875 N. Michigan Avenue
Suite 3100
Chicago, IL 60611
www.lugpa.org

September 7, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1734-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Requirements Related to Surprise Billing; Part 1 (CMS-9909-IFC)[1]

Via Electronic Submission

Dear Administrator Brooks-LaSure,

On behalf of the Large Urology Group Practice Association (LUGPA), we appreciate the opportunity to comment on the above captioned Interim Final Rule with Comment Period implementing the No Surprises Act enacted under the Consolidated Appropriations Act, 2021 (IFC).[2]

LUGPA recognizes that surprise medical bills are a source of significant concern for many Americans and that unexpected bills received in scenarios where patients have received care in an out of network setting can result in devastating financial consequences, particularly in cases involving emergency care. This is particularly troubling when care is rendered during life-threatening circumstances, in which patients may receive services while incapable of providing advance informed consent. As such, LUGPA generally endorses the paradigm that patient cost-sharing should be maintained at in-network levels in circumstances where the patient unknowingly receives care from a non-participating provider or is forced to receive emergent care in a non-participating facility.

Although LUGPA supports the precepts that led to the development of the IFC, and indeed, had many meetings with Congressional leaders in advance of the issuance of the rule's statutory basis, we write to raise concerns that the IFC is problematically vague in critical areas, is otherwise incomplete or has potential implications which may serve to undermine its mandate. For example, while LUGPA recognizes that the No Surprises Act includes ambulatory surgical centers (ASCs) under the definition of "health care facility" subject to the law's provisions, the Department fails to expressly recognize that ASC services are

[1] "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Pay"Requirements Related to Surprise Billing; Part I," 86 Fed. Reg. 36872 (July 13, 2021).
[2] Title I, Division BB, "Consolidated Appropriations Act, 2021," Pub. L. No. 116-260 (Dec. 27, 2020).

almost uniformly elective, and ASCs are virtually never the site of emergency care outside of extraordinary circumstancescircumstances. clarification is key because in most cases, the surprise billing requirements will apply in ASC settings only to the extent that a *non-participating provider* within a participating ASC furnishes care to the patient.

As LUGPA strongly endorses the patient care provisions espoused in the IFC, LUGPA is also concerned that these patient protections do not extended to care provided in the urgent care setting. This has the potential to create both direct and indirect consequences. Urgent care centers may be the most immediate site of service to which patients are transported, especially by family members. In addition to providing professional services—which have the potential to be performed by out-of-network providers—these centers often have the capacity to perform potentially expensive ancillary services, with laboratory and imaging services leading this list. Furthermore, excluding such sites creates a potential loophole in which patients are "triaged" for certain services to urgent care centers, developed on the campus of out-of-network sites subject to the provisions of the IFC. LUGPA can envision circumstances in which facilities seeking to preserve their historical out-of-network processes could create a business model that would technically be compliant with the regulations but circumvent the IFC through creative financial engineering. As a consequence, patients seen at such facilities could still be exposed to substantial financial harm from out-of-network urgent care charges that are exempt from the protections of the IFC, thereby potentially continuing to expose patients to substantial economic downside.

Finally, we have significant concerns about the dynamic that the proposed framework may produce as it relates to negotiations between insurers and providers. Even as providers have been struggling to meet the nation's health care needs during the COVID-19 Public Health Emergency (PHE), health insurers are enjoying record profits. We have concerns that the IFC has the potential to shift bargaining leverage to insurers, thereby potentially contributing to a "race to the bottom" where insurers leverage regulatory constructs to drive down payment rates to providers. This is particularly true of independent physician groups, who lack the resources of national insurance conglomerates. These groups, who may have been called upon to render life-saving services as part of on-call obligations with facilities, will be substantially disadvantaged in any after-care fee negotiations. Consequently, we urge the Departments of the Treasury, Labor, and Health and Human Services (the Departments) to closely monitor insurer contracting behavior following the implementation of these requirements and ensure that in the second part of the IFC, due to be released later this year, the Departments include appropriate economic protections for providers.

Our comments, which are discussed in more detail below, can be distilled into the following calls for action:

- The broad definition of "ancillary services" and its exclusion from the notice and consent exception serves to undermine patient choice without any corresponding protections from "surprise" medical bills. The broad ancillary services provision discourages nonparticipating providers from engaging patients due to reimbursement concerns, even if the nonparticipating providers acquired the patient's notice and consent that they would be treated out-of-network.

- The Departments should extend the surprise billing requirements to urgent care centers, or at a minimum, enact provisions that prevent using this site of service as vehicle to circumvent the intent of the rule. As the Departments note, studies show that patients use urgent care centers in a similar way as emergency room departments, and the surprise billing protections should be extended to them as well. The notion that the patient "chooses" the urgent care center does not take into consideration the acutely ill individuals to properly provide informed consent, circumstances where they may have been

transported to an urgent care facility, nor the relative availability of services in a particular geography.

- The Departments should protect against insurers' exploitation of a nonparticipating providers/facility's obligation to furnish post-stabilization care at in-network rates by explicitly placing the burden on insurers to arrange for nonemergency, nonmedical or medical transportation to a participating provider/facility. LUGPA proposes that the Departments should require a nonparticipating provider to communicate to a patient's insurer when the patient has (1) been stabilized, and (2) refuses to provide notice and consent or (3) cannot provide notice and consent. The burden would then shift to the insurer to arrange and/or approve nonemergency, nonmedical or medical transportation for their patient within 2 calendar days or else be liable to the nonparticipating provider/facility for their standard charges associated with services furnished after the second calendar day.

- The QPA mechanism may provide insurers with incentive to create artificially lower rates for certain services as well as an opportunity to make these the standard in the marketplace. Thus, the Departments should closely monitor how insurers leverage the surprise billing requirements to drive down payment rates with providers, such as by monitoring how insurers (and independent dispute resolution arbitrators) may leverage the Qualifying Payment Amount (QPA) to negotiate rates with providers. Furthermore, protections should be elucidated in Part 2 of the IFC to protect independent providers from potential harm from intrinsically unbalanced resources in fee negotiations

I. Background on LUGPA

The Large Urology Group Practice Association (LUGPA) was formed in 2008 as a way to facilitate communication between independent urology-focused (GU) groups of ten or more providers. This served the complementary priorities of: (1) the promotion clinical and operational benchmarking to guide best practices (2) the establishment and promulgation of quality guidelines, and (3) the utilization of resources for advocacy and communication in the legislative and regulatory arena to ensure that these providers also had an opportunity to advocate on behalf of their patients and their specialty. Since that time, LUGPA has expanded its mission to incorporate any group practice who shares the foundational principles of commitment to providing integrated and comprehensive GU services to those impacted by genitourinary diseases and conditions. LUGPA has gained membership steadily; it currently includes 150 urology group practices in the United States, representing more than 2,100 physicians who, collectively, provide approximately 35% of the nation's Medicare urology services.(ref 2018 PUF data). Furthermore, LUGPA's members provide the majority of the GU care delivered in the independent physician office setting.

As health care reform efforts in the US have evolved to direct focus towards the development and promotion of outcome driven, "best-practice" patient care delivered in the most cost-effective setting, LUGPA practices have consistently been leaders in innovative and adaptive care models. Expanding both the range of procedures and the integration of care that can be safely and effectively provided in the more convenient and cost-effective independent physician setting has resulted in demonstrable concomitant reduction in the cost of care delivery, as well as improved outcomes. In addition, LUGPA practices have been at the forefront of adopting team-based healthcare, with the inclusion of other physician specialists and a variety of advanced practice providers, maximizing both convenience and accessibility to expert treatment for a broad spectrum of GU conditions. LUGPA practices have embraced value-based care models, and the organization was among the first to create a physician-focused payment model. As such, LUGPA has served

as a high-quality, cost-effective alternative to cost increases associated with the consolidation of health care services.[3,4]

LUGPA's mission has been to provide and maximize access to the resources, technology, management tools and advocacy efforts that optimize the ability of urological surgeons and their clinical partners in the independent setting to provide integrated, comprehensive care for patients with acute and chronic illnesses affecting the GU system. During the global Public Health Emergency (PHE) LUGPA's mission was expanded to provide crucial resources to independent physician practices that enabled continuity of outpatient services even as the nation's inpatient capacity was overrun by patients stricken with COVID-19. Whether facilitating understanding and access to government assistant programs, coordinating sourcing of personal protective equipment, or providing crucial safety data to its members.[5] Through these and other efforts, LUGPA helped ensure that vulnerable populations continued to be able to access life-saving urological services.[6]

LUGPA will continue to work on behalf of its membership to ensure that the critical role of independent GU practices is recognized and optimized as we work to expand access to current and up-to-date treatment alternatives in the most cost-effective setting.

II. LUGPA urges the Departments to limit the definition of "ancillary services" to its statutorily-defined boundaries because the broad definition has the effect of limiting patients' informed choice without actually protecting them from unexpected medical bills.

A. The broad definition of "ancillary services", and its exception to the notice and consent process, discourages nonparticipating providers from engaging a patient even when they may have the best expertise to treat that patient, thereby undermining patient choice without actually protecting them from "surprise" medical bills.

The "notice and consent" exception allows for non-participating providers and facilities to balance bill patients in certain non-emergent situations. However, the notice and consent exception does not apply to "ancillary services" under any situation, meaning that the balance billing protections apply to ancillary services in all cases, irrespective of whether the services in question are emergency or non-emergency services.[7]

Ancillary services are defined in statute, but the Secretary has the authority to expand the definition through rulemaking. The current statutory definition for "ancillary services" mean, with respect a participating health care facility:

> (A) …items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a physician or non-physician practitioner, and items and services provided by assistant surgeons, hospitalists, and intensivists;
> (B) …, diagnostic services (including radiology and laboratory

[3] Scheffler RM, Arnold DR, Whaley CM. Consolidation trends in California's health care system: impacts on ACA premiums and outpatient visit prices. Health Affairs. 2018 Sep 1;37(9):1409-16.
[4] Capps C, Dranove D, Ody C. The effect of hospital acquisitions of physician practices on prices and spending. Journal of health economics. 2018 May 1;59:139-52.
[5] Kapoor DA, Latino K, Hodes G, et al. The Impact of Systematic Safety Precautions on COVID-19 Risk Exposure and Transmission Rates in Outpatient Healthcare Workers. Rev Urol. 2020;22(3):93-101.
[6] Harris RG. After COVID-19, LUGPA More Important Than Ever. Rev Urol. 2020;22(2):75-76
[7] 86 Fed. Reg. at 36910.

> services);
> (C) items and services provided by such other specialty; practitioners, as the Secretary specifies through rulemaking; and
> (D) items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.[8]

LUGPA urges the Departments to recognize that the statutory definition of ancillary services effectively serves to limit patients' informed choice without bearing any relationship to the legislation's goal of protecting them from unexpected medical bills. The notice and consent exception enhances informed patient choice by providing patients with an opportunity to receive medical care from providers that they would likely not otherwise ever consider because of the providers' nonparticipating status with their health plan. Particularly in the case of specialty providers, the notice and consent exception exposes patients to a wider breadth of choices from whom to receive medical care while also ensuring that they understand the financial consequences of their choice. Through the notice and consent process, a patient may learn that they can access services from a nonparticipating but leading surgeon with specific expertise on their condition, and depending on the patient's unique circumstances, they may elect to access those services.

The ancillary services definition and its relationship with the notice and consent requirement, however, significantly limits the patient choice-enhancing benefits of the notice and consent requirement by prohibiting nonparticipating providers from sharing information covered by the ancillary services definition as part of the notice and consent process. If ancillary services, which are defined extraordinarily broadly to include ubiquitous services like diagnostic services, can never be exempted through notice and consent, nonparticipating providers effectively lose all incentive to engage and educate patients on their choices. In turn, patients lose the benefit of learning of nonparticipating providers that may be better positioned to treat their conditions than participating providers in their network.

Making matters worse still is that the ancillary services definition is wholly disconnected from the intent of the legislation, which is to protect patients from unexpected medical bills. By definition, the notice and consent process ensures that patients "expect" balance billing if they so choose to move forward with the item or service in question. In other words, to the extent that a patient goes through the notice and consent process and provides their informed consent to receive services from a non-participating provider and/or facility, that patient is proceeding with full knowledge that the care they receive will not be covered by their insurance. Thus, excluding ancillary services from the notice and consent exception adds no discernible benefit in terms of protecting the patient from unexpected medical bills because the patient already understands that they are receiving out-of-network medical care. At the same time, as noted above, excluding ancillary services from ever being eligible for balance billing, including where there is notice and consent, strongly incentivizes nonparticipating providers to simply not engage patients even when they may possess superior expertise to treat that patient's condition.

LUGPA acknowledges that the perverse dynamic described above is a result of Congress' legislative drafting, specifically Congress' sweeping definition of "ancillary services" and the fact that the notice and consent exception can never apply to "ancillary services." LUGPA will continue to work with Congress to address the unintended consequences of a provision that was intended to protect patients but, in practice, undermines patient choice without necessarily protecting them from "surprise" bills.

[8] Public Health Service Act, § 2799(b).

However, LUGPA urges the Departments to recognize this dynamic and exercise its regulatory authority in such a way to minimize it. This may include *not* expanding the definition of ancillary services beyond the scope provided by Congress, as Congress only provided the Secretary with discretionary authority to expand the definition and its applicability. Similarly, *the Departments* could explore its authority to clarify specific aspects of the existing definition that has the effect of limiting its application to particularly egregious circumstances without encompassing all conceivable situations involving "ancillary services."

III. LUGPA urges the Departments to categorically extend the surprise billing requirements to urgent care centers regardless of their licensure under state law.

A. Irrespective of whether "urgent care" centers are licensed and authorized by a state to provide emergency services, patients may still experience surprise bills when receiving care by these facilities and should be protected.

The Departments note that section 102 of the No Surprises Act extends the definition of "emergency services" under the law to independent freestanding emergency departments that provide "emergency services," and are geographically distinct from a hospital, and separately licensed as such by a state.[9] The Departments also note that state regulation of urgent care centers varies significantly and is "evolving as these types of centers become more common."[10] As a result, in some states, an urgent care center may meet the definition of an "independent freestanding emergency department" depending on whether they are licensed by the state to provide emergency services covered under the No Surprises Act.

In the context of non-emergency services, Congress did not expressly extend the surprise billing requirements to urgent care centers. However, the Departments note that they have authority under the No Surprises Act to designate additional facilities as "health care facilities" subject to the balance billing protections. The Departments express a view that "it is possible that individuals may be using urgent care centers (regardless of how they are licensed) in a similar way to how they use independent freestanding emergency departments, in which case it may be appropriate to designate urgent care centers as health care facilities."[11] The Departments solicit comments on potentially including urgent care centers under the definition of "health care facilities."

LUGPA agrees with the Departments' inclination that urgent care centers should be included within the definition of "health care facilities" subject to the surprise billing requirements. As the Departments recognize in the IFC, state regulation of urgent care centers vary significantly, resulting in an esoteric patchwork of protections for patients who receive services from non-participating providers at participating urgent care centers. Patients should not be expected to assess whether receiving care at a participating urgent care center will protect them from unexpected medical bills based on applicable state licensure law. As the Kaiser Family Foundation found in a recent report:

> Regardless of what's prescribed in state regulations, what's considered an "emergency" versus "urgent" can vary by patient. That potentially creates confusion about whether patients would be protected from certain kinds of out-of-network bills if they show up at an urgent care facility for an acute illness or injury.[12]

[9] 86 Fed. Reg. at 36879; *see also* Public Health Service Act, § 2799A-1(a)*(3)*(D).
[10] 86 Fed. Reg. at 36879.
[11] *Id.* at 36882.
[12] Rachana Pradhan, "At Urgent Care, He Got 5 Stitches and a Big Surprise: A Plastic Surgeon's Bill for $1,040," Kaiser Health News (Aug. 2, 2021), https://khn.org/news/article/urgent-care-surprise-billing-plastic-surgeon-

Moreover, excluding urgent care centers from the balance billing prohibitions not only undermines the consumer certainty that the balance billing prohibitions were designed to engender, it also potentially creates a significant loophole that unscrupulous actors may exploit. The same KFF report also found that some urgent care clinics may include misleading descriptions of their offered services in marketing materials that suggest they are emergency services, when in fact they may not constitute emergency services under federal law.[13] This may give consumers the misconception that there can be no surprise bills at urgent care centers because the surprise billing requirements apply to "emergency services," and urgent care centers offer "emergency services."

In summary, LUGPA urges the Departments to include urgent care centers under the definition of "health care facilities" so that the surprise billing requirements apply to both emergency and non-emergency services performed at urgent care centers.

IV. LUGPA is concerned that the Departments' proposed interpretation of the notice and consent requirement in the context of post-stabilization services is far too expansive and could distort the market by significantly favoring insurers.

A. The Departments' expansive interpretation of when a patient is not capable of providing their notice and consent when receiving post-stabilization services will artificially increase the bargaining leverage of insurers in provider network negotiations.

In the IFC, the Departments clarify the applicability of the surprise billing requirements on services that a nonparticipating provider/facility furnishes to an emergency patient *after* they have been stabilized (post-stabilization services).[14] Ordinarily, post-stabilization services are considered emergency services unless the nonparticipating provider/facility satisfies the notice and consent requirements and receives the patient's consent to continue to provide post-stabilization services, albeit at an out-of-network rate. The Departments indicate that it is their view that in cases where the patient cannot travel using nonmedical transportation or nonemergency medical transportation, or cases where there are no participating facilities/providers located within a "reasonable travel distance", the patient cannot "consent freely" and therefore they are protected from balance billing for all of their post-stabilization treatment from the nonparticipating provider/facility.[15] Moreover, to the extent that a patient requires medical transportation to travel, including transportation by either ground or air ambulance vehicles, the balance billing protections will continue to apply to additional post-stabilization services as "the individual is not in a condition to receive notice or provide consent."[16]

LUGPA agrees with the Departments' concerns regarding a patient's ability to provide notice and consent where they have limited resources or ability to genuinely exercise their discretion. These concerns may be most prevalent in rural and underserved communities which have historically had access to smaller provider networks due to geographical challenges.

However, we also have significant concerns about the impact that the Departments' position will have on provider-insurer contracting, especially in the same rural and underserved areas that the Departments are concerned about, and the downstream effects on patients. In particular, we are

---

biden-proposal/.

[13] *Id.*; *see also* Julie Appleby "Surprise! That Urgent Care Center May Send You A Big Bill (Just Like The ER)," Kaiser Health News (July 20, 2015), https://khn.org/news/surprise-that-urgent-care-center-may-send-you-a-big-bill-just-like-the-er/.

[14] 86 Fed. Reg. at 36889.

[15] *Id.*

[16] *Id.* at 36881.

concerned that the Departments' expansive interpretation of post-stabilization services could help insurers deliberately secure smaller networks by insulating them from discontent of their enrollees because they will be protected from balance billing. If insurers know that their enrollees will be guaranteed in-network cost-sharing for a comprehensive set of services (i.e. post-stabilizaiton services) even when these enrollees receive such services from out-of-network providers/facilities due to an emergency, insurers are less incentivized to contract with those providers and fold them into their network. From the perspective of insurers, why make contractual concessions with a provider to enhance your network at all if you can (1) negotiate on a case-by-case basis when the services have already been furnished and the provider is in need of reimbursement, and (2) conceal from your enrollees the limited scope of their network by leveraging a legal system to holding their cost sharing amounts constant?

B. The Departments should rein in the potential adverse impact on provider-contracting negotiations attributable to post-stabilization services by shifting the burden of facilitating nonemergency or nonmedical transportation to the insurer through a nonparticipating provider/facility notification requirement.

In the IFC, the Departments solicit comment on the definition of "reasonable travel distance" and whether specific standards or examples should be provided regarding what constitutes an unreasonable travel burden.[17]

At a more fundamental level, however, LUGPA urges the Departments to explicitly place the burden on *insurers* to arrange for nonemergency, nonmedical *or* medical transportation for their enrollees. The Departments' focus on a "reasonable travel distance" obfuscates that, as currently proposed, nonparticipating providers would not only bear the full costs of the emergency care they were required to furnish, but *also* to bear the full costs of the patient's insurance status and the lack of a participating provider/facility within a "reasonable travel instead." This type of financial exposure in turn limits a provider's ability to provide quality and cost efficient care to their other patients.

LUGPA proposes that the Departments should require a nonparticipating provider to communicate to a patient's insurer when the patient has (1) been stabilized, and (2) refuses to provide notice and consent or (3) cannot provide notice and consent. Upon notifying the insurer of the status of their enrollee, the nonparticipating provider/facility may set forth a specific period of time not to exceed 2 calendar days from the patient's date of admission within which the *insurer* must make or approve arrangements to tranpsort the patient to a participating provider/facility. Where the insurer fails to make or approve the required arrangements within the allotted time, the nonparticipating provider should be reimbursed at their standard charges for any services furnished after the 2 calendar days. If the insurer refuses and both parties go to the IDR arbitraror, the Departments should require the IDR arbitraror to award the nonparticipating provider their standard charges for the period in question, including any amounts that would ordinarily be attributable to the patient's cost sharing.

LUGPA believes that the proposed approach above better balances the Departments' interests in ensuring patients are held harmless when they require emergency out-of-network care and refuse or are incapable of providing notice and consent for post stabilization services, with the desire to preserve the financial health of providers in recognition that they do not have any control upon who walks through their emergency room, but they have an obligation to furnish the best care for them until they leave their institution.

[17] *Id.* at 36881.

V. LUGPA has significant concerns that insurers will leverage the legal instruments of the surprise billing regulations to undermine competition and drive down rates with both participating and non-participating providers/facilities.

A. The QPA mechanism can be exploited by insurers with sufficient market power to drive down participating provider/facility rates.

In the IFC, the Departments set forth the methodology to calculate the qualifying payment amount (QPA) that insurers would use to determine a patient's *cost sharing* amount when the surprise billing requirements apply to their medical care and there is no established All-Payer Model Agreement or state-required payment amount. There are a variety of ways to calculate the QPA, but generally the QPA will represent the median contracted rate for an item or service calculated by arranging in order form least to greatest the contracted rates of all plans of the plan sponsor or all coverage offered by the issuer in the same insurance market for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the geographic region in which the time or service is furnished.[18]

The QPA is *not* intended to represent the payment amount ultimately made to the nonparticipating provider/facility—it only serves as the "recognized amount" from which to calculate a patient's cost sharing.[19] However, it also true that if the insurer and nonparticipating provider/facility fail to agree on the out-of-network rate and go through the independent resolution (IDR) process, the QPA is one of several factors the arbitrators is *required* to consider in assessing the appropriate out-of-network rate.[20] The Departments solicit comments on all aspects of the QPA methodology, including its impact on "cost sharing, payment amounts, and provider network participation…."[21] The Departments also express a concern that the QPA methodology may be susceptible to manipulation by "large consolidated health care systems" whose contracting practices "could inflate the QPA."[22]

LUGPA appreciates the Departments recognition that the QPA may be subject to influence by certain market factors, but we are deeply disappointed that the Departments do not also recognize how insurers may be able to use the QPA to drive down payment rates for providers. In particular, large insurers may leverage the QPA mechanism to effectively set a ceiling on in-network provider rates for certain services, and also progressively drive down out-of-network rates towards an equilibrium that approximates a lower QPA.

For example, suppose a larger insurer within a specific geographic area has five contracted rates for a particular item/service from which to draw upon in determining the QPA: $100, $200, $300, $400, and $500. Under the law, the QPA would be the "median" of the contracted rates, in this case being $300. In a situation where the nonparticipating provider and insurer cannot agree on an out-of-network rate and go through the IDR process, the arbitrator must select among various offers proposed by the parties, but the arbitrator's assessment *must* be informed, at least in part, by the QPA. In essence, the QPA serves as an "anchor" to assist the arbitrator in assessing an

[18] 86 Fed. Reg. at 36889.

[19] *Id.* at 36883 ("By requiring plans and issuers to calculate the cost-sharing amount using the recognized amount, rather than the amount the plan or issuer ultimately pays the nonparticipating provider or nonparticipating emergency facility for the furnished items or services, the No Surprises Act and these interim final rules limit the effect of provider-payer disputes about the payment amounts on participant, beneficiary, or enrollee cost sharing.").

[20] Public Health Service Act, 42 U.S.C. § 300gg-111(c)(5)(C)(i)(I).

[21] Fed. Reg. at 36889.

[22] *Id.*

appropriate out-of-network rate.

The "anchoring effect," which refers to a cognitive bias where decision makers that are required to estimate a certain numerical value tend to ground their estimate on the first and/or most salient numerical value they encounter, is one of the most reliable results of experimental psychology.[23] We are concerned that in the context of the IDR process, the QPA may serve as an "anchor" for both insurers and the arbitrator by (1) anchoring the out-of-network rate offers that insurers make to the IDR arbitrator for consideration, and (2) anchoring the IDR arbitrator's assessment of what the appropriate out-of-network rate should be. In effect, this means that because the QPA will likely represent a lower amount than what the nonparticipating provider/facility would ordinarily charge for such services, the QPA could indirectly drive down the out-of-network rates that nonparticipating providers/facilities actually receive in payment.

Anchors are pervasive and difficult to dislodge, even with subsequently acquired information.[24] Moreover, it would be inconsistent with prevailing research to assume that IDR arbitrators would "split the baby" between insurers and providers by selecting a "compromise" payment rate somewhere in the middle of the two entities. According to one research's survey:

> [R]esearch into commercial arbitration awards by Christopher Drahozal, as well as Stephanie Keer and Richard Naimark, shows that what can appear to be a 50/50 compromise (if one only focuses on raw means) could conceal the fact that arbitrators actually tend to make decisions at either end of the spectrum. Compromise awards are actually the exception, rather than the rule.[25]

Moreover, the impact that the anchoring effect may have in skewing out-of-network rates closer to the QPA (which would generally be lower than the provider's charges) through anchored offers by the insurers and anchored-decision making by IDR arbitrators could extend beyond the dispute being arbitrated. This is because as QPAs help place downward pressure on out-of-network rates, it simultaneously places a limit on what insurers could anticipate to offer *contracted* providers, especially in markets that heavily favor the insurer. That is to say, if an insurer can reasonably estimate that it must pay out-of-network providers at or around a given QPA (because of surprise billing regulations), the insurer has a benchmark to then apply to its in-network providers during the next contracting cycle and demand that they accept lower rates, and if they so refuse, the insurer could expect to pay them around the QPA amount in any event.

Furthermore, this represents a complex, arduous (as described) and, likely lengthy, process of dispute which will serve to: (1) discourage providers from advocating to receive fair remuneration (2) create additional financial burdens to physician practices already straining to adapt to marketplace changes and the COVID disruption (3) create an opportunity to generate significant additional insurance infrastructure designed to maximize company profit (by limiting provider payments) while ultimately passing these costs along as premiums.

In summary, the Departments correctly raise concerns that providers with sufficient market power

---

[23] Piotr Bystranowski et al., "Anchoring Effect in Legal Decision-Making: A Meta-Analysis," *Law and Human Behavior* Vol. 45 No. 1, 1-23 (2021), https://doi.apa.org/fulltext/2021-26899-001.html; Teovanović, Predrag. "Individual Differences in Anchoring Effect: Evidence for the Role of Insufficient Adjustment." *Europe's journal of psychology* vol. 15,1 8-24. 28 Feb. 2019, doi:10.5964/ejop.v15i1.1691.

[24] Jennifer K Robbennolt & Jean R Sternlight," Psychology for Lawyers: Understanding Human Factors in Negotiation, Litigation, and Decision Making," (Chicago: American Bar Association, 2012) at 72.

[25] Susan Franck, "International Arbitration: Between Myth and Reality," 5 MCGILL J. Disp. Resol. 1 (2018-2019), at 24-25.

may be able to exert undue influence on the calculation of the QPA, but LUGPA urges the Departments to recognize that the current iteration of the rule creates a more immediate risk of effective rate-setting by insurers who might thus be able to both: (1) subsidize lower rates for certain services thereby artificially lowering the rates considered in the QPA and (2) manipulate the QPA mechanism to drive down contracted rates over time, and by extension, non-contracted rates as well. We ask that the Departments closely monitor insurer behavior, particularly as it relates to the QPA, and that the Departments closely study how IDR arbitrators are making decisions about the appropriate out-of-network rate relative to the QPA.

VI. Conclusion

On behalf of LUGPA, we would like to thank CMS for providing us with this opportunity to comment on the Proposed Rule. Please feel free to contact Dr. Kapoor at (516)-342-8170 or dkapoor@impplc.com if you have any questions or if LUGPA can provide additional information to assist CMS as it considers these issues.

Respectfully submitted,

R. Jonathan Henderson, MD
President

Deepak A. Kapoor, M.D.
Chairman, Health Policy