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January 27, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS 9911-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 [CMS-9911-P]

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to comment on the "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023" notice of proposed rulemaking issued by the Centers for Medicare and Medicaid Services (CMS). This letter comments on one aspect of CMS' proposal to resume network adequacy reviews for qualified health plans (QHPs) offered through Federally-facilitated Exchanges (FFEs).[1] Specifically, we urge against implementing network adequacy standards related to emergency physicians because doing so would increase patient out-of-pocket costs and premiums without improving patient access.

Network adequacy standards have a role to play in protecting patient access to care and limiting their need to seek out-of-network care for which they may face higher out-of-pocket costs. While insurers have incentives to ensure adequate access to in-network providers in order to attract enrollees, those incentives may not always be strong enough to ensure that all networks are sufficiently broad. This may be because insurers are seeking to avoid higher-risk enrollees who would find a broader network attractive or because consumers have trouble assessing the adequacy of a plan's network. While the root causes of inadequate networks can sometimes be addressed directly, such as by ensuring that risk adjustment appropriately compensates insurers who attract higher-risk enrollees or by making information on plan networks more accessible to consumers, network adequacy standards can be a useful tool in cases where these other approaches are unavailable or insufficient.[2]

However, in crafting network adequacy standards, policymakers must tread carefully. While these standards can expand patient access, they can also make it harder for insurers to credibly threaten to exclude providers from their networks. As the proposed rule correctly notes, this can reduce insurers' leverage in negotiations with

[1] The views expressed in this letter are our own and do not necessarily reflect the views of the Brookings Institution or anyone affiliated with the Brookings Institution other than ourselves.

[2] As one of us (Fiedler) has discussed elsewhere, CMS' proposal to use a "two-stage" estimation procedure to set risk scores would exacerbate network adequacy concerns by strengthening insurers' incentives to avoid higher-risk enrollees and raising the relative premiums of broader network plans. Given CMS' evident concerns about QHP network adequacy, we urge CMS to abandon this proposed change to risk adjustment. See Matthew Fiedler and Timothy Layton, "CMS Should Abandon Its 'Two-Stage' Risk Adjustment Estimation Proposal," January 27, 2022, https://www.brookings.edu/essay/cms-should-abandon-its-two-stage-risk-adjustment-estimation-proposal/.

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providers and, in turn, raise the prices insurers pay.[3] Higher prices ultimately translate into higher out-of-pocket costs (for consumers subject to deductibles or coinsurance) as well as higher premiums, which may be borne either directly by consumers or by the federal government via larger premium tax credits.

In our view, there are instances in which the benefits of imposing network adequacy requirements outweigh the costs. However, this is unlikely to be the case for emergency physicians. Because of the patient protections implemented by the No Surprises Act (NSA), having a broader network of emergency physicians no longer benefits patients. For these services, the NSA limits cost-sharing to what would normally be owed to an in-network provider, regardless of the nominal network status of the provider. Similarly, the Emergency Medical Treatment and Labor Act will continue to ensure that patients will receive needed care regardless of an emergency physician's network status. In short, following implementation of the NSA, there is no meaningful difference between in- and out-of-network emergency physician services from the patient perspective.

While the proposed network adequacy standards for emergency physicians would do nothing to improve patient access or limit out-of-pocket costs, they would likely increase health care spending. Large staffing companies and group practices play a major role in the market for emergency physician services, and the operations of individual staffing companies or practices are frequently concentrated in particular geographic markets.[4] Thus, we believe it is common for one or a small number of entities to control a large fraction of the emergency physicians in any particular geographic market. Network adequacy requirements would make it more difficult for insurers to threaten not to contract with entities that hold a dominant market position, granting these entities significant leverage to demand higher prices from insurers and thereby raising premiums and out-of-pocket costs.

The recently-implemented NSA sought to level the scales for negotiations between payers and emergency physicians, in light of evidence suggesting that large emergency physician staffing companies leveraged the ability to surprise bill into higher prices.[5] Network adequacy standards for emergency physicians would shift the scales back in providers' favor, undoing some of the cost reduction expected to result from the NSA.[6]

We also note that there is no reason to expect implementation of the NSA to reduce the share of emergency physicians that are in-network. Insurers and emergency physicians would retain strong incentives to reach network agreements when they have substantial claims volume with one another in order to streamline claims processing. In fact, by regulating out-of-network payment, the NSA has increased the likelihood that insurers and providers have shared expectations of what would occur if they fail to reach a network agreement, which is likely

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[3] 87 FR 684

[4] See, for example, Envision Healthcare Holdings, Inc., "Form 10-K for the Fiscal Year Ended December 31, 2015," accessed January 27, 2022, https://www.sec.gov/Archives/edgar/data/0001578318/000155837016003692/evhc-20151231x10k.htm; Envision Healthcare Corporation, "Form 10-Q for the Quarterly Period Ended June 30, 2018," accessed January 27, 2022, https://www.sec.gov/Archives/edgar/data/0001678531/000167853118000100/evhc-2018063010q.htm; Team Health Holdings, Inc., "Form 10-Q for the Quarterly Period Ended September 30, 2016," accessed January 27, 2022, https://www.sec.gov/Archives/edgar/data/0001082754/000108275416000083/tmh-10qx93016.htm.

[5] Zack Cooper, Fiona Scott Morton, and Nathan Shekita, "Surprise! Out-of-Network Billing for Emergency Care in the United States," *Journal of Political Economy* 128, no. 9 (September 2020): 3626–3677, https://doi.org/10.1086/708819.

[6] Congressional Budget Office, "H.R. 133, Estimate for Divisions O Through FF Consolidated Appropriations Act, 2021 Public Law 116-260," January 14, 2021, https://www.cbo.gov/publication/56962.

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to make reaching network agreements easier.[7] As an empirical matter, network participation in the affected specialties *rose* sharply following implementation of reforms similar to the NSA's in California.[8] The same was true following implementation of New York's somewhat different surprise billing law.[9]

In sum, because we expect the proposed network adequacy standards for emergency physicians to increase premiums and out-of-pocket costs without improving patient access, we urge CMS not to finalize this proposal.

Thank you for the opportunity to comment on this proposed rule. We hope this information is helpful to you. If we can provide any additional information, we would be happy to do so.

Sincerely,

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[7] Carl M. Stevens, "Is Compulsory Arbitration Compatible With Bargaining?," *Industrial Relations: A Journal of Economy and Society* 5, no. 2 (1966): 38–52, https://doi.org/10.1111/j.1468-232X.1966.tb00450.x; Henry S. Farber and Harry C. Katz, "Interest Arbitration, Outcomes, and the Incentive to Bargain," *ILR Review* 33, no. 1 (October 1, 1979): 55–63, https://doi.org/10.1177/001979397903300105.

[8] Loren Adler et al., "California Saw Reduction in Out-of-Network Care from Affected Specialties after 2017 Surprise Billing Law," September 26, 2019, https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/09/26/california-saw-reduction-in-out-of-network-care-from-affected-specialties-after-2017-surprise-billing-law/.

[9] Cooper, Scott Morton, and Shekita, "Surprise! Out-of-Network Billing for Emergency Care in the United States."