American Society of Anesthesiologists®

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December 6, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
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 *Requirements Related to Surprise Billing; Part II* Interim Final Rule (IFR), as the Departments of Health and Human Services, Labor, and Treasury (the Departments) implement the payment methodology for out-of-network services and the independent dispute resolution (IDR) process.

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. Anesthesiologists always 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, health plans are terminating their long-standing in network agreements with anesthesiology groups. Anesthesiology groups throughout the country have experienced a wave of contract terminations from health plans in advance of the implementation of this Act. An example is attached. Health plans will continue to terminate in network anesthesia group agreements leaving inadequate in network anesthesia coverage throughout the country.

In this letter, we share feedback on the payment methodology for out-of-network services, the IDR process, and provisions that uniquely impact the anesthesia community, including:

A. Weighting of IDR Factors;
B. Qualifying Payment Amount (QPA);
C. Batching of Claims;

D. Initial Payments and Final Offers;
E. Certifying IDR Entities;
F. Cost of IDR Entities;
G. "Cooling Off" Period;
H. Federal/State Law Interaction;
I. Good Faith Estimate;
J. "Shared Savings" Schemes; and
K. Pain Physician Services.

Executive Summary

Weighting of IDR Factors: All additional factors referenced in the originating statute, the "No Surprises Act," should be considered equally in IDR and the Departments should convey the limitations of the QPA to IDR entities. The Departments should define the terms "clearly demonstrates" and "material difference" and provide examples of when there is sufficient evidence to rebut the presumption that the QPA is the appropriate amount.

Qualifying Payment Amount: Payers should be required to disclose additional information about the QPA calculations, including the use of modifiers, bonus and supplemental payments in the network, and the subspecialties included in the final sum.

Batching of Claims: The Departments should allow all disputed anesthesia services to be batched in one determination, regardless of the associated procedure. Unlike other specialties, payments for anesthesia procedures, whether cardio-thoracic or orthopedic, are based on the same conversion factor, and only the conversion factor is subject to dispute resolution; batching such claims in one determination will help promote system efficiencies.

Initial Payments and Final Offers: A payer's initial payment should be considered the payer's final offer in IDR. Alternatively, at the very least, the payer's last offer in negotiation should be considered their final offer in IDR. This approach will motivate payers to offer a reasonable initial amount, while signaling that IDR is not intended to be used for every claim.

Certifying IDR Entities: Parties should have access to IDR entities that are free of direct conflicts, as well as general biases. Arbiters should be selected based on their experience with physician payments in the geographic region and the decision to certify an individual should not be influenced by their prior IDR decisions.

Cost of IDR Entities: Arbiter costs should be reasonable and not used to dissuade smaller providers from seeking resolution. The Departments should not approve arbiter fees that exceed the fixed fee ranges and should monitor for behaviors that attempt to use the costs of IDR as a lever to intimidate providers.

"Cooling Off" Period: The 90-day waiting period for bringing subsequent disputes should apply at the plan level and not at the payer level. The Departments should clarify that while unrelated anesthesia claims *may* be batched in one IDR determination based on anesthesia's shared conversion factor, only similar claims would be subject to the cooling off period.

Federal/State Law Interaction: In states that have surprise billing laws, but where access to dispute resolution may be restricted by one mechanism or another (e.g., minimum amounts in dispute), access to the Federal IDR process should be available.

Good Faith Estimate: The Departments should delay implementation of the good faith estimate for uninsured and self-pay individuals to allow providers more time to understand and properly implement the requirements. The good faith estimate should not displace providers' use of cost transparency tools and the Departments should provide enforcement flexibility where providers make good faith efforts to organize and convey estimates to consumers.
"Shared Savings" Schemes: The Departments should increase transparency of shared savings schemes which, because of the financial benefits these schemes bring to health plans often at the expense of patients and providers, are becoming an increasingly popular payer-driven tool, and therefore, as they continue to be used by payers, we seek the Departments oversight to ensure that patients receive the benefit of any savings derived under the Act.

Pain Physician Services: The Departments should clarify that pain management services furnished by anesthesiologists are eligible to participate in the notice and consent exception. The Departments should and can exclude from the exception non-urgent pain management services where patients have control and can deliberate over the provider they see.

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A. Weighting of IDR Factors

All factors should be considered equally in IDR and the Departments should convey the limitations of the QPA to IDR entities. The No Surprises Act (the Act) established certain criteria that an IDR entity must weigh when determining which payment offer to select, including the QPA, the provider or facility's level of training, experience, and quality and outcomes measurements, and demonstrations of good faith efforts between parties to enter network arrangements, among other factors. Congress clearly intended for each factor to play a role in the arbiter's decision when it stated – six times – that arbiters "shall consider" the QPA *and* "information on any circumstance" described in the statute as requested by the IDR entity or submitted by a party.[1] Despite this directive, the Departments add new restrictions that severely limit the scope of what an arbiter can assess. Instead of openly considering the information that Congress deemed relevant to payment, the Departments instead require arbiters to "select the offer closest to the QPA, unless credible information presented by the parties rebuts that presumption and clearly demonstrates the QPA is materially different from the appropriate out-of-network rate [.]"[2] This represents a significant departure from the statute's text, as well as expressions of congressional intent made by several U.S. Senators and Representatives who were lead authors of the final text, noting that the factors were designed to be given equal consideration.[3]

The Departments' approach, which includes the creation of a 'rebuttable presumption' standard, which the ASA asserts was not derived from the Act itself, will, in effect, force arbiters to select the QPA-like offer over equally compelling and valuable factors. This, in turn, creates momentum for rates to trend towards a potentially manipulated, but ultimately payer controlled QPA in future years. This is inconsistent with the Act's purpose and text. The law specifically avoids the creation of payment-setting benchmarks and for good reasons. Healthcare costs are highly complex and vary by patient characteristics, condition, severity, geography, market dynamics, and more. Congress acknowledged this reality when it designed a

[1] Pub. L. No. 116-260, tit. I, div. BB.
[2] 86 Fed. Reg. 55,980, 55,996.
[3] *See* M. Wood Hassan and B. Cassidy, Letter to Secretaries Xavier Becerra, Janet Yellen, Martin Walsh on the No Surprises Act (April 29, 2021); L. Bucshon and R. Ruiz, Letter to Secretaries Xavier Becerra, Janet Yellen, Martin Walsh on the No Surprises Act (May 5, 2021).

dispute resolution process that allowed the arbiter to evaluate the unique circumstances of each case through a broad lens.

Instead, the Departments, by establishing a rebuttable presumption standard have, in effect, gone further than the Act prescribes, creating instead, *de facto* rate setting by creating the presumption that the QPA is the appropriate payment amount. This approach gives payers power to offer payments at or below the QPA – a measure that is already not a true reflection of market rates by virtue of the statistically invalid calculation used to establish the median contracted rate (we reference our comments to IFR, Part 1). As the costs of providing care increase – see, for example¸ the good faith estimate disclosure obligations required by this law and regulation – and reimbursement to providers decreases, there is a real risk that patients' access to care may be compromised.

The Departments justify over-weighting the QPA because they believe it "represents a reasonable market-based payment [.]"[4] This is far from true. The QPA represents only a *fraction* of the market because it includes only in-network rates and excludes all other out-of-network and alternative payment arrangements. It also is based on a median of contracted rates, and not an average of or weighted calculation of actual claims paid. The Departments correctly note, "…providers charge discounted rates to the plans, issuers, and FEHB carriers [because] joining a…network assures providers of patient volume in exchange for lower reimbursements."[5] The Departments' therefore cannot conclude that a median *in*-network rate is the appropriate *out*-of-network rate when out-of-network providers are not getting the benefit that induces an in-network provider to accept discounted rates. For these reasons, the QPA lacks credibility, independence and objectivity, and cannot be presumed to be an appropriate out-of-network rate.

If Congress had wanted to establish default payment rates in the event of payer-provider disputes, it would have done so. Instead, Congress outlined a list of "considerations" (emphasis added) that arbiters must take into account, and it created a process for requesting and submitting information based on specifically delineated circumstances. The Departments should revise the regulations to align with Congress's vision and allow for unrestricted consideration of all factors. The Departments should also make clear to IDR entities the limitations of the QPA so arbiters can competently assess whether the QPA is truly representative of the disputed claim.

Nonetheless, if the Departments adhere to the prescribed construct, the Departments must define what "clearly demonstrates" and "material difference" mean. The Departments establish this high bar for introducing evidence in IDR, but then fail to define or provide examples of what it takes for a party to overcome the barrier. If the Departments do not revise their overall approach, we urge them to, at a minimum, define these terms and issue guidance confirming that each of the following scenarios are examples where sufficient evidence exists to rebut the presumption that the QPA is the appropriate amount:

- Within the prior four years, the payer and provider had a contract rate that was 5 or more percent greater than the QPA; adjusting for annual CPI since date of termination
- Within the prior four years, the payer and provider engaged in unsuccessful contract negotiations, during which the payer extended an offer that was documented in writing and was 5 or more percent greater than the QPA; adjusting for annual CPI since offer was extended
- Evidence that another payer's QPA in the same geographic market for the same item or service is 5 or more percent greater than the QPA;

[4] 86 Fed. Reg. 55,980, 55,996.
[5] *Id.* at 56,046.

- Fair Health's median allowable rate for the geographic market is 5 or more percent greater than the QPA;
- The provider's median contracted rate, as of January 2019, adjusted by the consumer price index for the geographic market is 5 or more percent greater than the QPA; and
- In January 2019, the payer had an inadequate network in the geographic market for its QPA to be statistically valid.

A 5 percent differential reflects the U.S. Securities and Exchange Commission's accounting guidance and is generally considered a universally accepted accounting metric indicating that a "material difference" exists. Though we strongly believe that arbiters should consider all evidence requested or submitted, any differential beyond 5 percent should warrant consideration, as it clearly demonstrates that additional circumstances are in play.

B. Qualifying Payment Amount

Payers should be required to disclose additional information about QPA calculations. Though payers are required to disclose some information related to the QPA, including the QPA for each item or service and a certification that the amount was calculated in compliance with the regulation, payers are not required to disclose sufficient information to fully evaluate the credibility of a QPA calculation. We believe that greater transparency around these calculations is necessary and that payers should be required to disclose the following:

- Whether the QPA is based on downcoding of the original claim; why the claim was downcoded; and what the QPA would be for the item or service had it not been downcoded;
- If the claim is denied, what the QPA would have been based on the original claim;
- Information pertaining to the use of modifiers (in effect on January 31, 2019) in calculating the QPA and which modifiers were used, if any;
- Information pertaining to the use of bonuses and other supplemental payments paid to providers within the payers' networks;
- The number of contracts used in the payer's network for which the QPA is based to determine the median, as well as the number of providers represented by those contracts;
- The percentage of total claims for the given services furnished in-network; and
- The types of specialties and subspecialists that have contracted rates included in the dataset used to determine the QPA.

Given the complexity of the regulation, the number of parties and claims involved, and the multiple steps payers must take to reach a final amount, there are opportunities to make mistakes in the calculations or apply assumptions that are not relevant. Since payers hold all the data, providers are at an information disadvantage and have little ability to confirm that payments were calculated appropriately. Providers, regulators and arbiters should have insight into how the calculations were performed and how to contextualize the QPA, and parties should act as a check and balance on one another as the law is implemented.

C. Batching of Claims

The Departments should permit anesthesia services to be batched in one determination at the discretion of the physician or practice. The IFR clarifies the criteria by which multiple qualified IDR items or services may be considered jointly as part of a single determination. We support the opportunity to resolve multiple disputes in one determination and appreciate the Departments' clarification that the "same provider or group of providers" condition will be met if the items or services are billed with the same

National Provider Identifier or Taxpayer Identification Number (TIN). Often, more than one provider may bill for the same procedure (e.g., both an anesthesiologist and a CRNA furnishing services under supervision), so having the ability to batch claims at the group/TIN level will help to streamline and expedite the IDR process. This approach will also make it easier for parties to track disputed claims as they work through the resolution process.

The IFR goes on to note that if items or services are billed by a provider as part of a bundled arrangement, or where a payer makes an initial payment as a bundled payment, those qualified items or services may be submitted and considered as part of one determination. We believe the Departments should expand this approach and allow all anesthesia services to be batched in one determination, regardless of procedure. For example, if an anesthesiologist has a payment dispute with a payer for 10 services, the anesthesiologist should be permitted to batch those claims even if the 10 services relate to different procedures/codes. Unlike other specialties where separate determinations may be needed because of variation between procedures, payments for anesthesia procedures are based on the same conversion factor, and only the conversion factor is being resolved in the IDR process. Therefore, it would be easy to combine and address these accounts in one proceeding and doing so would ultimately alleviate some of the burden on IDR entities. We urge the Departments to allow anesthesia claims to be batched collectively at the discretion of the physician or practice based on this shared characteristic.

D. Initial Payments and Final Offers

The Departments should require that a payer's initial payment be considered the payer's final offer in IDR. Alternatively, at the very least, the payer's last offer should be considered their final offer in IDR. The Act requires payers to issue an initial payment or notice of denial of payment within 30 days of receiving the information necessary to make a coverage determination. In the IFR Part I, the Departments clarified that the initial payment should represent what the payer reasonably intends to be payment in full based on the relevant facts and circumstances.

We share the Departments' view that an initial payment should not be a first installment. If payers use the initial payment and subsequent negotiation period to try to "low ball" providers, knowing they can shift behavior in the IDR process, we are likely to see an excessive, unnecessary use of IDR. The Departments can guard against this behavior by placing more relevance on a payer's initial payment. Providers should not have to spend time and costs working through the negotiation and initiating IDR to get to a credible offer in the IDR phase. Rather, payers should be required to offer reasonable amounts up-front and IDR should serve as a last resort.

To better align this process with Congress's design and cost-efficiency goals, the Departments should require that a payer's initial payment be considered the payer's final offer in IDR. This requirement will put the onus on payers to offer what they truly consider to be a fair and final amount and may help to prevent IDR from being used only as an instrument to prolong the payment process.

Alternatively, and at the very least, the Departments should require the payer's last offer in negotiation to be considered their final offer in IDR. If the parties have engaged in negotiations and are unable to reach agreement, we worry that IDR will only extend the dispute time if there are not stronger standards in place to push parties to a consensus. IDR should build on any progress gained in negotiations and should not be an opportunity to reset the clock. Without such additional stipulations, we are concerned that the Departments' guidance is based upon an overreliance on the willingness of payers to act in good faith and creates opportunities to game the IDR process. Our recommended approach is permissible under the statute and it is well within the Departments' discretion to specify that the payer's offered payment amount in the IDR process be the payer's initial payment amount, or their last best offer in the negotiation period.

E. 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 in the applicable geographic region and not based on prior decisions. The Act provides that the Departments must develop a process for certifying IDR entities and that, at a minimum, an IDR entity may not be a payer offering coverage or an affiliate, subsidiary, or trade association of a payer. The IFR then adds standards related to certification, including fiscal soundness, confidentiality, and IDR fees.

While this is a good starting point, additional safeguards are needed to ensure a fair process. The Departments should, for example, ensure that a party has access to multiple entities that are not only free of direct conflicts, but also general biases. If an entity has an indirect connection to a payer, they should not be included on the list of potential IDR entities. There are many experienced professionals that could serve in this role and the Departments should make efforts to protect the integrity of the process, especially when there is already an information imbalance between payers and providers.

In selecting potential arbiters, individuals or entities should be certified only if they have experience with physician payments and familiarity with payer/provider market dynamics, including claims processes (i.e., claims submissions and adjudications), provider appeals, and an understanding of the challenges and inadequacies associated with out-of-network payment amounts. Arbiters should also have an understanding of the payments issued in the geographic area and their certification should not hinge on any prior IDR decisions. Placing an emphasis on arbiter's experience and familiarity with the market will help to promote efficient and productive sessions and decrease system costs.

F. Cost of IDR Entities

The Departments should ensure that arbiter costs are reasonable and will not be used to dissuade smaller provider groups from seeking resolution. The Departments should not approve arbiter fees that exceed the fixed fee ranges. The Act establishes that the party whose final offer is not chosen will be responsible for paying all fees charged by the IDR entity. If the parties reach a settlement before a final determination is made, the parties will split the costs of the process, unless otherwise agreed to. The IFR clarifies that each IDR entity will establish its own fee; however, fees must fall within certain fixed ranges, unless otherwise approved.

Based on our experience with the surprise billing dispute resolution processes in other states, we believe that greater attention is needed to the costs charged by arbiters and how these costs may be manipulated to discourage providers from pursuing IDR resolution. For example, where parties are able to select the arbiter and split the associated fees, we have seen payers reject arbiters with lower fees as a way of increasing the costs of arbitration and seeking to intimidate physicians. We are concerned that IDR entities will request and receive approval to charge a fee above the fixed fee range. We believe the costs of arbiters should be reasonable and should not be used to dissuade providers with fewer resources from pursuing IDR. The IDR process should be accessible regardless of a provider's size and financing. The Departments should not approve arbiter fees that exceed the fixed ranges and should monitor for bad actors that use the costs of IDR as a lever to skirt fair resolution.

G. "Cooling Off" Period

The 90-day waiting period should apply at the plan level and not at the payer level. Following the determination of a claim in IDR, the Act provides that the "party" that submitted the initial IDR notification

may not submit another claim to IDR involving the "same other party" with respect to the same item or service for 90 days following the decision. We request clarification on whether "party" refers to the payer organization as a whole, which we oppose, or alternatively to a particular health plan, which we support.

Given the nature of the health insurance market today, we believe that the Departments intend to apply the cooling off rules at the plan level. In many regions, there are only one or two large payers in the market, though these payers offer dozens of plans. If the cooling off rules apply at the payer level, providers and patients will have to wait an unreasonable and inefficient amount of time before their dispute can be resolved. More time will likely be spent in the waiting period than in claims resolution. The Departments should, therefore, clarify that this wait will apply to the individual plan that was initially challenged and not to the entire payer organization.

While we urge the Departments to create efficiencies by allowing claims for anesthesia services associated with different procedures to be batched based on a shared conversion factor, the Departments should clarify that only claims involving identical procedures are subject to the cooling off period. We also request clarification that where claims are batched for the purposes of one IDR determination, such batching does not necessarily place a provider in the cooling off period for all other unrelated claims. For example, we believe that all anesthesia services should be eligible for batching in one determination, regardless of procedure, since anesthesia payments are based on one conversion factor. However, if a cardiac procedure and orthopedic procedure are batched in a determination with a particular payer, the anesthesiologist should still be able to submit a general surgery claim against the same payer. The anesthesiologist should not be required to wait out the 90-day period because their claim was bundled for efficiency in an unrelated dispute. The Departments should clarify that while unrelated claims *may* be batched in IDR due to anesthesia's shared conversion factor, only similar claims would fall within the cooling off period limitation.

H. Federal and State Law Interaction

In states that have limited surprise billing laws, parties should have access to the Federal IDR process. The Departments clarified that the Federal IDR provisions may be used only where an All-Payer Model Agreement or specified state law does not apply. Where a state has a specified state law, the state law, rather than the Federal IDR process, will apply. While we appreciate the Departments' efforts to defer to states' experience with surprise billing, we believe it is important for parties to have access to a fair, comprehensive IDR process. Access to dispute resolution should not be limited based on the state in which a provider practices; rather, providers should have the same opportunity to resolve a dispute in a uniform manner, regardless of location.

In states that have limited surprise medical billing laws (i.e., 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 to which parties can opt out), access to the Federal IDR process should be available. Otherwise, any claims that do not meet a state's eligibility criteria for IDR will continue at the status quo, taking sufficient time for the parties to reach resolution themselves and making it difficult to come to agreement later on. If a claim is not eligible for a state's IDR process, this should result in a default to the Federal IDR program.

I. Good Faith Estimate

The IFR requires providers to inquire about an individual's insurance status and provide a notification that the individual may receive a good faith estimate of the expected charges. The entity scheduling the services (i.e., the convening entity) is responsible for compiling all of the components of that estimate and

co-providers and co-facilities involved in care are required to cooperate with this entity. This summer, the Departments deferred enforcement of this requirement on behalf of insured individuals, recognizing the "complexities" of transmitting this information between payers and providers and noting that compliance would likely not be possible for January 1, 2022.[6] For uninsured (or self-pay) individuals, the Departments will exercise enforcement discretion in limited situations where a good faith estimate provided does not include expected charges from co-providers or co-facilities during the period of January 1, 2022, through December 31, 2022.

The Departments should delay implementation of the good faith estimate for uninsured and self-pay individuals to give providers more time to understand and properly implement the requirements. While ASA supports greater transparency and patient empowerment, the IFR contains complex requirements that place new burdens on providers to understand and implement. Even with the proposed enforcement discretion applicable to co-providers, more time is needed to determine what these estimates should be, how to coordinate information amongst providers, and how to train staff to ensure that consumers get the information they need.

There are significant gaps in the IFR regarding how good faith estimates should be calculated. The IFR states only that the estimate must include "any item or service that is reasonably expected to be provided in conjunction with such scheduled item or service and such items or services reasonably expected to be so provided by another provider or facility [.]"[7] To reach this bar, the provider offering the estimate will need to perform an assessment of the patient's medical record, engage with the patient to understand the reasons for scheduling care, and determine whether the presenting condition may warrant involvement of other providers. The requirement essentially forces providers to: complete a full intake evaluation – likely on the spot and over the phone; predict the appropriate treatment pathway without first examining the patient; and engage in comprehensive care coordination and the development of a plan of care without getting reimbursed for such services.

While we appreciate the Departments' efforts to promote greater understanding of healthcare costs, patient care is dynamic and each individual has a distinct medical history, lifestyle, and care preferences that may influence the final charged amount. The good faith estimate is a difficult number to get right and it should not be rushed, especially when the Departments have provided little guidance on how this estimate can be reached. We recommend that the Departments delay implementation of this requirement, similar to the delay of good faith estimates for insured individuals, to provide more time for providers to identify and prepare resources on the estimates and train staff on how to comply. The two obligations should be implemented in parallel fashion.

The good faith estimate should not displace providers' use of cost transparency tools. Providers have worked alongside the Departments on many initiatives aimed at improving cost transparency, better coordinating care, and empowering patients to be wise consumers of services. To that end, many providers use cost transparency tools today that work well for patients and practices and align with the Departments' goals of providing consumers with more information up front. These tools should not be displaced by the good faith estimate. The Departments should also clarify that discussions related to costs do not automatically trigger a responsibility to provide a good faith estimate. Providers should be able to openly discuss the costs of services when appropriate and these conversations should not be interpreted as a formal request for a good faith estimate under the scope of the IFR.

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[6] *FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49* (Aug. 20, 2021). Accessible at: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf.

[7] 86 Fed. Reg. 55,980, 56,016.

The Departments should provide additional flexibilities for providers who make good faith efforts in organizing and issuing estimates. The IFR creates a patient-provider dispute resolution process for uninsured or self-pay individuals when an individual is charged "substantially in excess" of the initial estimate. The Departments define "substantially in excess" to mean that the amount billed to a patient is at least $400 more than the total amount of expected charges.

We understand the importance of conveying estimates that are accurate and indicative of the final amount. However, as discussed, despite providers' best efforts, the estimate may not closely reflect the ultimate cost of care (e.g., an unanticipated specialist consult may be required, condition severity changes). Particularly for specialties, like anesthesia, $400 is a small margin for estimating the correct amount. Anesthesia charges are heavily based on the time spent caring for the patient, but anesthesia providers have little control over the duration of surgery. Surgeons' frequently underestimate surgical duration, making the chances of a correct estimate low. No matter how many resources providers invest, the likelihood of falling outside this range is high. Therefore, we ask for additional flexibilities in implementing these provisions, including deferred enforcement, a greater threshold for initiating the patient-provider dispute resolution, and assurances that the select dispute resolution entity will consider more than just "unforeseen events," but also the complexities involved in deriving an estimate.

J. "Shared Savings" Schemes

The Departments should increase transparency of payer derived 'shared savings' schemes and ensure that patients receive the benefit of any savings derived under the Act. An employer-sponsored health benefit plan typically pays an insurance carrier and/or third-party administrator (TPA) two types of fees for services each year: (1) a fixed administrative service fee that cover claims administration, provider network access, member services, and other plan management fees; and (2) variable fees, such as a fee for negotiating claims from out-of-network providers. More recently, employer plan sponsors have reimbursed out-of-network services through insurance carrier and/or TPA "shared savings" programs, which require payment of additional administrative fees to health plans for discounting rates to providers. In a shared savings arrangement, the insurance carrier and/or TPA negotiates the out-of-network claim and is paid a percentage of the savings – typically 25-40 percent – for successful negotiation or in other unscrupulous actions by merely unreasonably ratcheting down the amount the payer will remit for out-of-network services. This percentage is typically equivalent to the difference between a provider's billed charges and the rate paid by the insurance carrier and/or TPA. The shared savings fee is then often billed as a claim amount. In recent years, shared savings fees have grown rapidly, with shared savings expenses exceeding total administrative fees for many employers.

The Departments should create transparency around this payment scheme and should make clear that any savings derived from the Act should be directed to patients or plan sponsors.

K. Pain Management Services

The Departments should clarify that pain management services furnished by anesthesiologists are eligible to participate in the notice and consent exception. The Act and IFR Part I permit surprise billing in cases where non-emergency services are provided by an out-of-network provider at certain in-network facilities, so long as the notice and consent requirements are met. However, the Act excludes from the notice and consent exception items and services related to select ancillary services, including anesthesiology.

The IFRs do not address and the Departments should clarify that pain management services, even those furnished by anesthesiologists, are not subject to this exemption. We understand the Departments' perspective that the notice and consent exception should not apply to urgent services or in instances where individuals have little control over the provider. However, the Departments should and can exclude from the exception non-urgent pain management services where patients have control and can deliberate over the provider they see.

Patients seeking pain management services are not in an urgent situation when seeking such services. Rather, patients typically seek a provider of choice and can negotiate the payment amount with the provider in advance of services. Nothing in the Act intends to limit patient choice. Congress aims only to protect patients in unexpected scenarios and to ensure through the notice and consent process that patients are scheduling services with an understanding of the financial responsibilities involved. So long as these guardrails are in place, patients should have the ability to choose for themselves whether to consent to be balance billed for pain management services, even though these services are rendered by a physician who is Board Certified in Anesthesiology. If the notice and consent exception is not available, it may have the adverse effect of limiting patient choice if physicians feel that the financial risk is not sustainable.

The Departments should clarify that pain management services rendered in non-urgent situations and where the patient has the ability to select and meet with a physician in advance of care, is distinguishable from "anesthesiology." An anesthesiologist providing such services should be eligible to participate in the formal notice and consent exception, which simply builds on the practices they already engage in today.

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Thank you for the opportunity to provide these comments on the IFR Part II. Given the complexities of the Act and IFRs, we will continue to analyze the effect of these regulations on our patients and the anesthesia provider community at large. We look forward to working with the Departments on how to implement these concepts, while ensuring that patient care is not disrupted. If you have any questions, please contact Manuel Bonilla at M.Bonilla@asahq.org or XXX-XXX-XXXX.

Sincerely,

Randall Clark, MD, FASA
President

Enclosure: Redacted Blue Cross Blue Shield of North Carolina letter regarding payment reductions related to the "No Surprises Act"

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

[redacted]

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

Mark Werner
Vice President, Provider Networks