July 10, 2024

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

The Honorable Julie A. Su
Acting Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

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

RE: Shared Savings Programs (SSPs)

Dear Secretaries Becerra, Su, and Yellen:

On behalf of of the members of our respective medical organizations, we write to express our grave concerns regarding the onerous "shared savings" business practice of prominent health insurance companies and their partners. We urge the agencies to take action to address this egregious activity.

"Shared savings programs" ("SSPs") allow third party administrators/insurers ("TPAs") of group health plans funded by employers and employees to confound the intents and purposes of the *No Surprises Act* ("NSA"). More specifically, SSPs are explicitly undermining participating physician networks and incentivize TPAs to low-ball physician payments to maximize TPA profits.

We believe this behavior is the single largest factor in the high volume of NSA arbitration cases. We are concerned that left unchecked, insurance company profiteering from this practice could have a devastating impact on physicians across the country—most particularly physicians who work in small and medium sized community-based practices.

Background on Shared Savings

An SSP can take on various forms. Generally speaking, such programs involve the TPA charging the employer a fee based on a percentage of the "savings" achieved by the

plan from the TPA's processing of out-of-network claims. This fee is **in addition** to the traditional fees assessed to the self-funded plans for processing claims. The "savings" are calculated based on the difference between the out-of-network physician's billed charge and the amount the plan ultimately pays to the physician. This "savings" amount is fictitious because the plan (via the TPA) rarely, if ever, pays the out-of-network physician charge. Since there is no agreed upon rate when care is provided out-of-network, the TPA can drive higher fees from the employer by arbitrarily lowering the amount actually paid to the out-of-network physician. The result is a perverse incentive to keep physicians out-of-network and low-ball claims in order to line the pockets of big insurer companies with potentially billions in profits.

In our opinion, SSPs undermine the fiduciary relationship TPAs have with self-funded employer group plan customers (ERISA plans) who retain TPAs to administer an employer group's self-funded plan on their behalf.

***New York Times* Article Exposing This Practice**

Recently, a *New York Times* article provided further insight into the perverse incentives that TPAs have in place to keep payments to out-of-network physicians lower than a reasonable amount in order to achieve larger "shared savings" profits.[1]

Their investigation highlights the egregious impact that these SSPs can have on patients, particularly those who need long-term treatment or who depend on out-of-network specialists, including for mental health or substance abuse treatment. These patients face larger out-of-pocket costs, particularly when TPAs inappropriately drive down the payments made to out-of-network clinicians and patients are left responsible for the unpaid balance. As stated in the article, in some instances, TPAs "have collected more fees for processing a claim than the health care entity received for treating the patient."[2]

SSPs Have a Damaging Effect on the NSA

SSPs often include out-of-network claims that are now subject to the surprise medical billing protections of the NSA. Often, "savings" from such out-of-network claims are included in the SSPs even though the Federal Independent Dispute Resolution ("IDR")

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[1] Hamby, C., The New York Times, *Health Insurers' Lucrative, Little-Known Alliance: 5 Takeaways* (Apr. 7, 2024), *available at* https://www.nytimes.com/2024/04/07/us/health-insurance-medical-bills-takeaways.html.
[2] *Id*.

process required by the NSA eliminates the role that the TPA plays in achieving the "savings" in the first instance. Even worse, we fear TPAs are incentivized to leverage the NSA protections for this profiteering scheme at the expense of employers, employees and physicians. TPAs know that beneficiaries are protected from balance bills under the NSA. They also know that they can pass any costs associated with the NSA IDR process – administrative and IDR fees - along to the self-insured plans. Thus, TPAs have a strong risk-free financial incentive in maintaining physicians out-of-network status so they can low-ball payments and collect billions in profits from self-insured plans.

Recently released CMS data supports this conclusion. Although self-funded plans represent a little over 50% of all commercially insured patients across the country, CMS's data indicates that self-funded group plans account for a significant portion of IDR cases. Moreover, the IDR process recognizes the TPAs aggressive attempts to underpay physicians by ruling in favor of IDR physician initiators the vast majority of the time. SSPs are a main contributor to the massive backlog of IDR cases.

The Departments Must Take Action to Address this Profiteering Scheme

We are especially concerned about the negative effects that this type of predatory profiteering is having on many of our small and medium-sized anesthesiology, emergency medicine and radiology practices which do not have the financial ability to pursue IDR on an ongoing basis, nor the ability to wait more than nine months for a decision and payment. Consequently, they are often forced to accept these low payments.

This is not what Congress intended when the NSA was adopted. If left unchecked, we are concerned about our members' long-term viability and an end-result which will limit patient access to needed healthcare services.

ACEP, ACR and ASA believe that the Departments must take immediate action to address the impact these SSPs have on self-funded employer plans and by extension the physicians who serve them, including new regulations. Such regulations should, at a minimum, PROHIBIT TPAs from applying SSPs to NSA-eligible claims. Without intervention, health insurance companies will continue to leverage the NSA to pillage employer and employee healthcare funds and jeopardize access to care in the pursuit of billions of dollars in profits.

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Thank you for your consideration of these comments. Should you have any questions, please do not hesitate to contact Laura Wooster at lwooster@acep.org, Joshua Cooper at JCooper@acr.org or Manuel Bonilla at M.Bonilla@asahq.org.

Sincerely,

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