IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

TEXAS MEDICAL ASSOCIATION and DR. ADAM CORLEY, *Plaintiffs*, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; DEPARTMENT OF LABOR; DEPARTMENT OF THE TREASURY; OFFICE OF PERSONNEL MANAGEMENT; and the CURRENT HEADS OF THOSE AGENCIES IN THEIR OFFICIAL CAPACITIES, *Defendants*.	)	Civil Action No. 6:21-cv-00425-JDK

AMICUS CURIAE BRIEF BY
PHYSICIANS ADVOCACY INSTITUTE AND 13 STATE MEDICAL ASSOCIATIONS
IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

The Physicians Advocacy Institute ("PAI") and thirteen state medical associations—1) California Medical Association, 2) Connecticut State Medical Society, 3) Medical Association of Georgia, 4) Kentucky Medical Association, 5) Massachusetts Medical Society, 6) Nebraska Medical Association, 7) Medical Society of New Jersey, 8) Medical Society of the State of New York, 9) North Carolina Medical Society, 10) Oregon Medical Association, 11) South Carolina Medical Association, 12) Tennessee Medical Association, and 13) Washington State Medical Association—hereby submit this friend-of-the-court brief in support of plaintiffs' motion for summary judgment.

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INTRODUCTION

The patient-physician relationship is the core of our nation's healthcare system, centered on physicians' unique ethical duties to provide the best possible care to all patients. Every day, physicians balance a labyrinth of regulatory and administrative hurdles to provide that care, which is becoming more challenging due to payors' complex and sometimes conflicting rules for coverage and payment. There has never been "level" bargaining power between large insurers and physicians, and insurer consolidation concentrating market power[1] has exacerbated the imbalance. Payors wield market power with increasingly one-sided, "take it or leave it" contracts, forcing scores of physicians to flee private practice. The statistics are compelling. The percentage of physicians who no longer practice independently has jumped from 25% to nearly 70% from 2012 to 2020.[2]

To date, the federal government has been extremely reluctant to interfere in private marketplace negotiations between physicians and health insurers. As Congress tackled the challenge of protecting patients from unanticipated out-of-network medical bills, it heeded input from scores of patient and provider groups to reject government rate-setting to resolve reimbursement disputes. Instead, Congress very carefully struck a balance in the No Surprises Act ("NSA") to protect patients from surprise medical bills while creating an unbiased, workable process for health insurers and providers to resolve out-of-network payment disputes. The NSA's detailed independent dispute resolution ("IDR") process decidedly avoids elevating any single factor that must be considered in determining a fair reimbursement rate.

[1] *See* American Med. Association ("AMA"), "Competition in Health Insurance: a comprehensive study of U.S. markets" (2021 update), available online here.

[2] *See* Avalere Health, "COVID-19's Impact on Acquisition of Physician Practices and Physician Employment 2019-2020" (June 2021), available online here.

Defendants' ("Departments") administrative rule, the "Requirements Related to Surprise Billing; Part II," 86 Fed. Reg. 55,980 (Oct. 7, 2021) ("IFR"), bluntly undercuts the careful approach of the NSA. The IDR process that is created through the Departments' IFR veers sharply from the balanced process that Congress conceived but instead relies on government-facilitated rate-setting by health insurers who will have the power to unilaterally dictate reimbursement rates to providers. This severe imbalance of power in the marketplace will greatly diminish patient access to care.

By this amicus curiae brief, amicus parties PAI and thirteen state medical associations (collectively, "Physician Amici"), joined in open support by 18 additional specialty medical societies, explain that patients will be harmed because provider networks will contract in scope and degrade in quality as insurers shift their attention away from building robust networks of providers. North Carolina's largest commercial health insurer has relied on the Department's IFR to announce a new approach to physician contracting – not by negotiating but by demanding immediate drastic cuts up to 30% to existing contract rates. With unsustainable reimbursement from insurers, the trend in physician workforce consolidation into large corporate entities will further accelerate. Safety net providers, who are critical to providing care to rural and underserved urban populations, will be forced out of these communities. Specialists will no longer sign on for emergency call panels to provide critically necessary care in hospitals. Insurance premiums and out-of-pocket costs for care will rise.

Congressional leaders lauded the bipartisan passage of the NSA as a "free-market solution that takes patients out of the middle and fairly resolves disputes between plans and

providers," while emphasizing that the NSA's "text includes **NO** benchmarking or rate-setting."[3] (emphasis in original) The Departments' IFR, however, impermissibly does exactly what Congress designed the NSA not to do.

INTERESTS OF THE PHYSICIAN AMICI

PAI is a not-for-profit organization formed pursuant to a federal district court settlement order in multidistrict class action litigation brought by physicians and state medical associations based on systemic unfair payment practices by the nation's largest for-profit insurers. Consistent with the terms of that court order, PAI's mission is to advance fair and transparent payment policies and contractual practices by payors, in order to sustain the practice of medicine for the benefit of patients. PAI champions policies to allow physicians to sustain independent medical practices, which are a cornerstone for delivering care in our health care system, particularly in underserved and rural areas of the nation. For the past decade, physicians have grappled with increasingly complex payment policies by government and private payers. PAI develops free educational resources, tools, and market information to support physician practices as they navigate these programs and the administrative burdens and costs associated with them. PAI's research shows how challenging it has been for independent practices to survive.

The state medical associations are each nonprofit associations for physicians at every stage of their careers – medical students, interns, residents, and practicing or retired physicians.[4] They, along with the state associations that govern PAI, are comprised of more than 236,000 members across all of America practicing medicine in every mode and setting imaginable. The

[3] Joint Statement House Committees, "Protecting Patients from Surprise Medical Bills" (Dec. 21, 2020), available online here.

[4] More detail about each state association is provided in the Appendix hereto.

state associations work toward advancing the science and art of medicine by, among other things, helping physicians sustain viable medical practices and challenging unfair payor practices and policies to protect patient access to medical care.

DISCUSSION

A. The Departments Overstepped Their Limited Rulemaking Authority and Acted Directly Contrary to the NSA's Statutory Requirements and Express Purpose.

1. The Statutory Text of the NSA Reflects a Careful Balance of Competing Interests in Resolving Out-Of-Network Payment Disputes.

The NSA takes patients out of the middle of billing disputes. *See* 42 U.S.C. §§300gg-131(a), 300gg-132(a). It also creates an IDR process whereby providers and payors may resolve out-of-network payment disputes. 42 U.S.C. §300gg-111(c). The plain text of the statute reflects Congress's clear intent not to impose a benchmark for payment through the IDR process.

Following initial payment[5] for services rendered, either side has 30 days to initiate a 30-day "open negotiations" period. *Id*. at (c)(1)(A). If the parties are unable to agree upon a rate of payment during that time, either side may initiate IDR. *Id*. (c)(1)(B). The NSA then directs the parties to select a certified IDR Entity to resolve their dispute and "determine[] . . . the amount of payment" for the medical services. 42 U.S.C. §300gg-111(c)(4)(F).

IDR under the NSA follows a "baseball-style" process in which the IDR Entity must pick from competing offers submitted by both sides. *Id*.(c)(5)(A). This structure encourages the parties to submit reasonable offers. The parties must negotiate at length before initiating IDR and are permitted to continue to negotiate during the IDR process. *Id*. (c)(2)(B).

The NSA specifies the numerous factors that the IDR Entity "shall" and "shall not"

[5] The payor must make a timely "initial payment" to the rendering provider. 42 U.S.C. § 300gg-111(a)(1)(C)(iv); *id*. (b)(1)(C) and (b)(1)(D). But the NSA leaves that term undefined.

consider. *Id*.(c)(5)(C), *id*.(c)(5)(D). The IDR Entity must consider all information submitted by the parties and cannot arbitrarily disregard a party's submission. *Id*.(c)(5)(C)(i)(II). Factors to be considered include: "[t]he level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service"; "[t]he market share held by the nonparticipating provider . . . or that of the plan or issuer in the geographic region . . ."; "[t]he acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual"; "[t]he teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service"; and "[d]emonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider . . . or the plan . . . to enter into network agreements, and, if applicable, contracted rates between the provider . . . and the plan . . . during the previous 4 plan years." *Id*. at (c)(5)(C)(ii)(I)-(V). The IDR Entity "shall not consider" the "usual and customary charges" or rates paid by federal health care programs including Medicare and Medicaid. *Id.* at (c)(5)(D).

Notwithstanding this clear statutory language, the Departments' IFR imposed a new directive that the IDR entity "must select the offer closest to the QPA unless . . . credible information . . . clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate." 86 Fed. Reg 55980, 55985. The Departments say this rebuttable presumption represents the "best interpretation" of the NSA, but the IFR does not identify any statutory term that actually requires interpretation. The NSA just says that the IDR entity "shall" consider all the enumerated factors. It does not permit, as the IFR establishes, an IDR entity to disregard evidence of the other factors unless the provider meets a heightened burden of proof.

2. The Legislative History of the NSA Confirms that a Presumption in Favor of the QPA is Contrary to Congressional Intent.

The NSA's intricate and detailed scheme for IDR was the culmination of over two years of careful deliberation and compromise by Congress. As the legislative history illustrates, Congress expressly rejected an approach that would impose a benchmark payment rate, even indirectly by governing the outcome of the dispute resolution process.

By 2018, Congress recognized that a legislative solution was needed to address the problem of surprise billing. While all stakeholders agreed that the patient should be protected from unanticipated medical costs, the legislative proposals differed on how to determine appropriate payment for out-of-network services.

The first and ultimately successful approach was to resolve disputes over payment through an open-ended IDR process. In May 2019 a bipartisan group of senators proposed S. 1531[6], which proposed a baseball-style IDR process determined by five factors. The law did not employ a benchmark to resolve payment disputes. The bill attracted significant support, with thirty cosponsors in the Senate, and served as the framework for the NSA.

The second and ultimately unsuccessful approach was to establish a "benchmark" payment rate for providers. An early example was S. 1895.[7] It proposed a "benchmark for payment" that would be set at the payor's "median in-network rate" and would have given providers no ability to negotiate a different rate. The following month, H.R. 3630 established a benchmark payment at the "recognized amount," defined as the payment determined under state

[6] The STOP Surprise Billing Medical Bills Act of 2019, available online here.

[7] The Lower Health Care Costs Act, sponsored by Senators Lamar Alexander (R-TN) and Patty Murray (D-WA), available online here.

law, where applicable, or the median contracted rate.[8]

Subsequent proposals in 2020 moved closer towards a compromise but continued to diverge on rate-setting. On February 7, 2020, the House Ways & Means Committee released legislative text for the Consumer Protections Against Surprise Medical Bills Act of 2020, which proposed no payment benchmark and included an IDR process in which providers could submit any supporting evidence, with the exception of usual and customary or billed charges.[9] On February 11, 2020, a competing proposal, H.R. 5800, passed out of the House Education and Labor Committee.[10] It set payment at the "recognized amount," now defined as an amount set by state law or a state's All-Payer Model Agreement, or at the payor's median contracted rate.[11]

Ultimately, Congress expressly rejected the benchmark payment approach, leaving the level of payment open-ended. *See* 42 U.S.C. §300gg-111(a)(1)(C). The NSA retained the concept of the "recognized amount" – though the term "median contracted rate" was replaced with a more precise definition, the "Qualifying Payment Amount" (QPA),[12] which is used to calculate patient cost-sharing for services covered by the law. It is also one of many factors to be considered in IDR. *See* 42 U.S.C. § 300gg-111(a)(1)(C)(ii)-(iii); *id*. (c)(5)(C)(i)(I). In sharp contrast to competing legislative approaches, the NSA does not establish the QPA as the

[8] The bill was sponsored by Representatives Frank Pallone (D-NJ) and Greg Walden (R-OR) of the House Energy & Commerce Committee., available online here.

[9] Available online here. The bill passed the committee on a bipartisan voice vote on February 12, 2020.

[10] The Ban Surprise Billing Act, available online here.

[11] *See* proposed new Public Health Service Act (PHSA) §§ 2719(a)(1)(C) and *id*.(e)(1)(C), available online here.

[12] *See* 42 U.S.C. § 300gg-111(a)(3)(E) (defining QPA in relevant part as "the median of the contracted rates recognized by the plan . . . on January 31, 2019" for items or services furnished during 2022, adjusted every year thereafter based on the consumer price index for all urban consumers).

payment rate for initial payments under the law. In choosing the NSA approach, Congress voted against establishing a benchmark that limits how much the provider can be paid.

In summary, Congress considered, but rejected, the possibility of using median contracted rates to limit what providers may be paid. While the median contracted rate – the predecessor to the QPA – was included as a factor to be considered in several of the IDR proposals, it is never identified to be the predominant or overriding factor. Nor did Congress delegate to the Departments the ability to instruct IDR entities how to weigh such factors. In the NSA, Congress simply listed all of the factors for the IDR Entity to equally consider.

Congressional leaders who were instrumental in enacting the NSA continued to emphasize the importance of equal consideration of the statutory factors even after the NSA's passage. In an April 29, 2021, letter to the Departments – prior to issuance of the IFR – Senators Cassidy and Hassan stated, "we wrote this law with the intent that arbiters give each arbitration factor equal weight and consideration."[13] The Chair and Ranking Member of the House Ways & Means Committee later issued a letter strenuously objecting to the IFR establishing a rebuttable presumption in favor of the QPA.[14] The letter again emphasized that "[t]he law Congress enacted directs the arbiter to consider all of the factors without giving preference or priority to any one factor—that is the express result of substantial negotiation and deliberation among those Committees of jurisdiction and reflects Congress' intent to design an IDR process that does not become a de facto benchmark."

[13] Available online here (emphasis added).

[14] Available online here.

B. The Departments' IFR Effectively Establishes Health Insurer-Determined Rate-Setting for Out-of-Network Reimbursement.

The IFR's near-exclusive reliance on the QPA during the IDR process is inconsistent with Congress' intent that there be no benchmark for payment. By establishing its rebuttable presumption in favor of the QPA not grounded in any reasonable interpretation of the statute, the IFR elevates the insurer-determined QPA, at the expense of the other co-equal statutory factors, into a de facto payment rate. Such government-sponsored rate-setting is directly contrary to the plain language of and intent behind the NSA.

For the reasons explained, equal consideration by IDR Entities of all the statutory factors set forth in the NSA is crucial to the design of the IDR process. Unless all of the law's factors are given equal weight, there will be no meaningful "open negotiations" between parties to payment disputes as envisioned by the NSA. Congress declared that the information allowed in these enumerated factors are integral to fair payment determinations by IDR Entities, allowing providers to share information relevant to their specific practice characteristics as well as the costs they incur providing care to their patients. In creating the rebuttable presumption in favor of the insurer-determined QPA, which in practice will be difficult if not impossible to overcome, the IFR effectively eliminates any recourse providers may have against unfair network payments and thereby gives enormous marketplace advantage to payors. The IFR will have the de facto impact of setting the ceiling for all payment at the insurer-established in-network median rate.

Practically speaking, the burden to overcome the presumption in favor of the QPA will fall almost exclusively on providers. Payors calculate the QPA based on their own contracted rates, to which providers are not privy. They have no incentive to deviate from their own contracted rates. It is not hard to predict that "the offer closest to the QPA" will virtually always

be the payor's. Indeed, payors will have every incentive to reduce any payments, whether in-network or out-of-network, that exceed the QPA.

Moreover, physicians and other health care providers will find it nearly impossible to overcome the IFR's presumption favoring the QPA because they lack the necessary information to meet this burden. Providers will not even learn what the QPA is until they receive the payor's Explanation of Benefits (EOB) form, which explains what was paid on a claim and assigns an amount to patient responsibility. *See* 85 Fed. Reg. 36872, 36899 (July 13, 2021). Providers are also only entitled to a limited amount of information about whether the QPA was used and how it was calculated, and even then, only "upon request." *Id*.

Physicians and other providers also will not have access to information about the range of in-network rates from which the QPA was determined, or the practice characteristics of contracted physicians that informs those rates. This will dramatically and unfairly limit the types of information that physicians and other health care providers will be able to rely on to make their case to the IDR Entity that the appropriate level of payment is "clearly" and "materially" different than the QPA. The unreasonably high bar set by the IFR's rebuttable presumption, coupled with providers' inability to access or present crucial information that the IDR requires to prevail, will render the IDR process meaningless.

C. Patients will be Harmed by the IFR's Disruption of the Free Market Forces that Have Served to Check Health Insurer Overreach and Dominance.

During Congressional deliberations, Congress heard from a wide range of patient and provider organizations that relying on insurer-determined rate-setting would diminish and disrupt patients' access to affordable, quality health care, especially in rural and underserved urban areas that already struggle with accessibility. Scores of Congressional members expressed this assessment when they wrote to the Departments to criticize the imbalanced IDR process:

> This approach is contrary to statute and could incentivize insurance companies to set artificially low payment rates, which would narrow provider networks and jeopardize patient access to care – the exact opposite of the goal of the law. It could also have a broad impact on reimbursement for in-network services, which could exacerbate existing health disparities and patient access issues in rural and urban underserved communities.[15]

These harms to patients, as explained below, are the inevitable results of a new era ushered in by the IFR that will drastically alter health insurer behavior and incentives in their exercise of business judgment and market power.

On the same day that Congressional members were chiding the Departments for "incentiviz[ing] insurance companies to set artificially low payment rates," North Carolina's largest commercial health insurer seized on its newfound bargaining power to do just that. Citing the Departments' IDR and its reliance on the QPA, the insurer claimed in a letter to a contracted physician practice that "this new federal law allows a significant change to [our] contracting approach," and the insurer now is "able to seek to contract at a rate more in line with what we consider to be a reasonable, market rate."[16] Lest there be doubt, the insurer affirmed that "the Interim Final Rules provide enough clarity to warrant a significant reduction in your contracted rate." The insurer thereupon made a demand that the physicians immediately accept a 15% rate reduction or face near immediate termination from its provider network. Dozens other physician practices in North Carolina received similar letters with demands of up to 30% rate cuts.

1. Provider Networks will Deteriorate as Physician Practices and Other Healthcare Providers Face Widespread Under-compensation.

Under the IFR's rate-setting approach, strong-arm insurer actions like those taken in North Carolina will become standard industry practice. By enabling insurers to impose

[15] Letter from Congressional Members dated Nov. 5, 2021, available online here.

[16] *See* BlueCross BlueShield of North Carolina letter to Contracted Provider (Nov. 5, 2021), available online here.

artificially low reimbursement rates, the IDR all but ensures that physicians and other health care providers will be routinely under-compensated for the care they provide. Inadequate compensation threatens the long-term sustainability of physician practices, particularly small, independent practices that serve rural communities throughout Texas and other parts of the country as well as underserved, dense urban neighborhoods. This will allow insurers to shrink provider networks, thus deteriorating the quality of health insurance coverage for beneficiaries. Patients will suffer serious and immediate harm by losing access to providers.

Unfortunately, the NSA did not require meaningful network adequacy oversight to check insurers from offering inadequate provider networks, and state regulation in this area is notoriously weak. The IFR's rate setting approach allows insurers to adopt even more limited or "narrow" physician and hospital networks which means patients -- especially those needing specialized treatment – will be increasingly unable to access services in-network. When medically necessary in-network care is no longer available or illusory, patients will be forced to seek services out-of-network, resort to emergency rooms for their care, or forego medical care altogether. For out-of-network services not covered by the NSA, patients will typically incur much higher out-of-pocket costs under the terms of their benefit plans. This is particularly challenging for patients with high-deductible plans that impose unaffordably high deductibles for out-of-network services. These additional patient costs run directly counter to Congress's intent in enacting the NSA, namely to protect patients from unanticipated medical expenses.

With preserving patient access as a priority, Congress heeded dramatic warnings from California against the insurer-biased approach that the Departments have adopted in the IDR.

California's surprise billing law unintentionally operated like there was a state-set benchmark.[17] Shortly after the passage of this law, California's health plan regulator found no anesthesiologists in one of the state's largest health plan's networks.[18] A study by the RAND corporation documented that, like the IFR, California's law "has changed the negotiation dynamics between hospital-based physicians and payers [whereby] leverage has shifted in favor of payers, and payers have an incentive to lower or cancel contracts with rates higher than their average as a means of suppressing OON prices."[19] Health plans in California carried through with threats to kick providers out of their networks and terminate long-existing contracts, some as long as 25 years, disavowing any agenda to build up their networks.[20]

2. Access to Safety Net Providers and Critically Needed Specialists will be Jeopardized in Certain Communities.

While not parties to this amicus brief, eighteen medical specialty societies, including many in Texas, have submitted statements amplifying the concern that patients' access to care will suffer as a direct result of the Departments' IFR.[21] These declarations underscore that safety

[17] California's surprise medical billing law requires insurers to make an interim payment to out-of-network providers who then could initiate independent dispute resolution if they believed the rate to be inadequate. *See* Cal. Health & Safety Code §1371.31. The California Medical Association ("CMA") found that, even though the interim payment rate was not a factor under state law to be considered in the IDR process, arbitrators in over 90 percent of cases chose the interim rate as the "reasonable rate" because it was required by state law. *See* CMA Comments to No Surprises Act: Interim Final Rule: Part I (Sept. 7, 2021) at p. 4, available online here.

[18] *See id.* at 5.

[19] *See* Erin Lindsey Duffy, "Influence of Out-of-Network Payment Standards on Insurer-Provider Bargaining, California's Experience" AMERICAN J. OF MANAGED CARE (Aug. 23, 2019) at 1, available online here.

[20] *See* CMA Comments to IFR (Dec. 6, 2021) at pp. 11-12, available online here ("CMA IFR Comments").

[21] The specialty medical societies include the Texas Chapter of the American College of Physicians Services, Texas College of Emergency Physicians, Texas Orthopaedic Association, Texas Radiological Society, Texas Society of Plastic Surgeons, Alabama State Society of

net providers and specialist care in particular will be among the first to be shed from provider networks under the IDR's flawed approach. Moreover, reducing reimbursements in this manner will imperil patient access to critically-necessary specialty services, particularly in emergencies. When payment fails to cover the costs of delivering services, there will be little incentive for physician specialists to serve "on call" at hospitals. This will have dire implications for patients needing these services as emergency departments face physician shortages. These sites have been critical in the COVID pandemic and will continue to provide life-saving care to all Americans regardless of their ability to pay. Unfortunately, emergency departments also serve as the site for primary care for many Americans, who will lose such access.

California's experience substantiates these concerns.[22] CMA reports that an independent emergency physician group recently was threatened by a large health plan with termination from its network if the physicians did not accept a 20% rate cut consistent with the QPA.[23]

3. The IFR will Spur Further Consolidation that Will Undermine Market Competition, Raise Costs, and Limit Patient Access.

Giving insurers unfettered rate-setting ability will only exacerbate the serious financial pressures that have forced many physician practices to sell to larger corporate entities. The

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Anesthesiologists, California Society of Anesthesiologists, Colorado Society of Anesthesiologists, Illinois Society of Anesthesiologists, Florida Society of Anesthesiologists, Louisiana Society of Anesthesiologists, Maine Society of Anesthesiologists, Missouri Society of Anesthesiologists, Nebraska Society of Anesthesiologists, North Carolina Society of Anesthesiologists, New Jersey Society of Anesthesiologists, The New York State Society of Anesthesiologists, Inc., and Wyoming Society of Anesthesiologists. *See* Declaration of Eric Chan, Exs. A through R.

[22] The RAND Corporation study found that "[p]hysicians in anesthesiology, radiology, and orthopedic practices reported unprecedented decreases in payers' offered rates and less interest in contracting since [California's surprise medical billing law] was passed into law." Duffy, *supra*.

[23] *See* CMA IFR Comments, *supra*, at p. 4.

COVID pandemic has heightened these pressures as practices and small community hospitals suffered severe financial losses during the first year of the pandemic. PAI-Avalere research shows a sharp uptick in corporate acquisitions of physician practices in the last half of 2020, indicating a "last straw" financial impact of the pandemic. The American Medical Association explains that the Departments' IDR, by shifting leverage to insurers, "is certain to put an additional, if not fatal, financial strain on many independent practices and rural providers already struggling to make ends meet in their small businesses."[24] The RAND study that focused on the impact of California's surprise medical billing law also confirmed that increased consolidation was seen in the wake of the California law[25]

There is a large body of research showing that health care provider consolidation raises prices and increases overall healthcare spending without clear indications of quality improvements.[26] It also undermines choice and continuity of care for our nation's patients. Ultimately, individual health insurance premiums will rise, as will the out-of-pocket costs for health care that must be borne by patients.

CONCLUSION

For the foregoing reasons and the reasons in plaintiffs' brief on the merits, the Physician Amici respectfully urge the Court to GRANT the plaintiffs' motion for summary judgment.

DATED: December 17, 2021.

Respectfully submitted,

/s/ *Long X. Do*

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[24] *See* AMA Comments to IFR (Dec. 6, 2021) at pp. 1-2, available online here.

[25] Duffy, *supra.*

[26] *See* Karyn Schwartz et al., "What We Know About Provider Consolidation" Kaiser Family Found. (Sept. 2, 2020), available online here.

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CERTIFICATE OF SERVICE

The undersigned certifies that the foregoing document was filed electronically in compliance with Local Rule CV-5(a). This document was also served on all counsel via e-mail service, on this 17th day of December 2021.

/s/ *Long X. Do*
Long X. Do

APPENDIX

[Description of State Medical Associations]

California Medical Association: Founded in 1856 "to develop in the highest possible degree, the scientific truths embodied in the profession," the California Medical Association ("CMA") has served as a professional organization representing California physicians for more than 160 years. Throughout its history, CMA has pursued its mission to promote the science and art of medicine, protection of public health and the betterment of the medical profession. CMA contributes significant value to its 50,000 members with comprehensive practice tools, services and support including legislative, legal, regulatory, economic, and social advocacy. CMA works to help reduce administrative burdens in physician practices, support physicians in providing quality care and ensure they thrive amid industry consolidation.

Connecticut State Medical Society: Since 1792, the Connecticut State Medical Society ("CSMS") has worked on behalf of physicians and patients in Connecticut. Through the CSMS, physicians stand together regardless of specialty to ensure patients have access to quality care and to make our state the best place to practice medicine and to receive care. CSMS is a respected and powerful voice for the medical profession in Connecticut, representing 4,000 physician members and patients before the Connecticut General Assembly, state and federal agencies, health plans, licensing boards, the judicial branch, and more.

Medical Association of Georgia: Founded in 1849, the Medical Association of Georgia ("MAG") is the leading advocate for physicians in the state. MAG's mission is to "enhance patient care and the health of the public by advancing the art and science of medicine and by representing physicians and patients in the policy making process." With more than 8,400 members, including physicians in every specialty and practice setting, MAG's membership has increased by more than 35% since 2010.

Kentucky Medical Association: Established in 1851, the Kentucky Medical Association ("KMA") is a professional organization for physicians throughout the Commonwealth. Representing over 6,000 physicians, residents, and medical students, the KMA works on behalf of physicians and the patients they serve to ensure the delivery of quality, affordable healthcare. Members of KMA share a mission of commitment to the profession and services to the citizen of the Commonwealth that extends across rural and urban areas. From solo practitioners to academicians to large, multi-specialty groups, KMA is the only state association representing every specialty and type of medical practice in Kentucky.

Massachusetts Medical Society: The Massachusetts Medical Society ("MMS") is the statewide professional association for physicians and medical students, supporting 25,000 members. MMS is dedicated to educating and advocating for the physicians of Massachusetts and patients locally and nationally. A leadership voice in health care, the MMS contributes physician and patient perspectives to influence health-related legislation at the state and federal levels, works in support of public health, provides expert advice on physician practice management, and addresses issues of physician well-being. Under the auspices of its NEJM Group, MMS extends its mission globally by advancing medical knowledge from research to patient care through the New England Journal of Medicine and other publications.

Medical Society of the State of New York: The Medical Society of the State of New York ("MSSNY") is an organization of approximately 30,000 licensed physicians, medical residents, and medical students in New York State. MSSNY is a non-profit organization committed to representing the medical profession as a whole and advocating health-related rights, responsibilities, and issues. MSSNY strives to promote and maintain high standards in medical education and in the practice of medicine in an effort to ensure that quality medical care is available to the public.

Medical Society of New Jersey: Founded in 1766, the Medical Society of New Jersey ("MSNJ") is the oldest professional society in the United States. The organization and members are dedicated to a healthy New Jersey, working to ensure the sanctity of the physician-patient relationship. In representing all medical disciplines, MSNJ advocates for the rights of patients and physicians alike, for the delivery of the highest quality medical care. This allows response to the patients' individual, varied needs, in an ethical and compassionate environment, in order to create a healthy Garden State and healthy citizens. With 9,500 members, MSNJ's mission is "to promote the betterment of the public health and the science and the art of medicine, to enlighten public opinion in regard to the problems of medicine, and to safeguard the rights of practitioners of medicine."

Nebraska Medical Association: The Nebraska Medical Association ("NMA") was founded in 1868 and represents nearly 3,000 active and retired physicians, residents, and medical students from across the state of Nebraska. NMA's mission is "to serve physician members by advocating for the medical profession, for patients and for the health of all Nebraskans."

North Carolina Medical Society: North Carolina Medical Society ("NCMS") was founded in 1849 to advance medical science and raise the standards for the profession of medicine. Today, with 8,000 members NCMS continues to champion these goals and ideals while representing the interest of physicians and protecting the quality of patient care.

Oregon Medical Association: Founded in 1874, the Oregon Medical Association ("OMA") is Oregon's largest professional society engaging in advocacy, policy, community-building, and networking opportunities for 8,000 of Oregon's physicians, medical students, physician assistants, and physician assistant students. OMA's mission is to speak as the unified voice of medicine in Oregon; advocate for a sustainable, equitable, and accessible healthcare environment; and energize physicians and physician assistants by building and supporting their community.

South Carolina Medical Association: Since 1789, the South Carolina Medical Association ("SCMA") has served as the foremost association of physicians dedicated to pioneering advances in South Carolina's healthcare. The largest physician organization in the state, SCMA represents more than 6,000 physicians, resident, and medical students and through that representation provides a voice for the medical profession and creates opportunities to improve the health of all South Carolinians. SCMA works to promote the highest quality of medical care through advocacy on the behalf of physicians and patients, continuing medical education, and the promotion of medical and practice management best practices.

Tennessee Medical Association: The Tennessee Medical Association ("TMA") advocates for policies, laws and rules that promote healthcare safety and quality for all Tennesseans and improve the non-clinical aspects of practicing medicine. TMA's mission is to improve the quality of medical practice for physicians and the quality of healthcare for patients by influencing policies, laws, and rules that affect healthcare delivery in Tennessee. On behalf of 9,200 members, TMA works to be the most influential advocacy for Tennessee physicians in the relentless pursuit of the best possible healthcare environment.

Washington State Medical Association: The Washington State Medical Association ("WSMA"), established in 1889, is the largest medical professional association in Washington state, representing more than 12,000 physicians, physician assistants, and trainees from all specialties and various practice settings throughout the state. WSMA's mission is to advance strong physician leadership and advocacy to shape the future of medicine and advance quality care for all Washingtonians.