant reduction in (our) contracted rates with Blue Cross NC' and warns of additional rate reductions once the qualifying payment amount is established"); Decl. of Dr. Raley (BCBSNC's letter states that the "IFR provides 'enough clarity to warrant a significant reduction in [Wake Emergency Physicians, P.A.'s] contracted rate with Blue Cross NC'"). The letters from BCBSNC further state that if providers do not accept the rate reduction in light of the Departments' October 2021 IFR, their contracts will be "quickly terminated." *See* Decl. of Dr. Nicola; Decl. of Dr. Raley.

The August Final Rule, like the vacated October 2021 IFR, distorts the "independent" dispute resolution process in favor of the insurer-calculated QPA. Under the August Final Rule, the Departments effectively replaced the rebuttable presumption in favor of the QPA with a new set of rules that still skew the IDR entity's decision in favor of the QPA. Because the August Final Rule still unlawfully tilts IDR decisions in favor of the QPA, an amount that the July 2021 IFR miscalculates and drives down, insurers will continue to reduce in-network contracted rates, threatening existing contractual arrangements with providers. Ultimately, this will result in narrower networks.

III. The July 2021 IFR's QPA Calculation Will Result in Under-Compensation of Care, Incentivizing the Consolidation of Practices, and Undermining Market Competition

The Departments' flawed methodology for determining the QPA will systemically

depress QPAs. Because the August Final Rule's IDR process is improperly skewed in favor of the QPA, providers will receive unfair and inadequate compensation for their out-of-network services. This will impose serious financial pressures on all providers that render services out-of-network. The ensuing financial strain will disproportionately affect small, independent practices and rural practices that are already reeling financially from the COVID-19 pandemic. *See* Letter from Am. Med. Ass'n to Janet Yellen, Sec'y, U.S. Dep't of Treasury, et al., AMA Comments on Interim Final Rule Requirements Related to Surprise Billing: Part II Implementing the No Surprises Act (Dec. 6, 2021).[14]

These practices may have no choice but to sell to larger corporate entities—a phenomenon that occurred in California after the state passed its surprise medical billing law. Cal. Health & Safety Code § 1371.31. Like the NSA, California's law requires insurers to make interim payments to out-of-network providers who could then begin the California IDR process if they felt the rate was inadequate. *See* Cal. Health & Safety Code § 1371.31. However, the interim rate was chosen as the "reasonable rate" 98% of the time, essentially functioning as a benchmark rate. Letter from Cal. Med. Ass'n to Chiquita Brooks-LaSure, Adm'r, CMS, No Surprises Act: Interim Final Rule: Part I [RIN 0938-AU63; CMS 9909-IF] (Sept. 7, 2021).[15]

A RAND corporation study showed that the California law "changed the negotiation dynamics between hospital-based physicians and payers," resulting in leverage shifting "in favor of payers" and incentivizing them to "lower or cancel contracts with rates higher than their average as a means of suppressing [out-of-network] prices." Erin L. Duffy, *Influence of Out-of-*

[14] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-12-6-Letter-to-Yellen-Walsh-Becerra-re-IFR-Comments-v3.pdf.
[15] https://downloads.regulations.gov/CMS-2021-0117-7408/attachment_1.pdf.

Network Payment Standards on Insurer-Provider Bargaining: California's Experience, 25 Am. J. Managed Care e243 (2019).[16] These drastic changes in negotiating power and lower rates accelerated "consolidation and exclusive contracting with facilities" among hospital-based specialists. *Id.* Similarly, routine under-compensation of out-of-network care due to the biased IDR process under the August Final Rule and the warped calculation of the QPA under the July 2021 IFR threaten the viability of many smaller and independent physician practices and incentivizes the consolidation of practices.

IV. Market Disruptions and Narrower Provider Networks Stemming from the July 2021 IFR Will Harm Patients in Underserved Areas Struggling with Accessibility

The July 2021 IFR's flawed QPA calculation will result in fewer provider networks and the consolidation of practices, thereby threatening the stability of the nation's already fragile health care system. Ultimately, patients' access to care, particularly in underserved areas, will suffer.

Patients who are unable to access care from in-network providers may delay care, seek care from an in-network provider in the wrong specialty, rely on emergency departments to receive care, or forgo care altogether. Simon F. Haeder, *Inadequate in the Best of Times: Reevaluating Provider Networks in Light of the Coronavirus Pandemic*, 12 World Med. & Health Pol'y 282, 284 (2020) ("These issues raise concerns, even under relatively normal circumstances" but become "exacerbated" with the effects of the COVID-19 pandemic).[17]

Underserved communities that are already struggling with access to care are disproportionally impacted by narrowing provider networks. Members of Congress warned that a rule favoring the QPA could "have a broad impact on reimbursement for in-network services,

[16] https://www.ajmc.com/view/influence-of-outofnetwork-payment-standards-on-insurer-provider-bargaining-californias-experience.
[17] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7436480/pdf/WMH3-12-282.pdf.

which could exacerbate existing health disparities and patient access issues in rural and urban underserved communities." November Letter at 2.[18] Because the Departments' August Final Rule still puts its "thumb on the scale for the QPA" over the other statutory factors laid out by Congress, and because the Departments' flawed methodology for calculating the QPA produces an improperly deflated metric, the Congressmembers' concerns regarding access to care remain valid. *TMA I*, 587 F. Supp. 3d at 542; November Letter at 1-2.

If aggressive actions like Blue Cross Blue Shield of North Carolina's become commonplace, the Congressmembers' fears of insurers providing lower in-network payment rates will be realized and the IDR process—which favors a depressed QPA—will consistently undercompensate providers. *See* Decl. of Dr. Nicola; Decl. of Dr. Raley. Routine under compensation will threaten the viability of many smaller and independent physician practices that provide care to underserved areas already struggling with accessibility to care. Ultimately, losing providers in these areas will significantly harm patients and actively work against the Departments' longstanding efforts to preserve or bolster network adequacy. *See, e.g.*, 45 C.F.R. § 156.230(a)(1)(ii) (requiring each qualified health plan issuer that uses a provider network to maintain "a network that is sufficient in number and types of providers … to ensure that all services will be accessible without unreasonable delay").

CONCLUSION

For the foregoing reasons, *Amici* respectfully request that the Court grant Plaintiffs' Motions for Summary Judgment.

Respectfully submitted,

/s/Ronald S. Connelly

[18] https://www.acep.org/globalassets/new-pdfs/advocacy/2021.11.05-no-surprises-act-letter.pdf.

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Dated: January 31, 2023

CERTIFICATE OF SERVICE

The undersigned certifies that, on this 31st day of January 2023, the foregoing document was filed electronically in compliance with Local Rule CV-5(a), which provides service on counsel to all parties.

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