IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ASSOCIATION OF AIR MEDICAL SERVICES, Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	)	Case No.: 1:21-cv-3031-RJL

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS *AMICUS CURIAE* IN SUPPORT OF DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT AND OPPOSITION TO PLAINTIFF'S SUMMARY JUDGMENT MOTION

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CORPORATE DISCLOSURE STATEMENT

Under Local Rule 7(o)(5), *amicus curiae* America's Health Insurance Plans, Inc. (AHIP) submits the following corporate disclosure statement:

AHIP has no parent corporation and no publicly-traded company holds 10% or more of AHIP's stock.

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INTEREST OF *AMICUS CURIAE*[1]

America's Health Insurance Plans, Inc. ("AHIP") is the national trade association representing the health insurance community. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation. AHIP's members have broad experience working with virtually all health care stakeholders to ensure that patients have affordable access to needed treatments and medical services. That experience gives AHIP extensive first-hand and historical knowledge about the nation's health care and health insurance systems, and a unique understanding of how those systems work.

AHIP's members strive to reach agreements with health care providers, including air ambulance providers, to offer consumers affordable networks that provide them with choices in the delivery of quality medical care. When unable to secure network agreements before treatment is rendered, health insurance providers have long worked to negotiate out-of-network payments to prevent surprise medical bills and reduce costs for patients. This approach was no solution to the growing problem of providers developing business models that relied on remaining out-of-network and using that status to leverage higher reimbursement rates—a problem that had become particularly severe in the case of air ambulance providers, who, due to a constellation of market-specific factors and a unique regulatory regime, had especially low incentives to join networks. Invariably, the result was that out-of-network providers were paid well above typical market rates and consumers faced excessive costs when providers demanded to be paid the balance of unreasonable billed charges.

[1] No counsel for any party authored this brief in whole or in part, and no person or entity other than the amicus, its members, or its counsel made a monetary contribution intended to fund the brief's preparation or submission. All parties have consented to the filing of this brief.

AHIP strongly supports Congress's decision in the No Surprises Act to fix the market dysfunction that saddled patients with exorbitant medical bills for services they had no opportunity to turn down or voluntarily choose. To that end, the Act helps fill the previous regulatory vacuum that permitted the exorbitant billing practices of air ambulance providers. AHIP also agrees with Defendants' legal arguments that the Act's fix hinges on anchoring disputed out-of-network rates to the "qualifying payment amount" (QPA), absent credible information otherwise. The QPA reflects competitive, fair market rates, and Plaintiff's unbounded alternatives would create the very problems the Act aims to remedy.

AHIP writes to focus on two distinct issues within its expertise. The first is to explain the air ambulance specific factors that, before the Act, thwarted the operation of normal market incentives, resulting in supracompetitive charges for air ambulance services that are typically provided to the most vulnerable patients at their most vulnerable moments. Second, AHIP explains how centering dispute resolution guidance on the QPA—one appropriately calibrated to the unique air ambulance market—improves cost predictability and promotes fairness, which is critical to providing affordable access to quality coverage for everyone.[2]

INTRODUCTION AND SUMMARY OF ARGUMENT

Congress gave the governing Departments, health care providers, and health insurance providers only a single year to implement the No Surprises Act, given the urgency of protecting

[2] AHIP's interest in the implementation of the No Surprises Act extends to the Act's application to all health care providers subject to its provisions. Most recently, AHIP filed an amicus brief in *Texas Medical Association v. U.S. Department of Health and Human Services*, No. 6:21cv425 (E.D. Tex.), and has obtained consent to file an amicus brief in this Court in *American Medical Association v. U.S. Department of Health and Human Services*, No. 1:21cv3231. Although there are common issues presented in each of these cases, each case also presents unique issues. This brief therefore focuses on issues specific to air ambulance providers, while other briefs AHIP has filed and intends to file address operational issues relevant to the decision to proceed by interim final rule and explain incentives for health insurance providers to offer broad networks of medical providers.

Americans from surprise medical bills and addressing spiraling out-of-network costs. This urgency was particularly acute for the air ambulance sector, which involves a type of medical service where patients lack any opportunity to choose their provider. Key market dynamics for this sector include an absence of state regulatory authority due to a broadly written federal statute that preempts state regulation for air transport, a lack of incentives for air ambulance providers to join networks, an influx of private equity firms, and market consolidation in a handful of independent for-profit providers. Together, these factors meant health insurance providers routinely faced continual pressure to surrender to demands by air ambulance providers to pay their exorbitant charges and thereby avoid burdening patients with what would otherwise be astronomical surprise bills. Because the No Surprises Act is federal legislation, it can help fill the regulatory vacuum and address surprise billing for air ambulance services, providing a uniform solution to a growing problem that states have been thwarted from solving on their own.

To make the federal solution work, the Departments correctly adapted the QPA to address the unique market imbalances that had characterized air ambulance services before the Act, including by adjusting the geographic area of focus (as Congress expressly authorized) and by excluding from the QPA "one-off" rates that are not a reflection of considered network negotiations (as was done for all providers). The Departments likewise rightly interpreted the Act to require certified Independent Dispute Resolution (IDR) entities to select the reimbursement amount closest to the QPA, absent credible and material information otherwise. This QPA-centric approach, as the Departments recognized, makes out-of-network costs more predictable, and health coverage more affordable for everyone, due to lower administrative costs and more reasonable payments for out-of-network services. This directly translates to lower premiums for consumers and employers, as well as lower federal health care expenditures (in the form of reduced

premium tax credits that help Americans buy coverage).

Differing experience from the working laboratory of state practice for other emergency services shows that predictability lowers administrative costs of resolving charges disputes in two ways. First, it reduces the number of IDRs, as providers and health plans are more likely to settle disputes when they can predict an IDR's likely result. Second, predictability lowers costs of the IDRs that do occur, by limiting the possibility of extended open-ended inquiries about immaterial factors, as most cases can be resolved by reference to the QPA alone. The resulting reduced administrative costs directly benefit consumers and advance a key policy goal of limiting the share of premium dollars spent on administrative costs. A QPA anchor also works directly to reduce out-of-network costs, while recognizing that IDR entities may select higher payment amounts when warranted by credible information that makes a material difference. This results in more affordable health coverage and fair reimbursement, all while ensuring patients' access to quality networks.

ARGUMENT

I. The No Surprises Act Seeks To Remedy Market Dysfunction Where Patients Cannot Choose Providers—A Particular Concern For Air Ambulances.

a. For most medical services, payments are set in advance by negotiation of rates between health insurance providers and health care providers. Health plans work with providers to offer networks that provide Americans access to affordable, high-quality care. *See* AHIP, Center for Policy and Research, *Charges Billed by Out-of-Network Providers: Implications for Affordability*, at 3 (Sept. 2015), https://tinyurl.com/ba2v83er. Such networks benefit patients, health plan sponsors like employers, and the entire health care system by reducing costs, promoting access to and utilization of care, and providing high-quality choices for enrollees. *See* AHIP, *What's the Role of Networks in Providing High-Quality Affordable Care?*, https://tinyurl.com/2p94p4xz. Networks reduce costs because health insurance providers verify the credentials of the providers,

negotiate payment rates up front, and avoid the inefficiencies of negotiating every bill. The resulting contracts typically limit the provider to the agreed payment from the plan and prohibit surprise bills to patients. *See* 86 Fed. Reg. 36,872, 36,874 (July 13, 2021). Out-of-network providers, in contrast, often charge higher rates, and before the Act, sent patients surprise bills for any part of their billed charges that was not paid by insurance. *Id*.

For services where patients are unable to choose an in-network provider in advance, providers lack the same incentives to join networks, resulting in much lower network participation rates for certain providers, like those that provide emergency care, or are assigned by the hospital without patient direction, such as anesthesiologists and pathologists. *See* 86 Fed. Reg. 55,980, 56,046 (Oct. 7, 2021); Gary Claxton et al., *An analysis of out-of-network claims in large employer health plan*s, Peterson-KFF Health System Tracker (Aug. 13, 2018), https://tinyurl.com/3fp5psf9; *see also* 86 Fed. Reg. at 36,874. When these providers could "balance bill" the patient the difference between what they charged and how much the health plan paid, they were able to leverage much higher payments than other medical specialties. *See* 86 Fed. Reg. at 36,874.

b. Air ambulance services have been an extreme example of this skewed market dynamic, resulting in exorbitant surprise bills for patients and higher health care costs for all consumers with health insurance. Protected from state regulation by a separate broadly written federal law,[3] air ambulance providers have stayed outside of health plan networks at a greater rate than any other form of emergency care. About 69-75% of air ambulance transports are out-of-network, compared

[3]*See, e.g., Air Evac EMS, Inc. v. Cheatham*, 910 F.3d 751, 755 (4th Cir. 2018) (affirming district court decision that the "Airline Deregulation Act of 1978 (ADA), [which] expressly preempts state efforts to regulate the prices, routes, and services of certain air carriers," barred state regulation of air ambulance billing practices); *EagleMed LLC v. Cox*, 868 F.3d 893, 904 (10th Cir. 2017) (concluding, despite compelling policy arguments, that "[b]ecause air ambulances are included within the broad language of the Airline Deregulation Act's preemption statute as it is currently written, … the Wyoming statute and rate schedule" are expressly preempted").

to 51% of ground ambulance transports and 14-22% of emergency department services. *See* U.S. Gov't Accountability Office, GAO-19-292, *Air Ambulance: Available Data Show Privately-Insured Patients Are at Financial Risk*, at 16-17 (Mar. 2019) ("2019 GAO Report"), https://tinyurl.com/yrhkz3su.

Air ambulance providers have leveraged that out-of-network status—and the associated ability, until now, to send surprise bills to patients—to extract large payments from patients with commercial insurance. A presentation by the Association of Air Medical Service to the federal Air Ambulance and Patient Billing Advisory Committee showed that 70% of air ambulance revenue comes from the roughly 30% of their transports that are covered by commercial insurance, with privately insured patients and their health insurance providers paying more than double the cost of services—by even the industry's estimate. Presentation of Association of Air Medical Services, at 14-15 (Jan. 15, 2020), https://tinyurl.com/r5b2s6b8. Lacking any meaningful form of state or federal regulation of billing practices, a business model for the provision of air ambulance services has evolved, one funded by private for-profit independent investors, not non-profit hospitals, and that hinges on staying out-of-network. Under that business model, charges have soared, nearly tripling over ten years. Erin C. Fuse Brown et al., *The Unfinished Business of Air Ambulance Bills*, Health Affairs Forefront (Mar. 26, 2021), https://tinyurl.com/yxbzfpb7.

Several market-specific factors contribute to these overinflated charges by air ambulance providers. First, patients have no choice. Patients in need of emergency care cannot, and do not, choose whether to take an air ambulance at all, much less choose a particular air ambulance provider based on price or network status. U.S. Gov't Accountability Office, GAO-17-637, *Air Ambulance: Data Collection and Transparency Needed to Enhance DOT Oversight*, at 18 (July 2017), https://tinyurl.com/yd96ks3b. Instead, first responders or medical professionals decide

when to order an air ambulance, based on medical necessity, and which air ambulance service to call. *Id.* at 4-5.

Second, consolidation has enabled price increases. Over time, air ambulance providers have shifted from a non-profit hospital-based model to a model where air ambulance services are provided by a handful of independent for-profit firms, focused on "increas[ing] revenue." Gina Turrini et al., *Air Ambulance Use and Surprise Billing*, Ass't Sec'y for Planning & Evaluation Issue Brief, at 4 (Sept. 10, 2021), https://tinyurl.com/3yvtpvnu. Private equity firms, in particular, have invested heavily in air ambulance providers and leveraged their larger market share, and the absence of meaningful regulation (until now), to aggressively raise prices. A 2020 analysis by the Brookings Institution found that carriers owned by private equity firms were charging 7.2 times Medicare rates, in contrast with non-private equity owned firms charging roughly 4.3 times Medicare rates. Loren Adler et al., *High air ambulance charges concentrated in private equity-owned carriers*, Brookings Inst. (Oct. 13, 2020), https://tinyurl.com/3dbyn523.

Finally, because air ambulance charges are extremely high, health insurance providers "place[d] a high value on preventing enrollee surprise bills." Brown, *supra*. The median bill for a fixed-wing transport in 2017 was $40,600—up from $24,900 just five years earlier. 2019 GAO Report at 17. And those are *median* charges; air ambulances often charge far more, and do not hesitate to send sky-high surprise bills to vulnerable patients who are recovering from serious medical injuries or illnesses. *See* Alison Kodjak, *Taken for a Ride*, NPR (Sept. 25, 2018), https://tinyurl.com/vzjvp64a (reporting patient was first called by air ambulance provider three days after an accident, while he was still in the hospital, and told "the helicopter ride would most likely cost more than $50,000 and asked … how he planned to pay"). The GAO found bills ranging from $12,300 to $52,000 in one state. 2019 GAO Report at 18. Documents from nine states reveal

that from 2013 to 2016, state "insurance departments reviewed 55 incidences in which consumers complained of $3.8 million in combined charges—an average charge of $70,000 per trip." Eric S. Peterson & Brian Maffly, *Sky's the limit for what Utah air ambulances can charge*, Salt Lake Trib. (Aug. 29, 2016), https://tinyurl.com/bdf9s54m. To protect patients from these exorbitant balance bills, health insurance providers commonly paid air ambulance providers' (inflated) full out-of-network charges. Brown, *supra*. This created a vicious cycle that enabled air ambulance providers "to continuously raise charges" to otherwise stratospheric levels. *Id.*

c. The No Surprises Act seeks to help fill the regulatory vacuum caused by federal preemption of state regulatory efforts, by explicitly authorizing a federal regulatory regime for air ambulances that remedies this profoundly dysfunctional market dynamic. It does so by prohibiting balance billing and establishing a structured dispute resolution process for out-of-network charges for air ambulances as well as for certain medical providers. Together, these changes protect patients from receiving surprise bills and enhance the predictability of out-of-network costs. The Act limits a patient's cost-sharing amount to the cost-share that "would apply if such services were provided by … a participating provider," meaning an in-network provider. 42 U.S.C § 300gg-112(a)(1) (air ambulances); *id.* §§ 300gg-111(a)(1)(C)(ii), (b)(1)(A) (same for emergency department and certain hospital-based physicians). Air ambulance services and medical providers are prohibited from balance billing patients for the rest of the cost. *Id.* §§ 300gg-131, 300gg-132, 300gg-135.

If an air ambulance service and health insurance provider do not agree on the remainder of the payment for the service, Congress charged the Departments with "establish[ing] by regulation one independent dispute resolution process … in accordance with" the Act. *Id.* § 300gg-112(b)(2)(A). When selecting between the parties' offers in that process, the certified IDR entity

must consider the "qualifying payment amounts … for items or services that are comparable … and that are furnished in the same geographic region (as defined by the Secretary …)[.]" *Id.* § 300gg-112(b)(5)(C)(i)(I). The QPA is generally the health insurance provider's median contract rate for the same service in the same area. *Id.* § 300gg-111(a)(3)(E). It must be calculated according to detailed rules and is subject to audit. *Id.* §§ 300gg-111(a)(2), (a)(3)(E).

II. The QPA Rule Is Necessarily And Reasonably Calibrated To Address The Dysfunction Created By Air Ambulance Providers' Out-Of-Network Business Models.

As for all services covered by the Act, the QPA for air ambulance services is based on a particular health plan's median "contracted rates … determined with respect to all such plans of such sponsor" "for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the [same] geographic region," consistent with "the methodology established by the Secretary." 42 U.S.C. §§ 300gg-111(a)(3)(E), 112(b)(5)(C)(i)(I). Air ambulance services are distinct, however, given the dearth of in-network rates caused by providers' business models that turned on leveraging out-of-network status to increase charges before the Act. When establishing the QPA methodology for air ambulances, the Departments sensibly grappled with these unique—and uniquely inflationary—market dynamics.

First, air ambulance providers' business model of not entering into pre-negotiated network agreements before the Act led to a correspondingly high volume of ad hoc agreements between health insurance providers and air ambulance services that aimed only to address particular disputes after services had already been provided—termed "single case agreements." *See* 86 Fed. Reg. at 36.889. For example, health insurance providers often entered such agreements to avoid patients facing exorbitant balance bills. *See* Brown, *supra*. The QPA rule interpreted "contracted rate" (for the purpose of identifying the median) to include only network agreements and to exclude such one-off agreements (and did so for all providers, not just air ambulances). AHIP

agrees with Defendants that this interpretation fits best with the statutory text. *See* Defs. Cross-Mot. for Summ. J. at 27-28. It is also essential to the statutory purpose of protecting consumers from unpredictable and uncontrolled health care costs. Unlike network agreements, in which health insurance providers and medical providers reach agreement about competitive market rates in advance of services being provided, "single case" agreements are not the result of standard arms-length contracting regarding competitive market rates. *See* 86 Fed. Reg. at 36,889 (excluding single case agreements "most closely aligns with the statutory intent of ensuring that the QPA reflects market rates under typical contract negotiations"). They are instead the result of threats to balance bill a patient for an often excessive amount. Including such atypical arrangements would distort the calculation of median market rates the QPA represents.

Second, independent air ambulance providers—*i.e.*, not owned or operated by a hospital—now provide the majority of air ambulance services, and typically have much higher charges. That does not make them a different "specialty" than hospital-based air ambulances. As Defendants explain, the natural meaning of "specialty" in this context is medical specialty (*e.g.*, anesthesiology), not ownership structure. Defs. Cross-Mot. for Summ. J. at 30-31. Moreover, it is inconsistent with the overall consumer-protection objectives of the Act to distinguish between providers based on their usual mode of contracting, rather than any difference in the services they provide. Hospital-based air ambulances are more likely to join networks, and to charge lower rates. *See* 86 Fed. Reg. at 36,891. If the Departments ignored that hospital-based air ambulances provide the same services, it would only exacerbate, not ameliorate, the inflationary pressure from independent air ambulance providers' historical business model of remaining out-of-network.

Third, the QPA rule sensibly established distinct geographic areas for air ambulance services, *id*. at 36,893, and did so within the heartland of expressly delegated authority to define

geographic areas, 42 U.S.C. § 300gg-111(a)(2)(B)(iii). The nature of air transport intrinsically lends itself to a more expansive market area than, say, a hospital emergency department, including often crossing state lines. Beyond that, however, the Departments reasonably concluded that "narrow regions would result in more instances of insufficient information" given the extremely low participation rate of air ambulances in networks. 86 Fed. Reg. at 36,893. That low network participation rate also increases the risk that pulling contracted rates for a narrow area would skew market rates due to the effect of outliers in an otherwise small sample size. *Id.* at 36,892. Considering a broader area—consistent with the nature of the service and the need to identify a sufficient number of network agreements—fosters stability and predictability of the Act's cornerstone rate—the QPA.

Networks—and particularly in-network rates, as reflected in the QPA—are central to the No Surprises Act. Having largely relied on a business model that focused on remaining out-of-network for so long, air ambulance providers can hardly fault the Departments for implementing the QPA in a manner that reasonably responds to the dearth of air ambulance network agreements.

III. Predictable Rules For Independent Dispute Resolution Benefit Consumers.

A. Rulemaking Was Required to Guide IDR Decision-Making, and the Departments Reasonably Interpreted the Act to Favor Predictability.

Congress listed the QPA first among the "[c]onsiderations" for IDR entities, followed by "additional circumstances" in a separate paragraph. 42 U.S.C. § 300gg-112(b)(5)(C). It also centered the QPA in the IDR reporting requirements. *Id.* §§ 300gg-112(b)(7)(A)(iv), (B)(iii)-(iv). But it did not explicitly direct *how* IDR entities were to consider the QPA and additional factors.

The Departments reasonably determined that it was most "in accord[]" with the Act, *id.* § 300gg-112(b)(2)(A), for the QPA to be considered first, requiring selection of the offer closest to the QPA absent credible information dictating a materially different rate. *See* Defs. Cross-Mot.

for Summ. J. at 17-26. By expressly frontloading a congressionally defined numerical factor that is central to the statutory scheme, and then listing a variety of other potential considerations, Congress did not issue a self-executing command to weigh each consideration equally—particularly the open-ended possibility of "such information as requested by the certified IDR entity," 42 U.S.C. § 300gg-112(b)(5)(B)(i)(II). Nor did Congress authorize weighing the various factors however a particular IDR entity might choose from day to day, with no consistency even for the same decision-maker, much less across scores of decision-makers nationwide. Rather, Congress ensured consistency and predictability by focusing IDR on the QPA and charging the Departments with discretion to dictate how the factors would be weighed.

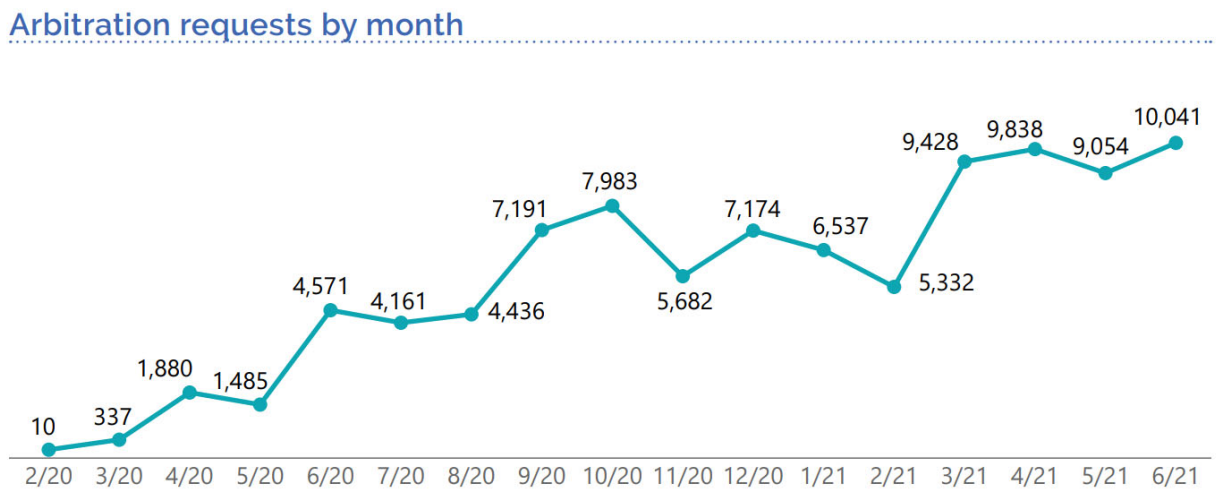
Absent clear guidance on how the different factors should be weighed to choose between the parties' offers, the IDR process would be subjective and unpredictable. In contrast, the rule as written enables predictable and uniform decisions while permitting IDR awards to align with credible, material information—including when such information dictates payments higher than the QPA. By clarifying how the Act ties IDR outcomes to the QPA cornerstone in most (but not all) cases, the IDR rule makes out-of-network costs more predictable. *See* 86 Fed. Reg. at 55,996 ("Anchoring the determination of the out-of-network rate to the QPA will increase the predictability of IDR outcomes."). That predictability, in turn, generates a host of beneficial effects for health care markets and, ultimately, patients and consumers.

B. IDR Predictability and Efficiency Reduce Administrative Costs.

IDR administrative costs are driven by the volume and efficiency of proceedings. On both counts, enhanced predictability helps reduce costs. As to volume, enhanced predictability reduces the number of disputes to resolve. As the Departments explained, predictable outcomes "may encourage parties to reach an agreement outside of the Federal IDR process." *Id*. at 55,996. The Act is designed to encourage voluntary dispute resolution and minimal use of IDR: It bars a party

from taking a dispute about the same service to IDR within 90 days of a decision in an earlier IDR invoked by that party and involving the same health plan, provider, and service. 42 U.S.C. §§ 300gg-112(b)(5)(D), 300gg-111(c)(5)(E)(ii). The rule works toward that same goal; an unpredictable IDR process would work at cross-purposes. State experience—albeit for other medical services given broad federal preemption of state efforts to regulate all forms of air transport, including air ambulances—confirms that the more predictable the dispute resolution results, the less likely that parties will need to invoke IDR.

Where arbitration is unstructured, there is a high volume of proceedings. In Texas, arbitrators are required to consider 10 disparate factors with no guidance on how to weight them. Tex. Ins. Code § 1467.083(b). New Jersey has a similar system. Benjamin Chartock et al., *Arbitration Over Out-Of-Network Medical Bills: Evidence From New Jersey Payment Disputes*, 40 Health Affairs 130, 131 (Jan. 2021). In both states, unpredictable decision-making has led to a high volume of dispute resolution proceedings for contested out-of-network charges, with numbers increasing over time. *See* Tex. Dep't of Ins., *Senate Bill 1264: 2021 midyear report*, at 4 (July 2021) ("Texas IDR Report"), https://tinyurl.com/yc34f3r5 (50,230 in first half of 2021, compared to 44,910 in 2020); *compare* N.J. Dep't of Banking & Ins., 2019 Report, https://tinyurl.com/4dfeevnf, *with* 2020 report, https://tinyurl.com/2p9dmvp7 (arbitrations nearly doubled from 2019 to 2020). This ever-increasing volume of arbitrations—for Texas depicted below—inevitably leads to higher administrative costs and thus higher premiums.



See Texas IDR Report at 6.

In contrast, in states with more predictable decision-making systems, arbitration is a relatively rare option for addressing unique circumstances. In California, an out-of-network provider is paid the higher of the average contracted rate or 125% of the Medicare rate; although the parties may negotiate a different amount or request arbitration, the initial payment amount is a strong anchor. *See* Cal. Health & Safety Code §§ 1371.30, 1371.31(a)(1). Data on median in- and out-of-network rates features in Washington's system. *See* Wash. Office of Ins. Comm'r, *Arbitration and using the Balance Billing Protection Act data set*, https://tinyurl.com/yeyuaemu. Compared to tens of thousands of arbitrations per year (as in Texas), California has seen only 124 proceedings since 2018, and Washington received 71 requests in the first year its system was operational. Cal. Dep't of Managed Health Care, *AB 72 Independent Dispute Resolution Process Quarterly Report*, at 1 (Oct. 13, 2021), https://tinyurl.com/2p8437ha; Wash. Office of Ins. Comm'r, *Balance Billing Protection Act Arbitration Proceedings: Annual Repor*t, at 6 (June 29, 2021), https://tinyurl.com/5ezh8axu.

For providers other than air ambulances, state out-of-network payment regulations may govern, limiting the volume of disputes that would otherwise pass through the federal system. 42

U.S.C. § 300gg-111(a)(3)(K)(i). Because of federal preemption, however, there are no analogous state procedures for air ambulances. The absence of results from comparative state proceedings, moreover—which might have otherwise helped health insurance providers and air ambulance providers estimate likely IDR results—will likely lead to a very high dispute rate for air ambulances. It is therefore all the more critical to promote predictability within the federal system to minimize unnecessary administrative costs from voluminous IDR proceedings.

When dispute resolution proceedings are not anchored to reasonable rates, not only does the number of disputes increase, so too does the cost of proceedings. Cost experience from Texas puts the median arbitration fee at $1,000 and the highest fee at $5,000. Texas IDR Report at 8. Furthermore, fee amounts don't include the parties' administrative costs to gather and present information to the arbitrator—which only increase with the number of factors to be considered. In contrast to such high arbitration fees in Texas, federal certified IDR entities, after considering the IDR rule, have set fees ranging from $285 to $500 for single proceedings. *See* Ctrs. for Medicare & Medicaid Servs., *List of certified independent dispute resolution entities*, https://tinyurl.com/2p9d7t72. Texas's experience shows that unbounded arbitrations are likely to be more costly, a result that cannot be squared with legal, commercial, and regulatory imperatives for health plans to limit the share of premium dollars they spend on administrative costs. *See, e.g.*, 42 U.S.C. § 300gg-18(b).

C. Predictability Makes Health Care More Affordable, While Ensuring Fair Reimbursement.

Centering the QPA also makes air ambulance costs more affordable by anchoring IDR results to market rates (absent credible information that the appropriate rate is materially different). Unlike billed charges—which are unilaterally set by air ambulance services—negotiated rates reflect competitive, fair market prices. And even these negotiated rates "may have been inflated

due to the practice of surprise billing prior to the No Surprises Act." 86 Fed. Reg. at 55,996. That is especially true for air ambulances, as discussed above. But the QPA negotiated rates—around which IDR is centered—are still substantially less than formerly-balance-billing air ambulance services' billed charges ("sticker" prices), which they demanded from patients before the Act.

Anchoring the IDR process to market rates determined through arms-length negotiation between health plans and providers, *id.*, helps to ensure premiums reflect reasonable negotiated rates, rather than unlimited billed charges. Without such structure, arbitration can result in out-of-network rates that are both volatile and excessive, thwarting the consumer-protection goals of the Act. In New Jersey, the median award is 5.7 times higher than the median in-network rate, and nearly a third of awards are more than 10 times higher than in-network rates. Chartock, *supra*, at 132. Predictability disappears, with awards reaching more than 25 times in-network rates, and 2-6% of awards distributed at each multiple from 3 to 13. *Id.* at 133. In Texas, awards were nearly 5 times the initial health plan payment in 2020, and although initial payments increased in 2021, awards are still 3.4 times higher. Texas IDR Report at 5.

Even though the Act bans surprise billing, Americans would still pay the increased costs of an unpredictable dispute resolution process through higher premiums. As the Departments explained, "anchoring the determination to the QPA will help limit the indirect impact on participants, beneficiaries, and enrollees 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." 86 Fed. Reg. at 55,996. Centering the QPA both stabilizes and reduces health care costs, as shown by the Congressional Budget Office's projection of premium savings—which hinged on the assumption that the QPA would anchor IDR. *See* Cong. Budget Office, Estimate for Divisions O Through FF, H.R. 133, at 2-3, https://tinyurl.com/3eec2a4n; Letter from Rep. Frank Pallone, Jr. &

Sen. Patty Murray to Secretary Becerra (Jan. 7, 2022). Lower premiums benefit consumers directly and reduce government health care expenditures for premium tax credits. *See* 86 Fed. Reg. at 56,059.

Contrary to the assertions of Plaintiff, greater predictability and affordability does not sacrifice fair reimbursement to providers. The QPA is a median negotiated rate that fairly reflects service characteristics that can increase costs. For example, ambulance vehicle type and clinical capability, 42 U.S.C. § 300gg-112(b)(5)(C)(ii)(IV), is captured in different billing codes. Stated another way, fixed wing transport is not the "same service" as rotary wing transport, and median, competitive market rates will reflect the difference. 86 Fed. Reg. at 36,891. Patient acuity and case severity is likewise reflected in distinct codes. *See* AHIP, Comment Letter, at 7 (Dec. 6, 2021), https://tinyurl.com/2crxsv52. Unlike air ambulance providers' unilaterally set and soaring charges that by their own estimate far exceed their costs, the QPA is the product of rates negotiated and agreed to between plans and air ambulance services. And additional credible information presented by either party must factor into the decision when that information demonstrates a material difference. 45 C.F.R. § 149.510(c)(4)(ii)(A); *id.* § 149.520(b)(1)-(2). But centering of the IDR process around the fair and competitively negotiated QPA rates reduces the likelihood and costs of resolving disputes, furthers predictability and efficiency, and helps remedy a uniquely dysfunctional market dynamic that foisted supracompetitive air ambulance charges on patients for far too long.

CONCLUSION

The Court should deny Plaintiff's motion for summary judgment and grant Defendants' cross-motion for summary judgment.

Dated: January 25, 2022

Respectfully Submitted,

/s/ Hyland Hunt
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CERTIFICATE OF SERVICE

On January 25, 2022, I electronically submitted the foregoing document with the clerk of court for the U.S. District Court, District of Columbia, using the electronic case filing system of the court. I hereby certify that I have served counsel for all parties of record electronically or by another manner authorized by Federal Rule of Civil Procedure 5(b)(2).

/s/Hyland Hunt
Hyland Hunt