

**UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION**

AMERICAN SOCIETY OF
ANESTHESIOLOGISTS, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES, *et
al.*,

Defendants.

Case No. 1:21-cv-06823

Honorable Marvin E. Aspen

PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Pursuant to Rule 56(a) of the Federal Rules of Civil Procedure and Rule 56.1 of this Court, Plaintiffs, the American Society of Anesthesiologists, *et al.* (“Plaintiffs”), hereby move for summary judgement on the grounds that there are no disputed issues of material facts, and the Plaintiffs are entitled to judgement as a matter of law. In support of their motion, Plaintiffs rely upon the accompanying statement of material facts not in dispute, the supporting memorandum of law, and the Declarations of Jennifer Raley, MD; Christopher E. Young, MD; and Lauren Golding, MD.

Defendants, the United States Department of Health and Human Services, *et al.* (“Defendants” or “Departments”), unlawfully promulgated provisions of an interim final rule, Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980 (Oct. 7, 2021) (“IFR”), that are contrary to the No Surprises Act (“Act”) and are procedurally invalid. No Surprises Act, Pub. L. No. 116-260, div. BB, tit. I, 134 Stat. 2757-890 (2020). The Act generally prohibits group health plans and group and individual health insurance coverage (collectively, “insurers”)

from charging patients more for receiving certain services outside the insurer’s contracted network than for services received within the insurer’s network. 42 U.S.C. § 300gg-111(a)(1)(C)(ii), (b)(1)(A); 29 U.S.C. § 1185e(a)(1)(C)(ii), (b)(1)(A); 26 U.S.C. § 9816(a)(1)(C)(ii), (b)(1)(A). The Act also contains consumer protections against balance billing—in which an out-of-network providers bills patients for amounts not paid by the insurer—under certain circumstances. 42 U.S.C. §§ 300gg-131(a)(1)-(2), 300gg-132(a)-(d).

To ensure fair reimbursement for non-emergency items or services provided by an out-of-network provider at an in-network health care facility and emergency services provided by an out-of-network provider or an out-of-network emergency facility, the Act also mandates an independent dispute resolution (“IDR”) process to resolve payment disputes between insurers and out-of-network providers/emergency facilities if there is no applicable All-Payer Model Agreement under section 1115A of the Social Security Act or specified state law. 42 U.S.C. § 300gg-111(c)(1)(B); 29 U.S.C. § 1185e(c)(1)(B); 26 U.S.C. § 9816(c)(1)(B). The Act identifies eight factors that the IDR entity “shall consider” when determining the payment amount. 42 U.S.C. § 300gg-111(c)(5)(C); 29 U.S.C. § 1185e(c)(5)(C); 26 U.S.C. § 9816(c)(5)(C). One of these factors is the “qualifying payment amount” (“QPA”), which is the median of the contracted rates recognized by the insurer for the same or similar item or service provided within the same or similar specialty and geographic area, increased by inflation. 42 U.S.C. § 300gg-111(a)(3)(E)(i), (c)(5)(C)(i)(I); 29 U.S.C. § 1185e(a)(3)(E)(i), (c)(5)(C)(i)(I); 26 U.S.C. § 9816(a)(3)(E)(i), (c)(5)(C)(i)(I).

Defendants’ IFR improperly requires the IDR entity to select the payment “offer closest to the qualifying payment amount unless the certified IDR entity determines that credible information submitted by either party ... clearly demonstrates that the qualifying payment

amount is materially different from the appropriate out-of-network rate, or if the offers are equally distant from the qualifying payment amount but in opposing directions.” Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. at 56,104, 56,116, 56,128. As explained in the attached memorandum of law, these provisions of the Departments’ IFR must be vacated because they are contrary to the Act, they were promulgated in excess of statutory authority, and they are substantively and procedurally invalid under the Administrative Procedure Act, 5 U.S.C. §§ 553(b)-(d), 706(2)(A), (C)-(D).

Respectfully submitted,

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Dated: February 9, 2022

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**MEMORANDUM OF LAW IN SUPPORT OF
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INTRODUCTION

Plaintiffs, American Society of Anesthesiologists, *et al.* (“Plaintiffs”) challenge specific provisions of an interim final rule (“IFR”) jointly published by the United States Department of Health and Human Services, *et al.* (“Defendants” or “Departments”), which unlawfully tie the hands of a statutorily mandated independent arbitrator—referred to as an independent dispute resolution (“IDR”) entity—in determining the appropriate reimbursement for certain health care items and services furnished by a provider or emergency facility that is not within the network of the insurer. Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980, 56,104, 56,116, 56,128 (Oct. 7, 2021) [hereinafter “IFR”]. Congress required the IDR entity to consider eight factors when determining the payment amount, but the Departments instead set one factor—the insurer’s in-network rate—as presumptive. The IFR’s presumption in favor of insurers’ in-network rates will empower private health insurers to drive down reimbursement, imperiling providers, emergency facilities, and their patients. These provisions of the IFR violate the plain language of the No Surprises Act, exceed the Departments’ authority granted by Congress, thwart the purpose of the statute, are inconsistent with the legislative history of the No Surprises Act, and were promulgated in violation of the Administrative Procedure Act (“APA”).

The No Surprises Act establishes a process to determine fair payment for certain out-of-network health care items and services provided to participants, beneficiaries, and enrollees (collectively, “patients”) in group health plans and group and individual health insurance coverage (collectively, “insurers”). No Surprises Act, Pub. L. No. 116-260, 134 Stat. 1182 (2020).¹ Congress took a balanced approach to setting the amount of payment for such out-of-

¹ The No Surprises Act amends provisions of the Public Health Service Act, the Employee Retirement Income Security Act, the Internal Revenue Code, and the Federal Employees Health Benefits Act. Plaintiffs’ Local Rule 56.1(a)(2) Statement of Material Facts Not in Dispute ¶ 12

network items or services, ensuring that payment determinations would not inherently favor insurers over health care providers/facilities. 42 U.S.C. § 300gg-111(c)(5); 29 U.S.C. § 1185e(c)(5); 26 U.S.C. § 9816(c)(5). To this end, Congress enumerated specific factors—known as Subparagraph C Factors—that the IDR entity “shall consider” when identifying the appropriate reimbursement amount for items or services furnished out-of-network: 1) the insurer’s in-network rate, known as the qualifying payment amount (“QPA”); 2) the provider’s or facility’s training, experience, and quality and outcomes measurements; 3) the market share held by the provider or facility and insurer; 4) the acuity and complexity of the care; 5) the provider’s or facility’s teaching status, case mix, and scope of services; 6) the good-faith efforts of the provider or facility and insurer to contract in-network rates; 7) information requested by the IDR entity relating to the party’s offer; and 8) any additional information submitted by a party relating to such offer of either party. 42 U.S.C. § 300gg-111(c)(5)(C); 29 U.S.C. § 1185e(c)(5)(C); 26 U.S.C. § 9816(c)(5)(C). Congress purposely avoided giving presumptive weight to any one factor—particularly the QPA, which would tip the scales during the IDR process in favor of insurers because the QPA is tied to the insurer’s median in-network rates.

Plaintiffs, the American Society of Anesthesiologists, the American College of Emergency Physicians, and the American College of Radiology, strongly support Congress’s reforms in the No Surprises Act. The Departments, however, have turned Congress’s reforms upside down and transformed an act intended to protect patients and their doctors into a giveaway to private insurers that will harm patients and providers/facilities. Despite Congress’s clear mandate that the IDR entity “shall consider” and balance all Subparagraph C Factors, the

[hereinafter “Material Facts”]. The Federal Employees Health Benefits Act, as amended by the No Surprises Act, cross references the requirements described in 42 U.S.C. § 300gg-111, 29 U.S.C. § 1185e, and 26 U.S.C. § 9816 (as applicable). 5 U.S.C. § 8902(p); Material Facts ¶ 12.

Departments established a standard for determining payment that *forbids* the IDR entity from considering the non-QPA Subparagraph C Factors “unless credible information submitted by the parties clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate, or unless the offers are equally distant from the QPA but in opposing directions.” IFR, 86 Fed. Reg. at 55,999; Material Facts ¶ 15. The IFR’s rebuttable presumption in favor of the QPA is thus contrary to the plain language of the No Surprises Act. The Departments exceeded the authority granted to them pursuant to the No Surprises Act in promulgating this flawed policy. This presumption in favor of the QPA and the “evidentiary standard” needed to rebut the Departments’ presumption contravene the statutory text and unlawfully abrogate the discretion afforded to the IDR entity, heavily tilting IDR decisions in favor of insurers.

The IFR’s rebuttable presumption undermines the purpose of the No Surprises Act, making the *independent* dispute resolution entity anything but independent. In fact, the Departments’ interpretation of the No Surprises Act has already empowered insurers to reduce in-network contracted rates and threaten existing contractual arrangements with providers. *See* Declaration of Dr. Raley, Exhibit 1; Declaration of Dr. Golding, Exhibit 2.

The Departments’ stated reasons for the rebuttable presumption fail to excuse their violation of the unambiguous language of the No Surprises Act. Thus, the Departments’ rebuttable presumption must be invalidated under *Chevron* step one as contrary to the unambiguous statute. Furthermore, even if the statute were ambiguous, the Departments’ interpretation is unreasonable and owed no deference under *Chevron* step two because the Departments’ construction of the statute is unreasonable, and the IFR’s rebuttable presumption is contrary to congressional intent. This Court should also not accord *Chevron* deference because

the Departments circumvented notice-and-comment rulemaking in promulgating the rebuttable presumption and failed to demonstrate “good cause” for doing so.

Therefore, the Plaintiffs ask the Court to “hold unlawful and set aside” the Departments’ rebuttable presumption in favor of the QPA because it is agency action that is “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;” “without observance of procedure required by law;” and “in excess of statutory jurisdiction, authority, or limitations, or short of statutory right.” 5 U.S.C. §§ 702, 706(2), (A), (C)-(D).

BACKGROUND

I. Reimbursement for Out-of-Network Services

Many insurers create networks of health care providers in which the insurer negotiates rates with providers for particular services as a condition of including the providers in the insurer’s network. *See* Ryan J. Rosso et al., Cong. Rsch. Serv., R46856, Surprise Billing in Private Health Insurance: Overview of Federal Consumer Protections and Payment for Out-of-Network Services 2 (2021) [hereinafter “CRS Report”]; Material Facts ¶ 9.² In general, insurers reimburse “in-network” providers a contracted, in-network rate for the provision of a covered item or service. CRS Report at 2; Material Facts ¶ 9. When patients receive care from an in-network provider, the patient will be responsible for a cost-sharing amount. CRS Report at 2; Material Facts ¶ 9. The patient’s out-of-pocket obligation, however, will typically be less for in-network services than if the patient received care from a provider outside the insurer’s network. CRS Report at 2; Material Facts ¶ 9. An in-network provider generally does not charge the patient the difference between the provider’s charges and the negotiated, in-network rate. CRS Report at 2; Material Facts ¶ 9.

² <https://crsreports.congress.gov/product/pdf/R/R46856>.

If the patient receives care from a provider who does not have a network agreement with the insurer, the patient's insurer will reimburse the provider at the insurer's out-of-network rate, which is not negotiated in advance by the provider and the insurer. CRS Report at 3-4; Material Facts ¶ 10. Prior to the enactment of the No Surprises Act, the difference between the provider's charge and the insurer's out-of-network payment could be billed by the provider to the patient unless prohibited under state law.³ CRS Report at 4-5; Material Facts ¶ 10. This practice is commonly referred to as "balance billing." CRS Report at 4-5; Material Facts ¶ 10. Similarly, "surprise billing" occurs when the patient unknowingly receives items or services from an out-of-network provider at an in-network healthcare facility or receives emergency care provided out-of-network, and the patient is billed for cost-sharing amounts that are not paid by the insurer and are higher than if the patient received care at an in-network provider. CRS Report at 1; Material Facts ¶ 11. Over the years, "surprise billing" has become more common due to insurers offering inadequate in-network rates to emergency and other ancillary service providers, including anesthesiologists and radiologists, forcing these providers to stay out-of-network.

II. The No Surprises Act

On December 27, 2020, the President signed into law the No Surprises Act as part of the Consolidated Appropriations Act, 2021. Material Facts ¶ 12. The No Surprises Act addresses the interrelated problems of surprise billing and inadequate reimbursement by insurers for out-of-network services. The No Surprises Act establishes a comprehensive framework to protect patients from surprise medical bills and to determine fair payment for non-emergency items or services provided by an out-of-network provider at an in-network health care facility and

³ Generally, in states that prohibit balance billing, the provider accepts the insurer's payment for out-of-network services as payment in full, even if the payment falls well below the provider's charge.

emergency services provided by an out-of-network provider or an out-of-network emergency facility. No Surprises Act, Pub. L. No. 116-260, div. BB, tit. I, 134 Stat. 2757-890 (2020) (codified at 42 U.S.C. §§ 300gg-111, 300gg-131 to 132; 29 U.S.C. § 1185e; 26 U.S.C. § 9816). An out-of-network emergency facility is statutorily defined as “an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship” with the insurer for providing such item or service under the plan or coverage. 42 U.S.C. § 300gg-111(a)(3)(F)(i); 29 U.S.C. § 1185e(a)(3)(F)(i); 26 U.S.C. § 9816(a)(3)(F)(i). The No Surprises Act defines a “health care facility” as (1) a hospital, (2) a hospital outpatient department, (3) a critical access hospital, (4) an ambulatory surgical center, and (5) any other facility specified by the Departments. 42 U.S.C. § 300gg-111(b)(2)(A)(ii); 29 U.S.C. § 1185e(b)(2)(A)(ii); 26 U.S.C. § 9816(b)(2)(A)(ii).

A. Reforms to Patient Cost-Sharing

The No Surprises Act prohibits insurers from imposing a cost-sharing requirement for such items or services that is greater than the amount that would apply if these items or services were provided in-network.⁴ 42 U.S.C. § 300gg-111(a)(1)(C)(ii), (b)(1)(A); 29 U.S.C. § 1185e(a)(1)(C)(ii), (b)(1)(A); 26 U.S.C. § 9816(a)(1)(C)(ii), (b)(1)(A). The No Surprises Act mandates that insurers use the “recognized amount” when calculating the cost-sharing requirement. 42 U.S.C. § 300gg-111(a)(1)(C)(iii), (b)(1)(B); 29 U.S.C. § 1185e(a)(1)(C)(iii), (b)(1)(B); 26 U.S.C. § 9816(a)(1)(C)(iii), (b)(1)(B). “Recognized amount” is defined in the No Surprises Act as (1) the amount that the state approves under the applicable All-Payer Model Agreement under section 1115A of the Social Security Act, (2) the amount determined in

⁴ The No Surprises Act provides an exception to this prohibition for non-emergency items and services if certain notice and consent criteria are satisfied. 42 U.S.C. § 300gg-111(b)(1)(A); 42 U.S.C. § 300gg-132(d); 29 U.S.C. § 1185e(b)(1)(A); 26 U.S.C. § 9816(b)(1)(A).

accordance with the “specified state law” (as defined in 42 U.S.C. § 300gg-111(a)(3)(I), 29 U.S.C. § 1185e(a)(3)(I), and 26 U.S.C. § 9816(a)(3)(I)) if there is no applicable All-Payer Model Agreement under section 1115A of the Social Security Act, or (3) the amount that is the QPA for the item or service if there is no “specified state law” or applicable All-Payer Model Agreement under section 1115A of the Social Security Act.⁵ 42 U.S.C. § 300gg-111(a)(3)(H); 29 U.S.C. § 1185e(a)(3)(H); 26 U.S.C. § 9816(a)(3)(H). The QPA is generally defined in statute as the “median of the contracted rates recognized by the [insurer] ... for the same or a similar item or service that is provided by a provider in the same or similar specialty and ... geographic region ... increased by the percentage increase in the consumer price index for all urban consumers.” 42 U.S.C. § 300gg-111(a)(3)(E)(i); 29 U.S.C. § 1185e(a)(3)(E)(i); 26 U.S.C. § 9816(a)(3)(E)(i).

B. Reforms to Out-of-Network Reimbursement

The No Surprises Act mandates that insurers reimburse out-of-network providers/facilities an “out-of-network rate,” minus the cost-sharing requirement of the patient. 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(II), (b)(1)(D); 29 U.S.C. § 1185e(a)(1)(C)(iv)(II), (b)(1)(D); 26 U.S.C. § 9816(a)(1)(C)(iv)(II), (b)(1)(D). The “out-of-network rate” is determined by the applicable All-Payer Model Agreement under section 1115A of the Social Security Act, or if no such agreement exists, the “specified state law.” 42 U.S.C. § 300gg-111(a)(3)(K)(i), (iii); 29 U.S.C. § 1185e(a)(3)(K)(i), (iii); 26 U.S.C. § 9816(a)(3)(K)(i), (iii). If there is no “specified state law” or applicable All-Payer Model Agreement under section 1115A of the Social Security Act, Congress permits insurers to determine the initial out-of-network reimbursement amount

⁵ Section 1115A of the Social Security Act authorizes the Department of Health and Human Services, via its Centers for Medicare and Medicaid Services, to allow “States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals [i.e., individuals eligible for both Medicare and Medicaid].” 42 U.S.C. § 1315a(b)(2)(B)(xi).

and to send the provider/facility the initial payment, or a notice of denial of payment, not later than 30 calendar days after the insurer receives the bill of the provider or facility. 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(I), (b)(1)(C), (a)(3)(K)(ii); 29 U.S.C. § 1185e(a)(1)(C)(iv)(I), (b)(1)(C), (a)(3)(K)(ii); 26 U.S.C. § 9816(a)(1)(C)(iv)(I), (b)(1)(C), (a)(3)(K)(ii).

If the provider/facility disagrees with the insurer's initial payment determination, the provider/facility can initiate a 30-day open negotiation with the insurer to determine the amount of payment for the out-of-network item or service. 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(I), (a)(3)(K)(ii), (c)(1)(A); 29 U.S.C. § 1185e(a)(1)(C)(iv)(I), (a)(3)(K)(ii), (c)(1)(A); 26 U.S.C. § 9816(a)(1)(C)(iv)(I), (a)(3)(K)(ii), (c)(1)(A). If parties cannot agree on the amount for the out-of-network item or service, either party may initiate the IDR process within four days after the open negotiation period. 42 U.S.C. § 300gg-111(c)(1)(B); 29 U.S.C. § 1185e(c)(1)(B); 26 U.S.C. § 9816(c)(1)(B).

The parties then have three business days to jointly select an IDR entity. 42 U.S.C. § 300gg-111(c)(4)(F)(i); 29 U.S.C. § 1185e(c)(4)(F)(i); 26 U.S.C. § 9816(c)(4)(F)(i). If the parties cannot agree on an IDR entity, the Departments will select an IDR entity for them. 42 U.S.C. § 300gg-111(c)(4)(F)(ii); 29 U.S.C. § 1185e(c)(4)(F)(ii); 26 U.S.C. § 9816(c)(4)(F)(ii). Within ten days of the IDR entity's selection, the provider/facility and insurer must each submit to the IDR entity an offer for a payment amount and information requested by the IDR entity relating to the offer. 42 U.S.C. § 300gg-111(c)(5)(B)(i); 29 U.S.C. § 1185e(c)(5)(B)(i); 26 U.S.C. § 9816(c)(5)(B)(i). The provider/facility and insurer also may submit to the IDR entity any additional information relating to the initial offers submitted by either party. 42 U.S.C. § 300gg-111(c)(5)(B)(ii); 29 U.S.C. § 1185e(c)(5)(B)(ii); 26 U.S.C. § 9816(c)(5)(B)(ii).

Within thirty days of its selection, the IDR entity “shall ... tak[e] into account the considerations specified in subparagraph (C)” (the Subparagraph C Factors) and “select one of the offers submitted” by the parties as the amount of payment for the item or service provided out-of-network. 42 U.S.C. § 300gg-111(c)(5)(A)(i); 29 U.S.C. § 1185e(c)(5)(A)(i); 26 U.S.C. § 9816(c)(5)(A)(i). Subparagraph C lists the factors that the IDR entity “shall consider” in its determination:

(I) the qualifying payment amounts ... for the applicable year for items or services that are comparable to the qualified IDR item or service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR item or service; and

(II) ... information on any circumstance described in clause (ii), such information as requested [by the IDR entity relating to the party’s offer], and any additional information [submitted by a party relating to such offer of either party].

42 U.S.C. § 300gg-111(c)(5)(C)(i)(I)-(II), (c)(5)(B)(i)(II), (c)(5)(B)(ii); 29 U.S.C. § 1185e(c)(5)(C)(i)(I)-(II), (c)(5)(B)(i)(II), (c)(5)(B)(ii); 26 U.S.C. § 9816(c)(5)(C)(i)(I)-(II), (c)(5)(B)(i)(II), (c)(5)(B)(ii). In “clause (ii),” referenced in subclause (II) above, Congress enumerates five additional factors that the IDR entity “shall consider”:

(I) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service

(II) The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided.

(III) The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual.

(IV) The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service.

(V) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the

provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

42 U.S.C. § 300gg-111(c)(5)(C)(ii); 29 U.S.C. § 1185e(c)(5)(C)(ii); 26 U.S.C. § 9816(c)(5)(C)(ii).

In subparagraph D, Congress also delineates specific factors that the IDR entity “shall not consider” (the “Subparagraph D Factors”). These factors include usual and customary charges; the reimbursement rate for such items and services payable by a public payer (*e.g.*, Medicare, Medicaid, the Children’s Health Insurance Program, TRICARE, United States Department of Veterans Affairs); or the amount that the out-of-network provider/facility would have billed for the item or service had the No Surprises Act not applied. 42 U.S.C. § 300gg-111(c)(5)(D); 29 U.S.C. § 1185e(c)(5)(D); 26 U.S.C. § 9816(c)(5)(D).

If the parties agree on a payment amount before the IDR entity makes its final payment determination, the agreed upon amount will constitute the out-of-network rate. 42 U.S.C. § 300gg-111(a)(3)(K)(ii), (c)(2)(B); 29 U.S.C. § 1185e(a)(3)(K)(ii), (c)(2)(B); 26 U.S.C. § 9816(a)(3)(K)(ii), (c)(2)(B). Otherwise, the decision of the IDR entity will be “binding ... in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim.” 42 U.S.C. § 300gg-111(c)(5)(E)(i)(I); 29 U.S.C. § 1185e(c)(5)(E)(i)(I); 26 U.S.C. § 9816(c)(5)(E)(i)(I).

Further, Congress directed the Departments to establish a process to certify (and recertify) IDR entities to ensure that the IDR entity acts as an independent arbiter. 42 U.S.C. § 300gg-111(c)(4)(A); 29 U.S.C. § 1185e(c)(4)(A); 26 U.S.C. § 9816(c)(4)(A). Specifically, the Departments’ certification process must ensure, among other things, that the IDR entity is not an insurer, a provider/facility, or an affiliate or subsidiary of a professional or trade association of such insurers, providers, or facilities; and does not carry out a payment determination if it (1) has

a “material familial, financial, or professional relationship” with a party to such determination; (2) is a party themselves or an employee or agent of a party with respect to the determination; or (3) otherwise has a conflict of interest with such a party. 42 U.S.C. § 300gg-111(c)(4)(A)(ii), (vi), (c)(4)(F)(i)(I)-(III); 29 U.S.C. § 1185e(c)(4)(A)(ii), (vi), (c)(4)(F)(i)(I)-(III); 26 U.S.C. § 9816(c)(4)(A)(ii), (vi), (c)(4)(F)(i)(I)-(III). The IDR entity must also have “sufficient medical, legal, and other expertise and sufficient staffing to make [payment] determinations.” 42 U.S.C. § 300gg-111(c)(4)(A)(i); 29 U.S.C. § 1185e(c)(4)(A)(i); 26 U.S.C. § 9816(c)(4)(A)(i).

Congress directed the Departments to implement the IDR process through rulemaking “in accordance with the succeeding provisions of this subsection” (*i.e.*, the statutory provisions governing how the IDR entity determines the appropriate payment amount). 42 U.S.C. § 300gg-111(c)(2)(A); 29 U.S.C. § 1185e(c)(2)(A); 26 U.S.C. § 9816(c)(2)(A). Congress granted the Departments one full year after the enactment of the No Surprises Act, by December 27, 2021, to engage in notice-and-comment rulemaking and promulgate implementing regulations on the IDR process. 42 U.S.C. § 300gg-111(c)(2)(A); 29 U.S.C. § 1185e(c)(2)(A); 26 U.S.C. § 9816(c)(2)(A).

III. Interim Final Rule Published on October 7, 2021

A. Promulgation Without Notice-and-Comment Rulemaking

On October 7, 2021, nine months after enactment of the No Surprises Act, the Departments published the IFR in the Federal Register, implementing the No Surprises Act’s provisions governing the IDR process. IFR, 86 Fed. Reg. 55,980 (Oct. 7, 2021); Material Facts ¶ 15.⁶ Prior to this publication, the Departments did not provide general notice of proposed

⁶ Prior to the IFR, on July 13, 2021, the Departments published in the Federal Register an interim final rule implementing other provisions of the No Surprises Act that are not at issue in this

rulemaking and did not afford interested parties an opportunity to participate in the rulemaking through the submission of written comments. Instead, the IFR went into effect on the same day of publication—October 7, 2021. Material Facts ¶ 22.

The Departments admitted that the timeframe from the No Surprises Act’s enactment on December 27, 2020, and the effective date for the application of the IDR provisions for plan years beginning January 1, 2022, “may have allowed for ... the full notice and comment rulemaking process.” IFR, 86 Fed. Reg. at 56,043-44; Material Facts ¶ 22. However, they concluded that it was “impracticable and contrary to the public interest to delay putting the ... interim final rules in place until a full public notice and comment process has been completed,” and they found that there was “good cause to waive the delay in effective date for certain provisions of these interim final rules.” *Id.* at 56,043; Material Facts ¶ 22. The Departments surmised that engaging in notice-and-comment rulemaking “would not provide sufficient time for the regulated entities to implement the requirements.” IFR, 86 Fed. Reg. at 56,044; Material Facts ¶ 22. The Departments further asserted:

Issuing these rules as interim final rules, rather than as a notice of proposed rulemaking, will allow plans and issuers to account for the regulations as they finalize rates and plan offerings and will allow IDR entities to seek certification and be available to take part in the Federal IDR process when these interim final rules go into effect. Health plans and issuers, and providers, facilities and providers of air ambulance services, require these rules to be in place to determine the out-of-network rates for emergency services, services by out-of-network providers at in-network facilities in certain circumstances, and air ambulance services. Without these final rules, providers, facilities and providers of air ambulance services will not be able to resort to the Federal IDR process (and are no longer able to balance bill patients), leaving the possibility that they will be undercompensated for their services. Such undercompensation could threaten the viability of these providers, facilities and providers of air ambulance services. This in turn, could lead to participants, beneficiaries and enrollees not receiving needed medical care, undermining the goals of the No Surprises Act.

action. Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36,872 (July 13, 2021); Material Facts ¶ 13.

Additionally, and for the same reasons, the failure to promulgate this rule in a timely fashion could lead to additional industry consolidation, potentially driving health costs higher.

IFR, 86 Fed. Reg. at 56,044; Material Facts ¶ 22.

B. Provisions Governing the Selection of an Offer Under the IDR Process

Despite Congress’s enumeration of multiple factors that the IDR entity “shall consider” in selecting an offer, the Departments published the IFR establishing a “rebuttable presumption” that the appropriate out-of-network rate is the offer closest to the QPA. IFR, 86 Fed. Reg. at 56,104, 56,116, 56,128; Material Facts ¶ 15. Specifically, under the IFR, the IDR entity is obligated to select the offer closest to the QPA unless it “determines that *credible information* submitted by either party ... *clearly demonstrates* that the [QPA] is *materially different* from the appropriate out-of-network rate, or if the offers are equally distant from the QPA but in opposing directions.” *Id.* at 56,104, 56,116, 56,128 (emphasis added); Material Facts ¶ 15. In determining whether information is “credible,” the IFR directs the IDR entity to conduct a “critical analysis” of whether information is worthy of belief and is trustworthy. IFR, 86 Fed. Reg. at 55,995, 56,100, 56,113, 56,125; Material Facts ¶ 16. The IFR further specifies that a “material difference” exists where “there is substantial likelihood that a reasonable person with the training and qualifications” of an IDR entity “would consider the information important in determining the out of network rate and view the information as showing that the QPA is not the appropriate out-of-network rate under such additional circumstances.” IFR, 86 Fed. Reg. at 55,995; Material Facts ¶ 17.

In contrast to this critical analysis of the non-QPA Subparagraph C Factors, the IFR makes clear that “it is not the role of the certified IDR entity to determine whether the QPA has been calculated by the [issuer] correctly.” IFR, 86 Fed. Reg. at 55,996; Material Facts ¶ 18. Moreover, if the IDR entity does not select the offer closest to the QPA, it must provide a written

decision including “a detailed explanation of the additional considerations relied upon, whether the information about those considerations submitted by the parties was credible, and the basis upon which the certified IDR entity determined that the credible information demonstrated that the QPA is materially different from the appropriate out-of-network rate.” IFR, 86 Fed. Reg. at 56,000; Material Facts ¶ 19.

In other words, the Departments gave presumptive weight to only one factor—the QPA—and imposed a heightened evidentiary standard for considering all other statutory factors in the likely event that the offers are not equally distant from the QPA and in opposing directions. In rationalizing this interpretation, the Departments did not identify explicit statutory text mandating the rebuttable presumption. Instead, the Departments argue that the IFR’s provisions governing the IDR entity’s selection of an offer is the “best interpretation” of the statute because they assert that the QPA “represents a reasonable market-based payment for relevant items and services.” IFR, 86 Fed. Reg. at 55,996; Material Facts ¶ 20. In an attempt to justify their rebuttable presumption in favor of the offer closest to the QPA, the Departments note that (1) the “statutory text lists the QPA as the first factor;” (2) the non-QPA factors appears “in a separate paragraph” and are subject to subparagraph (D), which describes certain factors that the IDR entity cannot consider in determining payment; (3) the statute “sets out detailed rules for calculating the QPA;” and (4) the No Surprises Act mentions the QPA in other provisions of the statute that do not govern the determination of payment to out-of-network providers/facilities. IFR, 86 Fed. Reg. at 55,996; Material Facts ¶ 20.

Additionally, the Departments reference various “policy considerations” in support for their interpretation, including that the rebuttable presumption “will increase the predictability of IDR outcomes, which may encourage parties to reach an agreement outside of the Federal IDR

process to avoid the administrative costs, and will aid in reducing prices that may have been inflated due to the practice of surprise billing prior to the No Surprises Act.” IFR, 86 Fed. Reg. at 55,996; Material Facts ¶ 21. They also claim that their policy “will help limit the indirect impact on [patients] that would occur from higher out-of-network rates if plans and issuers were to pass higher costs on to individuals in the form of increases in premiums.” IFR, 86 Fed. Reg. at 55,996; Material Facts ¶ 21. Lastly, the Departments assert, without any evidence, that the QPA “should reflect standard market rates ... established through arms-length negotiations.” IFR, 86 Fed. Reg. at 55,996; Material Facts ¶ 21.

IV. APA Rulemaking

Under the APA, an agency may adopt a substantive rule of general applicability only after providing general notice of proposed rulemaking to the public, considering comments received from the public, and publishing the final rule not less than 30 days before the rule’s effective date. 5 U.S.C. § 553(b)-(d). The notice-and-comment rulemaking “procedures are not a mere formality.” *Cap. Area Immigrants’ Rts. Coal. v. Trump*, 471 F. Supp. 3d 25, 44 (D.D.C. 2020). The procedural requirement is “designed (1) to ensure that agency regulations are tested via exposure to diverse public comment, (2) to ensure fairness to affected parties, and (3) to give affected parties an opportunity to develop evidence in the record to support their objections to the rule and thereby enhance the quality of judicial review.” *Id.* (quoting *Int’l Union, United Mine Workers v. Mine Safety & Health Admin.*, 407 F.3d 1250, 1259 (D.C. Cir. 2005)) (internal quotations omitted); *see also Hocror v. U.S. Dep’t of Agric.*, 82 F.3d 165, 167 (7th Cir. 1996) (“Notice and comment rulemaking ... facilitates the marshaling of opposition to a proposed rule, and may result in the creation of a very long record that may in turn provide a basis for a judicial challenge to the rule if the agency decides to promulgate it.”).

The APA creates a limited exception to the notice-and-comment rulemaking requirement

if the agency finds “good cause” that these procedures are “impracticable, unnecessary, or contrary to the public interest.” 5 U.S.C. § 553(b)(B), (d)(3). The “good cause” exception under 5 U.S.C. § 553 is “narrowly construed and only reluctantly countenanced.” *New Jersey, Dep’t Env’t Prot. v. EPA*, 626 F.2d 1038, 1045 (D.C. Cir. 1980). It is not to be construed as an “escape clause[]” that may be arbitrarily utilized at [an] agency’s whim.” *Am. Fed’n of Gov’t Emps., AFL-CIO v. Block*, 655 F.2d 1153, 1156 (D.C. Cir. 1981) (quoting S. Rep. No. 752, 79th Cong., 1st Sess. (1945), *reprinted in* Administrative Procedure Act, Legislative History, 79th Cong. 1944-46 at 200, 201).

V. Standard of Review

The APA authorizes judicial review of final agency actions, requiring a reviewing court to “hold unlawful and set aside” the agency action that is “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;” “without observance of procedure required by law;” and “in excess of statutory jurisdiction, authority, or limitations, or short of statutory right.” 5 U.S.C. §§ 702, 706(2), (A), (C)-(D); *see also Motor Vehicle Mfrs. Ass’n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 41 (1983); *Cook Cnty. v. Wolf*, 962 F.3d 208, 221 (7th Cir. 2020), *cert. dismissed sub nom. Mayorkas v. Cook Cnty.*, 141 S. Ct. 1292 (2021). “Cases arising under the APA are typically resolved by summary judgment on the basis of the administrative record compiled by the agency.” *Citizens for Appropriate Rural Rds., Inc. v. Foxx*, 14 F. Supp. 3d 1217, 1228 (S.D. Ind. 2014) (citing *Fla. Power & Light Co. v. Lorion*, 470 U.S. 729, 744–45 (1985)). When evaluating agency action under the APA, “the district court ‘sits as an appellate tribunal,’ and ‘the question of whether [the agency] acted in an arbitrary and capricious manner is a legal one which the district court can resolve on the agency record.”” *Great Am. Ins. Co. v. United States*, 55 F. Supp. 3d 1053, 1057-58 (N.D. Ill. 2014) (quoting

Univ. Med. Ctr. of S. Nev. v. Shalala, 173 F.3d 438, 440 n.3 (D.C. Cir. 1999)).

When reviewing the substantive validity of an agency's rule, a court must give effect to an unambiguous statute. *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984). "First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Id.*; see also *Cook Cnty.*, 962 F.3d at 221. A court "owe[s] an agency's interpretation of the law no deference unless, after 'employing traditional tools of statutory construction,'" it is "unable to discern Congress's meaning." *SAS Inst., Inc. v. Iancu*, 138 S. Ct. 1348, 1358 (2018) (quoting *Chevron*, 467 U.S. at 843 n.9). In ascertaining whether the statute is clear or ambiguous, courts "consider the language itself, the specific context in which that language is used, and the broader context of the statute as a whole, and reference to dictionary definitions is appropriate." *Emergency Servs. Billing Corp. v. Allstate Ins. Co.*, 668 F.3d 459, 465 (7th Cir. 2012) (internal quotations marks and citations omitted).

If the statute is silent or ambiguous, however, then the court must then determine, under the "step two" standard articulated in *Chevron*, if the interpretation provided by an agency is "based on a permissible construction of the statute." *Chevron*, 467 U.S. at 843; see also *Jeffers v. Comm'r of Internal Revenue*, 992 F.3d 649, 654 (7th Cir. 2021). In conducting this analysis, a court must "view the agency's interpretation in light of the legislative history, the purpose of the statute, and comparative statutes in order to determine whether the agency's interpretation is reasonable." *Emergency Servs. Billing Corp.*, 668 F.3d at 466; see *MBH Commodity Advisors, Inc. v. Commodity Futures Trading Comm'n*, 250 F.3d 1052, 1061 (7th Cir. 2001). "A court may strike down an agency's interpretation of a law if, for example, the agency's reading

disregards the statutory context; its rule is based on an unreasonable interpretation of legislative history; or its new position ‘would bring about an enormous and transformative expansion in [the agency’s] regulatory authority without clear congressional authorization.’” *Cook Cnty.*, 962 F.3d at 226-27 (internal citations omitted). The *Chevron* step two analysis often merges with arbitrary and capricious review under the APA. *Judulang v. Holder*, 565 U.S. 42, 53 n.7 (2011) (quoting *Mayo Found. for Med. Educ. & Rsch. v. United States*, 562 U.S. 44, 53 (2011)); *Reverse Mortg. Sols., Inc. v. U.S. Dep’t of Hous. & Urb. Dev.*, 365 F. Supp. 3d 931, 947 (N.D. Ill. 2019).

Lastly, “where a proper challenge is raised to the agency procedures, and those procedures are defective, a court should not accord *Chevron* deference to the agency interpretation.” *Cook Cnty.*, 962 F.3d at 222 (quoting *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 221 (2016)).

ARGUMENT

The Departments’ rebuttable presumption in favor of the QPA is contrary to the unambiguous text of the No Surprises Act, and the Departments’ unpersuasive reasons for the rebuttable presumption do not excuse their violation of the statute. Congress unequivocally mandated that the IDR entity “shall consider” all Subparagraph C Factors in determining the appropriate out-of-network rate for items and services. 42 U.S.C. § 300gg-111(c)(5)(C); 29 U.S.C. § 1185e(c)(5)(C); 26 U.S.C. § 9816(c)(5)(C). The No Surprises Act contains not a whisper of a “presumption” in favor of the QPA or the evidentiary standard established by the Departments. Had Congress wanted to establish a rebuttable presumption in favor of the QPA, it would have said so. Other provisions of the Consolidated Appropriations Act, 2021, which contains the No Surprises Act, expressly established rebuttable presumptions—in contrast, Congress did not explicitly (or implicitly) create a rebuttable presumption for the IDR entity’s consideration of factors for determining payment. Instead, Congress used precise terminology

requiring the IDR entity to review all statutory factors without elevating any single factor above the others. Accordingly, “Congress has directly spoken to the precise question at issue,” *Chevron*, 467 U.S. at 842, and those portions of the IFR creating the rebuttable presumption must be vacated.

The Departments flouted Congress’s intent by barring the IDR entity from considering the non-QPA Subparagraph C Factors unless a party satisfies a heightened evidentiary standard that is absent from the plain language of the No Surprises Act. IFR, 86 Fed. Reg. at 56,104, 56,116, 56,128. In establishing the rebuttable presumption, the Departments exceeded their statutory authority. Because the Departments’ interpretation contravenes the unambiguous text of the statute, it is invalid under *Chevron* step one.

Thus, a *Chevron* step two analysis should be unnecessary. However, the Departments’ rebuttable presumption would nonetheless fail under *Chevron* step two because it embodies an impermissible interpretation of the statute. Their interpretation, which impermissibly ties the hands of the independent arbiter and skews the IDR decision in favor of insurers, frustrates the No Surprises Act’s purpose. The rebuttable presumption is also inconsistent with the legislative history and the broader context of the No Surprises Act. Moreover, in creating a heightened evidentiary standard needed to overcome the presumption that the “QPA is [the] appropriate payment amount,” IFR, 86 Fed. Reg. at 55,995, the Departments “relied on factors which Congress has not intended it to consider.” *Motor Vehicle Mfrs. Ass’n of U.S., Inc.*, 463 U.S. at 43; *Zero Zone, Inc. v. U.S. Dep’t of Energy*, 832 F.3d 654, 668 (7th Cir. 2016). Therefore, the Departments’ interpretation is not “based on a permissible construction of the statute.” *Chevron*, 467 U.S. at 843. For the same reasons that it is an impermissible interpretation under *Chevron* step two, the Departments’ policy is also substantively invalid under the APA.

Lastly, the rebuttable presumption in favor of the QPA is procedurally invalid under the APA. 5 U.S.C. § 553(b)(B), (d)(3). The Departments failed to demonstrate “good cause” for circumventing APA notice-and-comment rulemaking in promulgating the rebuttable presumption. Because the IFR was promulgated in violation of the APA, the Departments’ rebuttable presumption is not entitled to *Chevron* deference. *Encino Motorcars*, 579 U.S. at 220-21.

For all these reasons, the Departments’ policy must be set aside as agency action that is “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;” “in excess of statutory ... authority;” and “without observance of procedure required by law.” 5 U.S.C. § 706(2)(A), (C)-(D).

I. The Departments’ Rebuttable Presumption Is Invalid Under *Chevron* Step One Because It Is Contrary to the Language of the Statute

The Departments’ rebuttable presumption contravenes the plain language of the No Surprises Act and is, therefore, invalid. Congress was clear that the IDR entity “shall consider” all Subsection C Factors. Elsewhere in the Consolidated Appropriations Act, 2021, Congress expressly created presumptions but did not do so for the IDR entity. The Departments have impermissibly rewritten the statute by creating a presumption in favor of the QPA and heightened standards for considering the other Subsection C Factors. Accordingly, the IFR fails under *Chevron* step one.

When interpreting a statute, a reviewing court must begin with its text. *Middleton v. City of Chicago*, 578 F.3d 655, 658 (7th Cir. 2009); *City of Evanston v. Barr*, 412 F. Supp. 3d 873, 883 (N.D. Ill. 2019) (“Statutory interpretation begins with the plain language of the statute.”); *Barnhart v. Sigmon Coal Co.*, 534 U.S. 438, 450 (2002) (“As in all statutory construction cases, we begin with the language of the statute.”). It is well-established that “words in statutes should

be given their common meanings” “[u]nless there is a persuasive reason to the contrary.” *Int’l Adm’rs, Inc. v. Life Ins. Co. of N. Am.*, 753 F.2d 1373, 1379 (7th Cir. 1985) (citing *In re Clark*, 738 F.2d 869, 872 (7th Cir. 1984)); *Niz-Chavez v. Garland*, 141 S. Ct. 1474, 1480 (2021) (“When called on to resolve a dispute over a statute’s meaning, this Court normally seeks to afford the law’s terms their ordinary meaning at the time Congress adopted them.”). “[W]hen the statute’s language is plain, the sole function of the courts ... is to enforce it according to its terms.” *Lamie v. United States*, 540 U.S. 526, 534 (2004) (internal quotations omitted).

A. The Departments’ Rebuttable Presumption in Favor of the Offer Closest to the QPA Is Contrary to the Text of the No Surprises Act

Congress unambiguously enumerated specific factors—Subparagraph C Factors—that the IDR entity “shall consider” when identifying the appropriate reimbursement amount for items or services furnished out-of-network.⁷ 42 U.S.C. § 300gg-111(c)(5)(C); 29 U.S.C. § 1185e(c)(5)(C); 26 U.S.C. § 9816(c)(5)(C). This clear mandate appears twice in the No Surprises Act. First, in describing payment determinations in general, Congress provided that the IDR entity “shall ... taking into account the considerations specified in subparagraph (C), select one of the offers submitted” by the parties to be the payment amount. 42 U.S.C. § 300gg-111(c)(5)(A)(i); 29 U.S.C. § 1185e(c)(5)(A)(i); 26 U.S.C. § 9816(c)(5)(A)(i) (emphasis added). Second, in subparagraph C, Congress unequivocally restated that in deciding which offer to apply, the IDR entity “shall consider ... the qualifying payment amounts... and... information on any circumstance described in clause (ii), such information as requested [by the IDR entity

⁷ The No Surprises Act also provides that the IDR entity “shall not consider” usual and customary charges; the reimbursement rate for such items and services payable by a public payer (e.g., Medicare, Medicaid, the Children’s Health Insurance Program, TRICARE, United States Department of Veterans Affairs); or the amount that the out-of-network provider/facility would have billed for the item or service had the No Surprises Act not applied. 42 U.S.C. § 300gg-111(c)(5)(D); 29 U.S.C. § 1185e(c)(5)(D); 26 U.S.C. § 9816(c)(5)(D).

relating to the party’s offer], *and* any additional information [submitted by a party relating to such offer of either party].” 42 U.S.C. § 300gg-111(c)(5)(C)(i); 29 U.S.C. § 1185e(c)(5)(C)(i); 26 U.S.C. § 9816(c)(5)(C)(i) (emphasis added). “Clause (ii),” referenced above, delineates five additional factors that the IDR entity “shall” consider.⁸ 42 U.S.C. § 300gg-111(c)(5)(C)(ii); 29 U.S.C. § 1185e(c)(5)(C)(ii); 26 U.S.C. § 9816(c)(5)(C)(ii).

The text of the statute is straightforward: the IDR entity *must consider all* Subparagraph C Factors when selecting the best payment offer. Congress’s use of the term “shall” creates an obligation upon the IDR entity that the Departments may not abrogate through the rulemaking process. It is a basic principle of statutory interpretation that “shall” is mandatory. *FDIC v. Chicago Title Ins. Co.*, 12 F.4th 676, 683 (7th Cir. 2021); *Jefferson v. United States*, 546 F.3d 477, 484 (7th Cir. 2008); *Lexecon Inc. v. Milberg Weiss Bershad Hynes & Lerach*, 523 U.S. 26, 35 (1998). Congress also enumerated factors that the IDR entity “shall not consider.” 42 U.S.C. § 300gg-111(c)(5)(D); 29 U.S.C. § 1185e(c)(5)(D); 26 U.S.C. § 9816(c)(5)(D). Congress was extraordinarily prescriptive, specifying precisely which factors the IDR entity “shall consider” and “shall not consider.” The IFR impermissibly rewrites the statute by forbidding the IDR entity from considering most of the Subsection C Factors unless the Departments’ heightened standards are met.

Moreover, Congress’s use of the conjunctive term “and” in describing the Subparagraph

⁸ These include (1) the “level of training, experience, and quality and outcomes measurements of the provider or facility;” (2) the “market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided;” (3) the “acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual;” (4) the “teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service;” and (5) “[d]emonstrations of good faith efforts (or lack of good faith efforts)” made by the provider/facility or issuer to enter into network agreements and the contracted rates between the provider/facility and the issuer during the previous 4 plan years. 42 U.S.C. § 300gg-111(c)(5)(C)(ii); 29 U.S.C. § 1185e(c)(5)(C)(ii); 26 U.S.C. § 9816(c)(5)(C)(ii).

C payment considerations indicates its clear intent that all Subparagraph C Factors must be taken into consideration by the IDR entity before selecting a payment offer. *See, e.g., In re DeMert & Dougherty, Inc.*, 271 B.R. 821, 842 (Bankr. N.D. Ill. 2001); *Illinois v. I.C.C.*, 687 F.2d 1047, 1054 (7th Cir. 1982).

Despite Congress's clear mandate, the Departments established a standard for determining payment that *forbids* the IDR entity from considering the non-QPA Subparagraph C Factors unless a party satisfies additional requirements that are not found in the No Surprises Act. Specifically, under the Departments' regulatory framework, except in the rare circumstance that the offers are equally distant from the QPA but in opposing directions, the IDR entity is prohibited from considering any Subparagraph C Factors other than the QPA unless "*credible information* submitted by the parties *clearly demonstrates* that the QPA is *materially different* from the appropriate out-of-network rate." IFR, 86 Fed. Reg. at 55,995, 55,999, and 56,061 (emphasis added); Material Facts ¶ 15. In determining whether information is "credible," the IFR directs the IDR entity to conduct a "critical analysis" of whether information is worthy of belief and is trustworthy. IFR, 86 Fed. Reg. at 55,995, 56,100, 56,113, 56,125 (emphasis added); Material Facts ¶ 16. This evidentiary standard, which is absent from the No Surprises Act's text, upends the statutory scheme by turning a multifactor analysis into one that virtually guarantees that the insurer's own in-network rate will be imposed upon out-of-network providers.

Accordingly, the Departments have not interpreted the statute—they unlawfully and fundamentally altered it. *See Whitman v. Am. Trucking Ass'ns, Inc.*, 531 U.S. 457, 468 (2001). By giving one factor—the QPA—controlling weight, the Departments ignored Congress's mandate that the Subparagraph C Factors must be considered together. Congress did not assign presumptive weight to any one statutory factor and did not prescribe how the IDR entity should

balance such factors. Instead, Congress requires the IDR entity to consider and balance all of the Subparagraph C Factors. 42 U.S.C. § 300gg-111(c)(5)(C); 29 U.S.C. § 1185e(c)(5)(C); 26 U.S.C. § 9816(c)(5)(C). The Departments have effectively tied the hands of the IDR entity, revoking its ability to consider and balance all of the Subparagraph C Factors when determining the appropriate out-of-network rate.

B. Congress Created Presumptions Elsewhere in the Same Act, Demonstrating That the Departments’ Presumption in Favor of the Offer Closest to the QPA Is Impermissible

A wholistic reading of the statute further demonstrates that the IFR’s presumption in favor of the QPA is contrary to the text of the No Surprises Act. *See FDIC v. Chicago Title Ins. Co.*, 12 F.4th 676, 683 (7th Cir. 2021) (“It is a fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme.”); *City of Evanston v. Barr*, 412 F. Supp. 3d 873, 883 (N.D. Ill. 2019) (“The language and design of the statute as a whole may also provide guidance in determining the plain meaning of its provisions.”).

Had Congress wanted to establish a presumption in favor of the QPA in the event of a payment dispute between providers/facilities and insurers, it would have done so. *See Krawczyk v. Centurion Cap. Corp.*, No. 06-C-6273, 2009 WL 395458, at *12 (N.D. Ill. Feb. 18, 2009); *Allison v. Liberty Sav.*, 695 F.2d 1086, 1089 (7th Cir. 1982). In the Consolidated Appropriations Act, 2021, which contains the No Surprises Act, Congress expressly created five different presumptions, none of which apply to the IDR entity. Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 1182, 2185, 2208, 2300-01. For instance, in a section governing trademarks, entitled “Rebuttable Presumption of Irreparable Harm,” Congress provided that a “plaintiff seeking any such injunction shall be entitled to a *rebuttable presumption* of irreparable harm upon a finding of a violation identified in this subsection” 134 Stat. at 2208 (codified

at 15 U.S.C. § 1116(a)) (emphasis added). Congress also ordered a governmental entity (the Central Montana Regional Water Authority) to create “presumptions.” 134 Stat. at 3271.

In contrast, Congress chose not to establish a rebuttable presumption in favor of the QPA in the No Surprises Act. Instead, Congress specifically listed the considerations that the IDR entity must consider when selecting an offer for payment. 42 U.S.C. § 300gg-111(c)(5)(C); 29 U.S.C. § 1185e(c)(5)(C); 26 U.S.C. § 9816(c)(5)(C). Congress’s express creation of presumptions in other portions of the Consolidated Appropriations Act, 2021, while stating no such rebuttable presumption for the Subparagraph C Factors, means that Congress did not intend to establish a rebuttable presumption in favor of the QPA. *See Salinas v. U.S. R.R. Ret. Bd.*, 141 S. Ct. 691, 698 (2021) (“Where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.”) (quoting *Russello v. United States*, 464 U.S. 16, 23 (1983)).

C. The Departments’ Presumption in Favor of the Offer Closest to the QPA Exceeds the Authority Granted by Congress to Implement the Act

The text of the No Surprises Act simply does not authorize a rebuttable presumption in favor of the offer closest to the QPA. “The jurisdiction and authority of [administrative agencies] is confined solely to that which Congress bestows.” *Marquette Cement Mfg. Co. v. FTC*, 147 F.2d 589, 592-93 (7th Cir. 1945); *Atlantic City Elec. Co. v. FERC*, 295 F.3d 1, 8 (D.C. Cir. 2002) (“In the absence of statutory authorization for its act, an agency’s ‘action is plainly contrary to law and cannot stand.’”). The No Surprises Act only directs the Departments to establish by regulation an IDR process under which an IDR entity will determine the appropriate amount of payment “in accordance with the succeeding provisions of this subsection.” 42 U.S.C. § 300gg-111(c)(2)(A); 29 U.S.C. § 1185e(c)(2)(A); 26 U.S.C. § 9816(c)(2)(A).

The “succeeding provisions” unambiguously specify that all Subparagraph C Factors must be considered when selecting an offer. The “succeeding provisions” do not authorize, and cannot be interpreted to authorize, the IFR’s provisions requiring IDR entities to “presume that the QPA is an appropriate payment amount” unless a party provides “credible information” concerning the Subparagraph C Factors “clearly demonstrating” that the QPA is “materially different from the appropriate out-of-network rate” or unless the payment offers submitted by the provider/facility and the insurer are equally distant from the QPA but in opposing directions. IFR, 86 Fed. Reg. at 55,996; *see* Material Facts ¶ 15. Accordingly, the Departments exceeded their authority granted by Congress by establishing a rebuttable presumption in favor of the QPA. The Departments’ interpretation is contrary to the unambiguously expressed intent of Congress and is invalid under *Chevron* step one. It is well-established that “no deference is due to agency interpretations at odds with the plain language of the statute itself.” *Smith v. City of Jackson*, 544 U.S. 228, 266 (2005) (O’Connor, J., concurring) (internal quotation marks and citation omitted). The plain language of the No Surprises Act clearly mandates that the IDR entity “shall consider” all Subparagraph C Factors in determining the appropriate out-of-network rate for items and services. Courts “must presume that a legislature says in a statute what it means and means in a statute what it says.” *United States v. Rosenbohm*, 564 F.3d 820, 823 (7th Cir. 2009) (internal quotation marks and citation omitted).

The statute forecloses the presumption in favor of the QPA and the heightened evidentiary standard needed to rebut the presumption. Accordingly, the No Surprises Act is neither silent nor ambiguous regarding the question at issue. “Congress has directly spoken to the precise question at issue,” and the Departments are required to “give effect to the unambiguously expressed intent of Congress.” *Chevron*, 467 U.S. at 842-43. Because the

Departments' interpretation flouts the unambiguous text of the statute, it is invalid under *Chevron* step one and owed no deference. Therefore, the Departments' interpretation must be vacated because it violates the plain language of the No Surprises Act and exceeds the agencies' authority under the statute.

II. The IFR's Rebuttable Presumption in Favor of the QPA Is Not Entitled to Deference Under *Chevron* Step Two Because the Departments' Statutory Analysis Is Unreasonable, the Presumption Is Contrary to Congressional Intent, and the IFR Is Procedurally Defective

Even if the statute were silent or ambiguous, however, the Departments' rebuttable presumption in the IFR would fail under *Chevron* step two. The Departments' interpretation is not "based on a permissible construction of the statute," *Chevron*, 467 U.S. at 843, because the IFR's rebuttable presumption is based on an unreasonable textual analysis of the statute, frustrates the statutory purpose, and is inconsistent with congressional intent. *See Util. Air Regul. Grp.*, 573 U.S. at 324 (2014) (A court may set aside an agency's interpretation if it "would bring about an enormous and transformative expansion in [the agency's] regulatory authority without clear congressional authorization."); *Brumfield v. City of Chicago*, 735 F.3d 619, 625-26 (7th Cir. 2013) (noting that an agency's interpretation is granted *Chevron* deference only if "Congress has authorized the agency to interpret the statute through rules carrying the force of law and the agency's interpretation is both reasonable and promulgated through the exercise of the authority given by Congress."); *Congregation of the Passion v. Johnson*, 79 F. Supp. 3d 855, 860 (N.D. Ill. 2015); *Reverse Mortg. Sols.*, 365 F. Supp. 3d at 947; *MBH Commodity Advisors, Inc. v. Commodity Futures Trading Comm'n*, 250 F.3d 1052, 1061 (7th Cir. 2001); *Coyomani-Cielo v. Holder*, 758 F.3d 908, 914 (7th Cir. 2014).

A. The Departments' Interpretation of the Statute Is an Unreasonable Textual Analysis Divorced From Canons of Construction

The Departments' stated "justifications" for establishing the rebuttable presumption in

favor of the QPA are unsupported by the unambiguous text of the No Surprises Act, which lists the Subparagraph C Factors that the IDR “shall” consider. 42 U.S.C. § 300gg-111(c)(5)(C); 29 U.S.C. § 1185e(c)(5)(C); 26 U.S.C. § 9816(c)(5)(C). In promulgating the IFR, the Departments failed to identify statutory text that explicitly directed the creation of the rebuttable presumption. Nonetheless, the Departments concluded that their atextual policy governing the IDR entity’s selection of an offer was the “best interpretation” of the No Surprises Act. IFR, 86 Fed. Reg. at 55,996; Material Facts ¶ 20. The Departments came to this conclusion by manufacturing heretofore unknown canons of statutory construction that should be rejected by this Court.

The Departments arrived at their rebuttable presumption by improperly emphasizing the following aspects of the statute: (1) the “statutory text lists the QPA as the first factor;” (2) the non-QPA factors appear “in a separate paragraph” and are subject to subparagraph (D), which describes certain factors that the IDR entity cannot consider in determining payment; (3) the statute “sets out detailed rules for calculating the QPA;” and (4) the No Surprises Act mentions the QPA in other statutory provisions that do not directly govern the determination of payment for out-of-network items or services. IFR, 86 Fed. Reg. at 55,996; Material Facts ¶ 20.

The Departments’ convoluted statutory analysis is divorced from established canons of construction, and the Departments cited no canon in support of their interpretation. “[L]ist[ing] the QPA as the first factor” does not imply Congress’s intent to establish a rebuttable presumption in favor of the QPA. If that were the case, then every time Congress catalogues any list, the first listed item would have more weight than the others, and if Congress did not intend to create a presumption, it would have to explicitly clarify that the first factor should *not* be accorded presumptive weight.

Congress simply does not legislate in this manner, and Courts do not interpret statutes as

the Departments suggest. For example, in *American Corn Growers Ass'n v. Environmental Protection Agency*, the United States Court of Appeals for the District of Columbia Circuit held that the Environmental Protection Agency (“EPA”) distorted Congress’s intent by promulgating a regulation that treated one of five statutory factors dramatically different than the other factors. *Am. Corn Growers Ass'n v. EPA*, 291 F.3d 1, 6 (D.C. Cir. 2002). The Clean Air Act enumerates certain factors that states must take into consideration when determining the best available retrofit technology for controlling emissions:

[I]n determining best available retrofit technology the State ... shall take into consideration the costs of compliance, the energy and nonair quality environmental impacts of compliance, any existing pollution control technology in use at the source, the remaining useful life of the source, and the degree of improvement in visibility which may reasonably be anticipated to result from the use of such technology.

42 U.S.C. § 7491(g)(2); *see Am. Corn Growers Ass'n*, 291 F.3d at 5. The EPA’s regulation, however, directed the states to consider the first four statutory factors on a source-specific basis and the fifth statutory factor on a group or “area wide” basis. *Am. Corn Growers Ass'n*, 291 F.3d at 6. In partially vacating the regulation, the court determined that “splitting ... the statutory factors [was] consistent with neither the text nor the structure of the statute.” *Id.* The court emphasized that “[a]lthough no weights were assigned, the factors were meant to be considered together by the states.” *Id.* Similarly, Congress intended that all Subparagraph C Factors would be considered together without giving presumptive weight to only one factor. By treating the QPA “in such a dramatically different fashion” than the other Subparagraph C Factors, the Departments unlawfully “distort[ed] the judgment Congress.” *See id.*

Second, even if the Departments’ structural argument had merit, it would not negate Congress’s unequivocal requirement that IDR entities “shall consider” all Subparagraph C Factors in determining payment. Within subparagraph C, the clause describing the QPA and the

clause generally describing the other Subparagraph C Factors co-exist in the same sentence, joined by the conjunctive term “and”: the IDR entity “shall consider . . . (I) the qualifying payment amount . . . and (II) . . . information on any circumstance described in clause (ii).” 42 U.S.C. § 300gg-111(c)(5)(C)(i)(I)-(II); 29 U.S.C. § 1185e(c)(5)(C)(i)(I)-(II); 26 U.S.C. § 9816(c)(5)(C)(i)(I)-(II). Accordingly, such provisions should be construed together. *See, e.g., Illinois v. I.C.C.*, 687 F.2d 1047, 1054 (7th Cir. 1982); *see also United States v. Kelly*, 500 F.2d 72, 74 (7th Cir. 1974) (“[I]t is immaterial whether Congress chose to state a rule and its exception in one clause or in separate clauses.”).

Third, the prohibition against the consideration of certain factors set forth in subparagraph (D) does not suggest that Congress intended a rebuttable presumption in favor of the QPA. The Subparagraph D Factors are immaterial to the QPA. Congress had no need, therefore, to clarify the prohibition’s application with regard to the QPA. 42 U.S.C. § 300gg-111(c)(5)(C)(i)(I); 29 U.S.C. § 1185e(c)(5)(C)(i)(I); 26 U.S.C. § 9816(c)(5)(C)(i)(I).

Fourth, the statute’s rules for calculating the QPA have no bearing on the weight that it should receive. *See* 42 U.S.C. § 300gg-111(a)(3)(E); 29 U.S.C. § 1185e(a)(3)(E); 26 U.S.C. § 9816(a)(3)(E). In fact, the Departments made clear that “it is not the role of the certified IDR entity to determine whether the QPA has been calculated by the [issuer] correctly.” IFR, 85 Fed. Reg. at 55,996; Material Facts ¶ 18. Moreover, the Departments promulgated policies governing the QPA calculation in a completely different interim final rule published approximately three months before the IFR was released, further suggesting that the Departments do not truly view the methodology for calculating the QPA as giving it presumptive weight. Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36,872, 36,888-98 (July 13, 2021); *see* Material Facts ¶ 13. Therefore, this “justification” is unpersuasive.

Fifth, it is unreasonable for the Departments to infer that Congress intended a rebuttable presumption based on the mention of the QPA in other provisions of the statute that do not directly govern the determination of payment. Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. at 36,888-98. Had Congress wanted to create a rebuttable presumption in favor of the QPA, it would not have hidden the directive in other, unrelated statutory provisions. *See Whitman v. Am. Trucking Ass 'ns, Inc.*, 531 U.S. 457, 468 (2001). (“Congress, we have held, does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—it does not, one might say, hide elephants in mouseholes.”). Notably, unlike the No Surprises Act’s provisions governing cost-sharing requirements, Congress did not establish the QPA as the “out-of-network rate” when there is no “specified state law” or applicable All-Payer Model Agreement under section 1115A of the Social Security Act. *Compare* 42 U.S.C. § 300gg-111(a)(3)(K); 29 U.S.C. § 1185e(a)(3)(K); 26 U.S.C. § 9816(a)(3)(K) *with* 42 U.S.C. § 300gg-111(a)(3)(H); 29 U.S.C. § 1185e(a)(3)(H); 26 U.S.C. § 9816(a)(3)(H). Thus, the Departments’ attempt to cobble together isolated provisions of the statute cannot overcome Congress’s unambiguous directive for IDR entities to consider all Subparagraph C Factors.

Additionally, in support for their decision to “[anchor] the determination of the out-of-network rate to the QPA,” the Departments point to several “policy considerations.” IFR, 86 Fed. Reg. at 55,996; Material Facts ¶ 21. The Departments have no authority to rewrite unambiguous statutory terms to further their own policy goals. *Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 325-28 (2014) (“[A] core administrative-law principle that an agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate.”); *Ciox Health, LLC v. Azar*, 435 F. Supp. 3d 30, 65 (D.D.C. 2020) (“Disagreeing with Congress’s expressly codified policy choices isn’t a luxury administrative agencies enjoy.”) (quoting *Cent. United Life Ins. Co.*

v. Burwell, 827 F.3d 70, 73 (D.C. Cir. 2016)). In creating a heightened evidentiary standard needed to overcome the presumption that the “QPA is [the] appropriate payment amount,” IFR, 86 Fed. Reg. at 55,995, the Departments “relied on factors which Congress has not intended it to consider.” *Motor Vehicle Mfrs. Ass’n of U.S.*, 463 U.S. at 43; *Zero Zone, Inc.*, 832 F.3d at 668. Accordingly, the Departments’ rebuttable presumption is an unreasonable interpretation of the statute. *Chevron*, 467 U.S. at 843.

B. The Departments’ Rebuttable Presumption in Favor of the Offer Closest to the QPA Thwarts Congress’s Intent

The rebuttable presumption in favor of the QPA undercuts the statute’s purpose and is inconsistent with congressional intent to create an unbiased IDR entity that would consider all Subsection C Factors when determining out-of-network rates. At *Chevron* step two, courts in the Seventh Circuit examine legislative history to determine whether an agency’s interpretation is reasonable under *Chevron* step two.⁹ See *Coyomani-Cielo v. Holder*, 758 F.3d 908 (7th Cir. 2015); see also, *Allison v. Liberty Sav.*, 695 F.2d 1086, 1089 (7th Cir. 1982); *Pfeiffer v. Essex Wire Corp.*, 682 F.2d 684, 686 (7th Cir. 1982) (a statute’s legislative history and purpose can illuminate congressional intent).

Congressional intent for the No Surprises Act demonstrates that Congress did not intend for the Departments to mandate a rebuttable presumption in favor of the QPA in the determination of payment for certain health care items and services furnished by a provider or

⁹ The Supreme Court, however, has considered legislative history at *Chevron* step one. See *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120 (2000). Most federal circuits also analyze legislative history at *Chevron* step one to determine whether Congress’s intent is clear. See *Santana v. Holder*, 731 F.3d 50 (1st Cir. 2013); *WPIX, Inc. v. IVI, Inc.*, 691 F.3d 275 (2d Cir. 2012); *Schafer v. Astrue*, 641 F.3d 49 (4th Cir. 2011); *BNSF Ry. Co. v. United States*, 775 F.3d 743 (5th Cir. 2015); *Sierra Club v. EPA*, 781 F.3d 299 (6th Cir. 2015); *N. Dakota ex re. Olson v. CMS*, 403 F.3d 537 (8th Cir. 2005); *Ron Peterson Firearms, LLC v. Jones*, 760 F.3d 1147 (10th Cir. 2014); *Catawba Cnty. v. EPA*, 571 F.3d 20 (D.C. Cir. 2009); *Kingdomware Techs., Inc. v. United States*, 754 F.3d 923 (Fed. Cir. 2014).

facility that is not within the network of the insurer. To resolve payment disputes between providers/facilities and insurers, Congress crafted an “*independent* dispute resolution process,” carefully enumerating statutory factors that a neutral arbiter must consider in rendering payment determinations. U.S. House Committees on Ways and Means, Energy and Commerce, and Education and Labor, *Protecting Patients from Surprise Medical Bills* (Dec. 21, 2020),¹⁰ (indicating that the “arbitrator must equally consider [the Subparagraph C] factors”); U.S. Senate Committee on Health, Education, Labor & Pensions, *Congressional Committee Leaders Announce Surprise Billing Agreement* (Dec. 11, 2020);¹¹ Letter from Members of Congress to Xavier Becerra, Janet Yellen, and Martin Walsh, Dep’t Sec’ys, 1 (Nov. 5, 2021) [hereinafter “November 5th Letter”].¹² Congress took a balanced approach to setting the amount of payment for the out-of-network items or services, ensuring that payment determinations would not inherently favor one party over the other. 42 U.S.C. § 300gg-111(c)(5); 29 U.S.C. § 1185e(c)(5); 26 U.S.C. § 9816(c)(5).

To this end, Congress intentionally avoided giving presumptive weight to the QPA, which would tip the scales during the IDR process in favor of the insurers because the QPA is tied to the insurer’s median in-network rates. *See* Letter from Richard E. Neal, Chairman, Comm. on Ways & Means, and Kevin Brady, Ranking Member of Comm. on Ways & Means, to Xavier Becerra, Janet Yellen, and Martin Walsh, Dep’t Sec’ys, 2 (Oct. 4, 2021) (“[T]he legislation reported out of the Committee on Ways and Means, which was adopted in the No Surprises Act, authorizes IDR but does not preference in-network rates to determine the payment

¹⁰ <https://gop-waysandmeans.house.gov/protecting-patients-from-surprise-medical-bills/>.

¹¹ <https://www.help.senate.gov/ranking/newsroom/press/congressional-committee-leaders-announce-surprise-billing-agreement>.

¹² <https://www.acep.org/globalassets/new-pdfs/advocacy/2021.11.05-no-surprises-act-letter.pdf>.

amount.”) [hereinafter “October 4th Letter”];¹³ U.S. House Committees on Ways and Means, Energy and Commerce, and Education and Labor, *Protecting Patients from Surprise Medical Bills* (Dec. 21, 2020).¹⁴ In fact, during the legislative process, Congress rejected the idea of “rel[ying] on the median in-network rate as the benchmark for payment.” October 4th Letter at 2; November 5th Letter at 1; *see, e.g.*, Lower Health Care Costs Act, S. 1895, 116th Cong. § 103(a) (2019) (proposing that insurers pay providers “the median in-network rate” for certain services); *cf.* U.S. House Committees on Ways and Means, Energy and Commerce, and Education and Labor, *Protecting Patients from Surprise Medical Bills* (Dec. 21, 2020) (The No Surprises Act “includes NO benchmarking or rate-setting.”).¹⁵

The Departments subverted Congress’s intent by establishing a rebuttable presumption in favor of the QPA, abrogating the discretion afforded to the IDR entity and heavily tilting IDR decisions in favor of insurers. *See* October 4th Letter; November 5th Letter. By letter dated October 4, 2021, the Chairman and Ranking Member of the House Ways and Means Committee expressed their significant concerns to the Departments that the IFR’s rebuttable presumption “biases the IDR entity” and “do[es] not reflect the law that Congress passed.” October 4th Letter at 1-2; *see* Material Facts ¶ 24. The letter underscores that the No Surprises Act’s directive “to consider all of the factors without giving preference or priority to any one factor” is the “express result of substantial negotiation and deliberation among those Committees of jurisdiction, and reflects Congress’s intent to design an IDR process that does not become a de facto benchmark.” October 4th Letter at 2.

In addition, on November 5, 2021, 152 Members of the U.S. House of Representatives

¹³ <https://www.aans.org/-/media/Files/AANS/Advocacy/PDFS/surprise-billing-regs-Neal-Brady-letter.ashx>.

¹⁴ <https://gop-waysandmeans.house.gov/protecting-patients-from-surprise-medical-bills/>.

¹⁵ <https://gop-waysandmeans.house.gov/protecting-patients-from-surprise-medical-bills/>.

sent a letter to the Department emphasizing that the IFR's rebuttable presumption "establishes a de-facto benchmark rate" and is "contrary to the statute." November 5th Letter at 1-2 (finding that the IFR's provisions on the IDR process "do not reflect the way the law was written, do not reflect a policy that could have passed Congress, and do not create a balanced process to settle payment disputes"); *see* Material Facts ¶ 25. The members of the U.S. House of Representatives stressed that the IFR's rebuttable presumption "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." November 5th Letter at 2.

The concerns expressed by Members of Congress, unfortunately, have already materialized. The Departments' interpretation of the No Surprises Act has empowered insurers to reduce in-network contracted rates and threaten existing contractual arrangements with providers. *See* Declaration of Dr. Raley; Declaration of Dr. Golding; *FDIC v. Chicago Title Ins. Co.*, 12 F.4th 676, 684 (7th Cir. 2021) (courts "may also consider the 'effects and consequence' of the interpretation of the statute"). For instance, Blue Cross Blue Shield of North Carolina sent letters to providers demanding a reduction in contracted rates as a direct result of the Departments' IFR. Declaration of Dr. Golding (stating that Blue Cross Blue Shield of North Carolina's "letter cites the IFR as justification to 'warrant a significant reduction in (our) contracted rates with Blue Cross NC' and warns of additional rate reductions once the qualifying payment amount is established"); Declaration of Dr. Raley (noting that Blue Cross Blue Shield of North Carolina's letter states that the "IFR provides 'enough clarity to warrant a significant reduction in [Wake Emergency Physicians, P.A.'s] contracted rate with Blue Cross NC'"); Material Facts ¶ 23. The letters from Blue Cross Blue Shield of North Carolina further state that if providers do not accept the rate reduction in light of the Departments' IFR, their contracts will

be “quickly terminated.” *See* Declaration of Dr. Golding; Declaration of Dr. Raley; Material Facts ¶ 23.

Congress clearly did not intend this result. By establishing a rebuttable presumption that skews IDR decisions in favor of the QPA, which benefits insurers at the expense of providers and facilities, the Departments disrupted Congress’ balanced approach to provider payment and adversely impacted providers/facilities’ negotiating position with insurers. This, in turn, jeopardizes provider networks and patient access to care. Therefore, the rebuttable presumption in favor of the QPA thwarts the purpose of the No Surprises Act and is inconsistent with congressional intent.

C. The Departments’ Interpretation of the Statute Is Not Entitled to *Chevron* Deference Because the IFR Is Procedurally Defective

Additionally, courts may not accord *Chevron* deference when a “regulation is ‘procedurally defective’—that is[,] where the agency errs by failing to follow the correct procedures in issuing the regulation.” *Encino Motorcars*, 579 U.S. at 220 (quoting *United States v. Mead Corp.*, 533 U.S. 218, 227 (2001)); *see also Abbas v. Selling Source, LLC*, No. 09 CV 3413, 2009 WL 4884471, at *5 (N.D. Ill. Dec. 14, 2009). As addressed below in section III, the Departments flouted the APA’s rulemaking requirements by ignoring the statute’s notice-and-comment procedures prior to publishing the IFR and failing to demonstrate “good cause” for doing so. Because the IFR was promulgated in violation of the APA, the Departments’ rebuttable presumption is not entitled to *Chevron* deference. *Encino Motorcars*, 579 U.S. at 220-21.

III. The IFR’s Presumption in Favor of the Offer Closest to the QPA Was Promulgated in Violation of the Rulemaking Requirements of the APA

The Departments’ flawed rebuttable presumption in favor of the QPA is procedurally invalid under the APA because the Departments failed to demonstrate “good cause” for

circumventing the APA's notice-and-comment requirements. Congress intended the "good cause" exception to apply "when the regular course of rulemaking procedure would interfere with the agency's ability to perform its functions within the time constraints imposed by Congress." *U.S. Steel Corp. v. EPA*, 605 F.2d 283, 287 (7th Cir. 1979). Here, Congress gave the Departments a substantial period of time within which to engage in notice-and-comment rulemaking and promulgate final regulations on the IDR process. 42 U.S.C. § 300gg-111(c)(2)(A); 29 U.S.C. § 1185e(c)(2)(A); 26 U.S.C. § 9816(c)(2)(A). Specifically, under the No Surprises Act, the Departments were required to promulgate regulations on the IDR process "[n]ot later than 1 year after December 27, 2020"—an *entire year* after the enactment of the No Surprises Act. 42 U.S.C. § 300gg-111(c)(2)(A); 29 U.S.C. § 1185e(c)(2)(A); 26 U.S.C. § 9816(c)(2)(A). This, by no means, is a tight statutory deadline. *Cf. U.S. Steel Corp.*, 605 F.2d at 285 n.1, 285-87 (60-day statutory deadline).

However, the Departments chose to wait almost nine months after the enactment of the No Surprises Act to issue regulations. IFR, 86 Fed. Reg. 55,980 (October 7, 2021); *see* Material Facts ¶ 22. They now "raise up the 'good cause' banner" to excuse their own delay in issuing rules on the IDR process. *See Nat. Res. Def. Council v. Nat'l Highway Traffic Safety Admin.*, 894 F.3d 95, 114-15 (2d Cir. 2018) (internal quotation marks and citation omitted). It would be improper for the Departments to benefit from their dilatory tactics. *See Nat'l Ass'n of Farmworkers Orgs. v. Marshall*, 628 F.2d 604, 622 (D.C. Cir. 1980) (finding that good cause did not exist where the "Department waited nearly seven months between the initial regulation promulgated through notice and comment and the first modification of it promulgated without the requisite procedures"). Simply put, "[g]ood cause cannot arise as a result of the agency's own delay." *See Nat. Res. Def. Council*, 894 F.3d at 114.

The Departments conceded Congress’s timeframe from enactment of the No Surprises Act on December 27, 2020, to the effective date of the IDR provisions for plan years beginning January 1, 2022, “may have allowed for ... the full notice and comment rulemaking process.” IFR, 86 Fed. Reg. at 56,043-44; Material Facts ¶ 22. Nonetheless, the Departments published the IFR approximately three months before the No Surprises Act’s December 27, 2021, deadline for promulgating regulations governing the IDR process. The Departments could have engaged in notice-and-comment rulemaking during this time and before the IDR process commenced in 2022.

The Departments’ assertions that good cause existed for ignoring the APA’s notice-and-comment rulemaking requirements fall short of the standard needed to invoke this exception. *See Jifry v. FAA*, 370 F.3d 1174, 1179 (D.C. Cir. 2004). Their assertions generally describe “the bare need to have regulations” and “the goal of reducing uncertainty,” which are insufficient to invoke the good cause exception. *Nat’l Ass’n of Farmworkers Orgs.*, 628 F.2d at 621; *United States v. Johnson*, 632 F.3d 912, 929 (5th Cir. 2011). “[D]esire to provide immediate guidance, without more, does not suffice for good cause.” *Johnson*, 632 F.3d at 929 (internal quotation and citation omitted). Furthermore, the “possibility of an alteration to the interim rule after its promulgation increases rather than eliminates uncertainty.” *Id.* (internal quotations and citations omitted). The Departments’ justifications also fail to acknowledge that, in light of the multi-step dispute resolution process (which includes a 30-day open negotiation period prior to IDR proceedings), an IDR entity would not begin reviewing offers until well after January 1, 2022. *See* 42 U.S.C. § 300gg-111(a)(1)(C)(iv), (b)(1)(C), (c); 29 U.S.C. § 1185e(a)(1)(C)(iv), (b)(1)(C), (c); 26 U.S.C. § 9816(a)(1)(C)(iv), (b)(1)(C), (c).

Lastly, the Departments’ speculation regarding under-compensation and access to care

does not supply good cause. *See Dialysis Patient Citizens v. Burwell*, No. 4:17-CV-16, 2017 WL 365271, at *4 (E.D. Tex. Jan. 25, 2017) (“Speculation that some patients will not have foresight to arrange for alternative coverage does not provide good cause to bypass notice and comment.”). To the contrary, the IFR’s rebuttable presumption will likely cause the potential harm described by the Departments. The QPA, for various reasons, is not reflective of the fair market value of items and services furnished by out-of-network providers/facilities in the marketplace.¹⁶ *See* Declaration of Dr. Christopher E. Young, Exhibit 3; Declaration of Dr. Raley; Declaration of Dr. Golding. By significantly restricting the IDR entity’s consideration of all statutory factors, the IFR will result in a disproportionately high number of IDR decisions that are closer to the QPA. As a result, the IFR’s rebuttable presumption will undermine providers’ and facilities’ ability to be fairly reimbursed for their out-of-network services, which will, in

¹⁶ The QPA does not accurately represent the prevailing market rates for out-of-network items and services due to the manner in which the median contracted rate is calculated pursuant to the Departments’ interim final rule published on July 13, 2021. Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. at 36,888-899; *see* Material Facts ¶ 13. For example, in calculating the median contracted rate, each contracted rate for an item or service is treated as a single data point regardless of the total number of claims paid at that rate. *Id.* at 36,889. Ignoring the volume of claims paid at the contracted rate misrepresents the true market value of the item or service. *See* Letter from Am. Coll. of Emergency Physicians & Emergency Dep’t Prac. Mgmt. Ass’n to Xavier Becerra, Janet Yellen, and Martin Walsh, Dep’t Sec’ys 11 (Aug. 31, 2021), <https://www.regulations.gov/comment/CMS-2021-0117-5695> [hereinafter “ACEP Comment Letter”]; Letter from Am. Soc’y of Anesthesiologists to Xavier Becerra, Janet Yellen, and Martin Walsh, Dep’t Sec’ys 3 (Sept. 7, 2021), <https://www.regulations.gov/comment/CMS-2021-0117-7410> [hereinafter “ASA Comment Letter”]; Letter from Am. Coll. of Radiology to Chiquita Brooks-LaSure, Adm’r, CMS 2 (Sept. 7, 2021), <https://www.regulations.gov/comment/CMS-2021-0117-7239> [hereinafter “ACR Comment Letter”]. Moreover, the Departments prohibit insurers from including risk sharing, bonus, or penalty, and other incentive-based and retrospective payments or payment adjustments in the determination of the median contracted rate. Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. at 36,894. This exclusion results in QPAs that are lower than the full payment amount for the applicable out-of-network item or service. *See* ACEP Comment Letter at 14-15; ASA Comment Letter at 3; ACR Comment Letter at 2. Plaintiffs submitted letters to the Departments in response to this interim final rule describing in greater detail the various reasons why the QPA does not reflect fair market value. ACEP Comment Letter at 10-17; ASA Comment Letter at 3-4; ACR Comment Letter at 2; Material Facts ¶ 14.

turn, threaten their ability to operate in the marketplace. Additionally, the Departments have created a perverse incentive for insurers to significantly reduce their in-network rates or to refuse to enter into network agreements with providers/facilities. *See* Declaration of Dr. Golding; Declaration of Dr. Raley. If more providers/facilities are forced out-of-network due to this rebuttable presumption, patients will lose access to in-network care. Accordingly, the IFR’s rebuttable presumption will hinder patients’ access to care.

In sum, the Departments did not demonstrate that engaging in notice-and-comment rulemaking would be “impracticable, unnecessary, or contrary to the public interest.” 5 U.S.C. § 553(b)(B), (d)(3). Because good cause did not exist for circumventing the APA’s rulemaking procedures when issuing the IFR’s provisions establishing the rebuttable presumption in favor of the offer closest to the QPA, the rebuttable presumption violates the APA’s notice-and-comment rulemaking procedures. Such provisions of the IFR were issued “without observance of procedure required by law,” and are, therefore, invalid. *Id.* § 706(2)(D).

CONCLUSION

For the foregoing reasons, the Court should vacate the following provisions of the Departments’ IFR requiring the IDR entity to select the offer closest to the QPA unless it determines that credible information submitted by either party clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate, or if the offers are equally distant from the QPA but in opposing directions:

- a. 45 C.F.R. § 149.510(a)(2)(v); 45 C.F.R. § 149.510(a)(2)(viii); the second and third sentence of 45 C.F.R. § 149.510(c)(4)(ii)(A); the final sentence of 45 C.F.R. § 159.510(c)(4)(iii)(C); 45 C.F.R. § 510(c)(4)(iv); and 45 C.F.R. § 510(c)(4)(vi)(B).
- b. 26 C.F.R. § 54.9816-8T(a)(2)(v); 26 C.F.R. § 54.9816-8T(a)(2)(viii); the second

and third sentence of 26 C.F.R. § 54.9816-8T(c)(4)(ii)(A); the final sentence of 26 C.F.R. § 54.9816-8T(c)(4)(iii)(C); 26 C.F.R. § 54.9816-8T(c)(4)(iv); and 26 C.F.R. § 54.9816-8T(c)(4)(vi)(B).

- c. 29 C.F.R. § 2590.716-8(a)(2)(v); 29 C.F.R. § 2590.716-8(a)(2)(viii); the second and third sentence of 29 C.F.R. § 2590.716-8(c)(4)(ii)(A); the final sentence of 29 C.F.R. § 2590.716-8(c)(4)(iii)(C); 29 C.F.R. § 2590.716-8(c)(4)(iv); and 29 C.F.R. § 2590.716-8(c)(4)(vi)(B).

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Dated: February 9, 2022