



June 1, 2021

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

The Honorable Martin Walsh
Secretary
U.S. Department of Labor
200 Constitution Ave N.W.
Washington, DC 20210

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

Dear Secretaries Becerra, Walsh and Yellen:

On behalf of the members of the American Society of Anesthesiologists (ASA), please accept and consider these comments on the *No Surprises Act*, Public Law Number 116-260, as the Departments of Health and Human Services, Labor, and Treasury (the Departments) develop regulations to implement this new law.

ASA is a membership organization of physician anesthesiologists and others involved in the medical specialty of anesthesiology, critical care, and pain medicine. Our members practice in a variety of settings, including small, medium, and large practices, as well as private and academic practices. Approximately 75 percent of ASA members work in small or medium sized practices or academic institutions. ASA acknowledges the role that hospital-based physicians, including anesthesiologists, have had in surprise medical billing. Anesthesiologists generally attempt to contract with as many health plans in their market as possible. In fact, according to a 2020 report by the Health Care Cost Institute, over 90 percent of claims submitted by anesthesiologists for inpatient and outpatient services were in-network. With in-network claims, patients do not receive surprise medical bills. Unfortunately, it is becoming more difficult to maintain in-network status today, as anesthesia groups throughout the country have experienced a wave of contract terminations from health plans in advance of the implementation of this Act, likely in an effort to reduce median in-network rate calculations.

In this letter, we share comments on the following five broad topics:

- Independent dispute resolution;
- Qualifying payment amount and initial payment;
- Patient engagement;
- Interaction with state laws; and
- Auditing.

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Executive Summary

Independent Dispute Resolution (IDR): Regulations implementing the *No Surprises Act* should clearly define the factors that an IDR entity may consider and reiterate that the factors are to be weighed equally. Parties should have access to IDR entities that are free of general biases, and arbiters should be selected based on their experience with physician payments and payment amounts issued in the geographic region. Anesthesiologists should be allowed to batch claims based on anesthesia code families and by either the individual provider or the group entity submitting the claim. The 90-day waiting period for bringing subsequent disputes should apply at the plan level and not at the payer level.

Qualifying Payment Amount (QPA) and Initial Payment: The median amount should represent the amount actually paid to providers, based on a base anchoring year of 2019, adjusted annually for inflation by the prior year's consumer price index (CPI), and weighted by the frequency of payments. The median should reflect amounts paid to providers in the same or similar specialty, as recognized by the Medicare specialty identifier, and should account for providers' level of training. Median rates should be developed for plans in the same geozips, rather than broader geographic regions, and payers should be incentivized to offer reasonable initial payments. If an insurer fails to make an initial payment or provide notice of denial within 30 days, it should be considered a denial.

Patient Engagement: The requirement to engage in coverage and cost discussions prior to scheduled care should apply to the scheduling entity and not to anesthesiologists who are typically removed from the provider-patient negotiation process. Anesthesiologists providing pain management services should be eligible to participate in the notice and consent exception.

Interaction with State Laws: In states that have limited surprise medical billing laws, access to the federal IDR process should be available. States' all-payer claims database (APCDs) should include real time payment data for all payers in that state's geography.

Auditing: The audit process should reflect statistically valid samples of payments. Audit results should be made public and the Departments should implement an enforcement mechanism to hold parties who fail audits accountable.

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I. Independent Dispute Resolution

A. Factors an IDR Entity May Consider

The regulation should clearly define the factors that an IDR entity may consider and reiterate that the factors are to be weighed equally. The Act outlines certain criteria that IDR entities must weigh when determining which offer is the payment to be applied. This includes the QPA, any additional information requested, the provider or facility's level of training and experience, and the parties' market shares, among other factors. However, the Act does not specify how the factors are to be weighed. We believe it is necessary for the Departments to be specific as to these considerations so the IDR process is

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standardized and does not vary significantly from one entity to the next. Even in the best of circumstances, these factors are subjective and will be assessed differently by each arbiter.

To promote as much consistency as possible, the regulation should carefully define each component to be used in the IDR decision. For example, the regulation should explain what constitutes training and “acuity of the individual.” These descriptions will enable arbiters to be more aligned in their approaches. The regulation should also clarify that each factor must be given equal weight in reaching the final decision. Not only does the Act list each factor one after another indicating that Congress intended for the items to be weighed equally, but U.S. Senators Margaret Wood Hassan and Bill Cassidy, M.D. recently sent a letter to the Departments clarifying that the Act’s intent was for arbiters to “give each arbitration factor equal weight and consideration.”¹ U.S. Representatives Larry Bucshon, M.D. and Raul Ruiz, M.D. sent a similar letter to the Departments asking them to “refrain from issuing guidance, or taking any other action that would give preference to one factor over the others,” since “[d]oing so could upset the delicate balance between providers and payers that the law strikes [.]”²

Additionally, the Departments should explicitly state that the physician’s median in-network payment amount and the FAIR Health allowable payment may also be considered in the IDR process. Both sources reflect statistically valid amounts that payers have paid providers. This addition is within the Department’s authority because when determining a final payment amount, IDR entities must consider the QPA, any information parties are required to provide as requested by the IDR entity, and the additional circumstances enumerated (e.g., level of training, market share, etc.). The Departments may bring the in-network and FAIR Health payment amounts into this consideration by requiring that IDR entities request this information from parties.

In reaching the final amount selected, arbiters should be mindful that anesthesia payments are generally structured differently from other specialties. Anesthesiologists typically calculate charges based on a standard, universally accepted “unit value” methodology that is used across private and government payers. This “unit value,” otherwise referred to as a “conversion factor,” is the foundation of an anesthesia claim. Payment then increases based on the time spent rendering care. Because anesthesiologists negotiate payment based on the conversion factor, parties should submit conversion factor offers and arbiters should select from one of those amounts.

B. Certifying IDR Entities

Parties should have access to IDR entities that are free of general biases. Arbiters should be selected based on their experience with physician payments and with physician allowed payment amounts issued in the geographic region; arbiter selection should not be based on prior decisions. The Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury, is tasked with establishing a process for certifying IDR entities for payment dispute resolution. The Act prescribes certain guardrails for this certification, including that an entity may not be a

¹ See M. Wood Hassan and B. Cassidy, Letter to Secretaries Xavier Becerra, Janet Yellen, Martin Walsh on the No Surprises Act (April 29, 2021).

² See L. Bucshon and R. Ruiz, Letter to Secretaries Xavier Becerra, Janet Yellen, Martin Walsh on the No Surprises Act (May 5, 2021).

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group health plan or insurer offering coverage or an affiliate, subsidiary, or trade association of such plan or insurer. While this helps to prevent IDR entities from overseeing disputes in which they have a *direct* conflict, it does not guard against the general biases that entities may have towards one party or the other. Though there is no way to guarantee that IDR entities will never bring biases with them into the process, we think there are measures that can be taken to enhance the likelihood of a fair deliberative process.

For example, the selection criteria for certifying IDR entities should ensure that a party has access to multiple entities that are not only free from direct conflicts, but that are also free of general biases. If an entity has even an indirect connection with a payer that entity should not be included on the list of potential IDR entities. As the Departments select potential arbiters, the decision to certify individuals should not be influenced by their previous IDR decisions. Arbiters should also be considered for certification only if they have experience with physician payments as well as an understanding of physician/health plan market dynamics associated with in- and out-of-network claims processes, including claims submissions, claims adjudication, and provider appeals and challenges to the inadequacies of recently issued out-of-network payment amounts. Arbiters should have an understanding of payments issued in the geographic area in which the services were rendered. Having this experience and familiarity with the unique circumstances that exist in the locality will help to promote efficient and productive sessions and decrease system costs.

C. Batching of Claims

Anesthesiologists should be allowed to batch claims based on anesthesia code families and by either the individual provider or the group entity submitting the claim. The Act allows for multiple qualified IDR dispute items and services to be jointly considered in a single determination if they meet four criteria: (i) the items and services are furnished by the same provider or facility; (ii) payment for the items and services is made by the same group health plan or health insurer; (iii) items and services are related to the treatment of a similar condition; and (iv) items and services were furnished during the same 30-day period following the date of the first service. The opportunity to resolve multiple claims disputes in one determination will reduce the time and cost associated with the IDR process. However, more clarity on how the criteria are defined and will apply in practice is needed, and special consideration of the unique features of the anesthesia code set must be reflected in the batching rules.

i. “Similar Condition”

The Act does not describe what constitutes a “similar condition.” We believe that flexibility is needed in interpreting this phrase, since the concept of and care related to a “similar condition” can vary considerably by specialty. For example, anesthesia services are classified in a distinct code set in which CPT codes are grouped according to body parts (e.g., head, neck, thorax, spine, etc.). If “similar condition” is not defined to permit anesthesiologists to batch claims for services within a related body-part code group, anesthesiologists will confront uniquely significant administrative burdens in the IDR process. An anesthesia service for one spinal procedure may be related to a different condition – e.g., stenosis – than an anesthesia service for another spinal condition – e.g., discectomy. Those procedures may be treating different “conditions,” but the anesthesia administration is substantially similar. The Departments should allow anesthesiologists to batch claims by anesthesia code families given that it is the established

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framework in the field. Specifically, we urge the Departments to provide that the definition of “similar condition” may be based on specialty code sets to reflect the unique nature of anesthesia services.

ii. “Same Provider or Facility”

The Act does not state who or what qualifies as the “same provider or facility.” We believe it is important for the regulation to clarify that the definition of “provider” could include either an individual provider or the group entity submitting the claim, such as a group (composed of multiple providers) identified by a common Tax Identification Number or TIN. Having the ability to batch claims at the group/TIN level is particularly important for anesthesia where more than one provider/practitioner may bill for the same procedure (e.g., both an anesthesiologist and a CRNA furnishing the service under supervision). This approach would help to simplify the process of resolving multiple claims, as well as the administrative task of tracking disputed claims through to final determination.

D. “Cooling Off” Period

The 90-day waiting period should apply at the plan level and not at the payer level. Once a final determination is rendered, the law requires a 90-day “cooling off” period for the party that submitted the initial IDR request. During this time, the “party” may not submit a subsequent request involving the “same other party” and same item or service. It is not clear whether the definition of “party” refers to the entire payer organization or to a particular health plan. The Departments should apply the cooling off rules to the plan level. As the Departments know, there are a dwindling number of payers, and in many regions, a few – or often one – large payers dominate the market. If the Departments apply the cooling off period at the payer level, providers will be at a severe disadvantage, as will patients who will have to wait unreasonably long periods before these disputes are resolved.

Large payers often offer dozens, perhaps hundreds of plans. Providers should not be expected to sit on the sidelines for 90 days with respect to an entire payer when a dispute under one of that payer’s plans arises. Rather, the wait should be with respect to the individual plan that initially was challenged through IDR. If this waiting period is imposed at the payer organization level it could lead to a dramatic backlog of unresolved claims as disputes wait in limbo to be processed. Therefore, the regulation should differentiate plans in the application of the cooling off period, so that the period applies to plans, and not payers.

II. Qualifying Payment Amount & Initial Payment

A. Qualifying Payment Amount

i. The median amount should represent the amount actually paid to providers based on the frequency of payments. Under the Act, the QPA is defined as the median of the contracted rates recognized by the plan or issuer as the total maximum payment under such plans or coverage in 2019 in the geographic area where the service was delivered, adjusted each year thereafter for inflation according to the prior year’s CPI. The Departments now must determine how to define and implement the terms “contracted rates recognized by the plan or issuer.” ASA urges the Departments to define these terms as the amounts actually paid to providers by plans and issuers weighted based on the frequency of payments remitted. Oftentimes, payers will include comprehensive fee schedules in contracts with providers. Those fee schedules will include hundreds of services not relevant to the provider. For

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example, fee schedules presented to an anesthesiology group may include payments for dermatology codes, just as those presented to dermatologists may include payments for anesthesia services. Providers have ample incentive to negotiate payments for services they perform, but they do not negotiate payments for services that are not relevant to their practice. For this reason, contracted amounts often do not reflect genuine arms-length negotiations between providers and payers, except with respect to a small subset of services. If the Departments use contracted rates in payer-provider contracts, and give equal weight to each contracted amount, regardless of whether that amount was actually subject to a true negotiation, the Departments will end up with a QPA that does not reflect market realities. As such, the terms “recognized by the plan or issuer” should be defined as amounts paid weighted by the number of actual payments issued to individually contracted providers. Contracted amounts with no actual payments rendered should be excluded from the median calculation. Additionally, the median should include self- and fully-insured plans, as well as any re-pricing arrangements (also frequently referred as “leased” or “rental” networks) secured through third parties (see e.g., Multiplan).

ii. The median should reflect amounts paid to providers in the same or similar specialty, as recognized by the Medicare specialty identifier, and should account for providers’ level of training. The Medicare specialty identifier is a recognized benchmark that allows practitioners to self-designate the specialty that best describes their practice. This standard coding system has helped to improve the quality of utilization data and is a well-known and accepted method for distinguishing providers by field. “Same or similar specialty” should be grounded in these Medicare designations since providers are already familiar with and actively using the identifiers today. Applying this scheme to the new payment mechanism will promote greater consistency across the health care system and could make it easier for providers and claims departments to adapt. The median should also incorporate the provider’s level of training, given the distinct backgrounds providers bring into practice. Congress expressly recognized the importance of providers’ training by naming the “level of training, experience, and quality and outcomes measurements of the provider” as one of five circumstances that must be considered in determining the final payment amount in dispute resolution. It would therefore be consistent with the Act’s intent to consider training in establishing the median.

iii. The median rates should be developed for plans in the same geozips, rather than broader geographic regions. Within a geographic region there can be significant differences in the cost of delivering care, patient morbidity, and the impact of rural and urban settings. In some communities, a population’s health and ability to access care can change within only a few miles. These differences can lead to wide variations in contracted rates within the same region. To capture these circumstances, the median should be calculated for plans in the same geozips, which are areas defined by the first three digits of a zip code. At least one independent nonprofit company, FAIR Health, which manages the country’s largest database of private and Medicare claims, has taken this approach and has organized its claims data by geozips for a number of years. Developing a median based on geozips would better reflect the unique qualities of our communities.

B. Initial Payment

Payers should be incentivized to offer reasonable initial payments. If an insurer fails to make an initial payment or provide notice of denial within the 30-day period, it should be considered a denial. The statute requires insurers to make an initial payment or issue a notice of payment denial no

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later than 30 days after the bill for services is transmitted by a provider or facility. While the law clearly imposes this 30-day obligation, we are concerned about the quality of the payment that insurers may offer up-front and how administrative or intentional delays during this phase may impact the subsequent negotiation and IDR timeframes.

i. Defining the Initial Payment

The law does not expressly specify how much an initial payment must be. Nonetheless, congressional intent is clear on this point. Without clear regulations consistent with intent, payers may use this lack of clarity to make low, unrealistic initial payments to providers to push these practices into IDR. An excessive amount of claims resulting in IDR actions is not feasible for many providers, and it should not be desirable to regulators. The Departments could address this concern by requiring IDR entities to consider the initial payment made under the “Demonstrations of good faith (or lack of good faith efforts)” factor. This factor requires IDR entities to consider good faith efforts made by parties in entering network agreements and, if applicable, the contracted rates between them. This factor and the requirement that the final payment amount selected be from one of the two offers made indicates that Congress clearly intended to motivate parties to put forth reasonable payment amounts. The Act’s inclusion of a 30-day negotiation period places further emphasis on Congress’s desire that parties reach a consensus and that IDR not be over-used as a backstop for all claims. Consideration of the initial payment by the arbiter would therefore be consistent with congressional intent and would incentivize insurers to offer reasonable initial amounts, which could ultimately reduce the time and resources spent in IDR.

ii. Failure to Respond Within 30 Days

The regulations should reinforce that the 30-day period for making a payment or issuing a denial begins upon the provider or facility filing the claim. If a payer fails to make an initial payment or provide notice of denial within 30 days of the filing, it should be considered a *de facto* denial. Insurers should be barred from pending claims. Providers do not have the resources to both submit claims and monitor that insurers fulfill their end of the process. We are concerned that a delay in insurers’ responses (or no response at all) will interrupt the subsequent negotiation timeframe and will only prolong disputes when consensus could have been reached. If claims are not addressed in a timely manner, it will create a stockpile of unresolved cases and will slow parties’ access to the negotiation and IDR processes that Congress carefully designed. The Act calls on IDR entities to ensure “the timely and efficient provision of determinations,” which can only occur if insurers have complied with the initial 30-day period. The Act plainly states that health plans and insurers must take action within this timeframe, which gives the Departments authority to enforce the requirement in regulation. The Department should establish these expectations from the start to ensure that the Act’s timelines are respected and the process is predictable. Maintaining these standards will go a long way in helping payers and providers to engage effectively as we navigate the new framework.

III. Patient Engagement

A. Patient Information Prior to Care

The requirement to engage in coverage and cost discussions prior to scheduled care should apply to the scheduling entity and not to anesthesiologists who typically are removed from the provider-patient negotiation process. When an individual schedules care at least three business days

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prior to the date of service, the Act imposes a new requirement that providers and facilities must ask whether the individual is enrolled in certain forms of coverage. Providers and facilities must then provide a good faith estimate of the expected charges for the service. However, the Act does not specify the exact entity responsible for providing this information to patients. Typically, when a patient schedules treatment in advance their services are scheduled with a hospital, surgeon, or another practitioner's scheduling staff. These appointments are not made directly with anesthesiologists. In fact, anesthesiologists often do not encounter the patient until the moment of the procedure. As such, anesthesiologists are not in a position to engage in these conversations. We encourage the Departments to consider how this requirement will be operationalized given the realities of scheduling and the individuals patients are most likely to interact with prior to care. We urge the Departments to clarify that the three business day requirement does not apply to anesthesiologists, since services are not scheduled with the providers directly.

B. Notice and Consent

Anesthesiologists providing pain management services should be eligible to participate in the notice and consent exception. The Act allows for surprise medical billing in cases of non-emergency services performed by non-participating providers at certain participating facilities, so long as the notice and consent requirements are met. However, the Act excludes from this notice and consent exception select ancillary services, including anesthesiology. This means that anesthesiologists may not balance bill, even if notice and consent are obtained. We are concerned that excluding the entire specialty of anesthesiology from the notice and consent exception paints too broad a stroke that could disadvantage patients.

Congress's intent to prohibit surprise medical billing in certain settings was to protect patients when they find themselves needing services that they did not anticipate or are unable to negotiate. The Act strives to remove the patient from the payment exchanges between insurers and providers, which have become increasingly complex. However, the Act is not intended to limit patient choice or to drive patients to certain providers over others.

In anesthesiology, there is a subspecialty that focuses on patient pain management services unrelated to a surgical or other interventional procedure. For these services, the patient is not in an emergent situation and they typically are seeking a provider of choice, and negotiating directly with that provider before the service is furnished. Patients should be permitted to consent to be balance billed for pain management services even though these services are technically rendered by a physician who is Board Certified in Anesthesiology, and who therefore may be considered to be an "anesthesiologist." We request that the Departments include anesthesiologists providing pain management services as eligible to participate in the notice and consent exception. In these situations, anesthesiologists would still need to comply with all of the Departments' requirements; the decision to pursue such care would simply remain with the patient. The Departments have the authority to create this exception because the relevant statutory language refers to "anesthesiology," and not anesthesiologists. Pain management is distinguishable from "anesthesiology."

IV. Interaction with State Laws

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A. State Law Treatment

In states that have limited surprise medical billing laws, access to the federal IDR process should be available. Prior to the *No Surprises Act*, there was no federal scheme that comprehensively regulated out-of-network services. In this absence, some states enacted surprise medical billing laws that vary widely in comprehensiveness and approach. We are concerned that the interaction of these federal and state frameworks will result in a patchwork scheme that creates tremendous uncertainty about which laws apply, placing the burden on parties to analyze which regulatory scheme they fall under. We believe this is asking too much of providers and patients. Providers' primary concern is patient care and patients' primary concern is obtaining the care needed to promote good health. We urge the Department to never lose sight of these important objectives.

The Departments should establish a minimum threshold for when a state's surprise medical billing regime will be recognized and deferred to. In states that have limited surprise medical billing laws (*i.e.*, where there is no state IDR process; where the state imposes a minimum dollar threshold to access IDR; where the state excludes plans not written in that state; or where IDR is a voluntary process that parties can opt out of), access to the federal IDR process must be available.

Additionally, the Departments should require that beneficiaries' insurance cards specifically indicate their plan type (*e.g.*, ERISA, ACA, Medicare Managed Care, etc.). The Departments should require use of the standardized NAIC message code N830, noting that services were processed in accordance with surprise billing regulations. This should be identified on Remittance Advice (RA) and Electronic Remittance Advance (ERA). The optimal identifier is the use of standard ERA nomenclature, ANSI 835, which offers adequate opportunity for payers to communicate this vital information to providers.

Resolving the conflicts between states' surprise medical billing laws and the Act will take thoughtful analysis and time; however, these initial steps could eliminate at least some areas of confusion and alleviate the burden on providers and patients.

B. All-Payer Claims Databases

APCDs must include real time payment data for all payers in that state's geography. There are multiple opportunities in the law for state APCDs to be relied on. In determining the QPA, the Act provides that when there is insufficient information to calculate the median, contracted rates will be calculated "through use of any database that is determined . . . to have sufficient information reflecting allowed amount paid [.]". The database used could be a state APCD. The "recognized amount" may also be established based on a "specified State law," which could include a state's APCD amount. Therefore, it is important that the information state APCDs collect is comprehensive and accurately reflects the market.

We are concerned that some states' APCDs contain data that is inconsistently reported. We believe that APCDs must reflect and include the delivery of real time payment data for all commercial payers in that state's geography, including all plan types and all payment arrangements. This data should include both self-insured and fully insured plans. Any incentive and bonus payments that providers receive should be incorporated, since they reflect part of the provider's overall payment relationship with the plan. Data should also include payment made under third party arrangements that bring together payers and

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networks of providers, but where the providers and payers are not in contract privity (e.g., companies like MultiPlan³). It is common in the provider-payer market for third-party organizations to assemble networks of providers and market these networks (plus other support and management services) to payers. Providers have increasingly turned to third-party arrangements when they are unable to reach an agreement with an insurer directly. While the provider and payer are not directly contracted, the ultimate payer of the claim is the insurer or benefit plan to which the network is contracted. These arrangements can constitute a high-volume of services and claims, and are an important source of data that should be included in APCDs because they reflect the full scope of commercial claims paid in the market.

This data should not include payments from government payers and managed care payers that contract with governments to administer state and federal benefits. This is consistent with the Act's approach to exclude consideration of Medicare and Medicaid rates when selecting a final payment amount in IDR. All payments included in the APCDs should reflect actual payments issued in the state in the preceding year based on the plan's "allowed amount" calculated prior to the plan's application of the member's deductible and cost sharing. We urge the Departments to closely assess the quality of state's APCDs and consider imposing certain minimum standards before these APCDs may be relied on. If the benchmarks established are based on data that is not representative or is distorted, then parties will be no closer to reaching an accurate payment amount than they are today.

V. Auditing

The audit process should reflect statistically valid samples of payments. Audit results should be made public and the Departments should implement an enforcement mechanism to hold parties who fail audits accountable. The Act charges the Secretaries with establishing a rulemaking process under which health plans and insurers are audited to ensure compliance with the QPA. Congress included an audit process to not only ensure payer compliance, but also to assure the provider community that payers are in fact complying. We support a robust audit process. To remain consistent with congressional intent and provide this level of assurance, we offer the following recommendations.

A. Valid Sampling

Implementing regulations should specify that auditors are to review statistically valid samples of actual payments (i.e., those actually issued at the allowed, adjudicated amount before the patient's cost sharing is applied) issued to an individual clinical or clinician in the same medical specialty. The regulations should reiterate that the Act's limit on sampling data from no more than 25 plans does *not* apply to audits that may be performed as a result of complaints or information that suggests non-compliance. We believe it is important for the Departments to maintain the authority to audit when complaints arise and closer evaluation is needed.

B. Public Display of Auditing Results

The Departments also should consider making some of the audit results public. Beginning in 2022, the Secretaries are already required to submit an annual report to Congress on the number of plans and

³ See e.g., MultiPlan (2021). Accessed: <https://www.multiplan.us/>.

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insurers for which audits were conducted. Therefore, more public transparency would not impose a significant additional burden on the Departments; it would go a long way toward boosting provider confidence in this regulatory regime.

C. Implementation of an Enforcement Mechanism

Related, the regulation should include a penalty or enforcement mechanism to hold plans accountable if they fail an audit or demonstrate repeated non-compliance. If repeated non-compliance has no consequences, providers will lose confidence in these regulations. We urge the Departments to incorporate sufficient checks in the regulation to ensure compliance – which is consistent with congressional intent – and provider confidence.

Thank you for the opportunity to provide these initial comments. Given the span and complexities of the Act, we will continue to analyze its immediate and long-term impacts on the anesthesia provider community and the patients we serve. We look forward to working with the Departments on how best to implement these concepts and ensure that patients continue to receive the care and attention they deserve. If you have any questions, please contact Manuel Bonilla at M.Bonilla@asahq.org or 202-289-7045.

Sincerely,



Beverly Philip, MD, FACA, FASA
President, American Society of Anesthesiologists

Cc: Jeff Wu, Deputy Director for Policy, Consumer Information and Insurance Oversight