UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

AMERICAN MEDICAL ASSOCIATION, *et al.*, *Plaintiffs*, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants.*	Civil Action No. 1:21-cv-03231-RJL

[PROPOSED] AMICI CURIAE BRIEF OF CONGRESSIONAL COMMITTEE LEADERS IN SUPPORT OF DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT/OPPOSITION

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INTEREST OF AMICI CURIAE

Amici, Senator Patty Murray and Representative Frank J. Pallone, are members of Congress who are the respective chairs of the U.S. Senate Committee on Health, Education, Labor, and Pensions (HELP) and the U.S. House Energy and Commerce Committee, which have jurisdiction over health care issues.[1] They were intimately involved in drafting the federal surprise medical billing law, the No Surprises Act, Pub. L. No. 116-260, div. BB, tit. I, 134 Stat. 1182, 2758–890 (2020) (NSA): they championed the need for bipartisan solutions, held hearings on the practice of surprise billing, and co-sponsored bills that laid the groundwork for the NSA. Amici also drafted and negotiated the final legislative language of the NSA and submitted comments to the implementing agencies regarding how the law should be interpreted. As a result, amici have unique insight into the statute, its legislative history, and Congress's intent in enacting it.

This insight will benefit the Court as it adjudicates the plaintiffs'[2] challenge to the defendant[3] agencies' administrative regulation, "Requirements Related to Surprise Billing; Part II," 86 Fed. Reg. 55,980 (Oct. 7, 2021), which implements provisions of the NSA.[4] The plaintiffs

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[1] No party or counsel for any of the parties authored any part of this brief, nor did they contribute money intended to fund preparing or submitting the brief. In addition, no person other than the amici curiae or amici's counsel contributed money intended to fund the preparation or submission of this brief.

[2] The plaintiffs are the American Medical Association, American Hospital Association, Renown Health, UMass Memorial Health Care, Inc., Stuart M. Squires, M.D., and Victor F. Kubit, M.D.

[3] The defendants are the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL), the U.S. Department of Treasury (Treasury), the U.S. Office of Personnel Management (OPM), Secretary of Health and Human Services Xavier Becerra, Secretary of the Treasury Janey Yellen, Secretary of Labor Martin J. Walsh, and OPM Director Kiran Ahuja.

[4] The NSA enacts parallel amendments to three laws, administered by three different departments of the federal government: the Public Health Service Act (administered by HHS), the Employee Retirement Income Security Act (administered by DOL), and the Internal Revenue

challenge provisions of this rule that govern how arbitrators—referred to as Independent Dispute Resolution (IDR) entities in the statute and rule—resolve payment disputes between out-of-network providers and payors. This issue was of significant importance to members of Congress, including amici, in enacting the NSA.

As amici elaborate below, the final NSA legislation reflects a bipartisan congressional compromise to rely on the Qualifying Payment Amount (QPA)—i.e., a figure calculated from a payor's median in-network rates, subject to certain adjustments—as the driving factor for consideration by arbitrators resolving payment disputes while also allowing the parties to submit additional information for consideration. Importantly, the Congressional Budget Office (CBO) analysis showing that the legislation would not only protect patients from surprise medical bills but also *lower* health insurance premiums hinged on the assumption that out-of-network payment rates would move towards median in-network rates.

Because of their central leadership role in negotiating this compromise on behalf of constituents who stand to meaningfully benefit from it, amici have an interest in ensuring that the NSA is implemented in a manner that effectuates Congress's twin goals of protecting patients from surprise medical bills and reducing health insurance premiums and without unnecessary delay.

Code (administered by the Treasury). For simplicity, this brief refers to the provisions of the Public Health Service Act and Title 45 of the Code of Federal Regulations in its citations and collectively to the three departments, as well as OPM (which co-authored the rule and administers the Federal Employee Health Benefit Program), as "the agencies."

I. INTRODUCTION

Congress enacted the NSA to protect patients from surprise medical bills from out-of-network health care providers. In enacting this bill, Congress was careful to ensure its reforms did not simply shift the costs of such medical bills onto consumers in the form of higher health insurance premiums. Instead, Congress intended the NSA to complement broader efforts to reduce U.S. health care costs and lower insurance premiums. Accordingly, much of the legislative debate centered on the amount that commercial payors—private health insurance companies and employer-sponsored health insurance plans—would be required to pay out-of-network providers when disputes arose.

To achieve this, the leaders from the four committees with jurisdiction over the issue,[5] including amici, struck a critical compromise. In the event of a payment dispute, the payor and out-of-network provider may enter an arbitration process—the IDR process—in which the arbitrator would select the price offered by one of the parties to be the amount of payment. In making this selection, the arbitrator *must consider* the QPA—i.e., the payor's median in-network (contracted) rate for similar items and services. The arbitrator will also consider additional information the parties may submit, subject to certain restrictions.

A review of the legislative history demonstrates the importance of the QPA to the passage of the NSA. All four of the jurisdictional committees included in-network rates as a key factor in determining the amount to be paid to out-of-network providers in their draft surprise medical bill legislation. Relying on this aspect of all four draft bills, CBO found the bills would reduce health

[5] The four committees with jurisdiction over the issue are: the Senate Health, Education, Labor, and Pensions (HELP) Committee, the House Energy and Commerce Committee, the House Education and Labor Committee, and the House Ways and Means Committee.

insurance premiums by driving out-of-network payments closer to median in-network rates, an outcome which amici and other members of Congress considered essential for passage of any proposal to end surprise billing. As a result, reliance on median in-network rates, or the QPA, became a cornerstone of the final legislation that Congress enacted and charged the agencies with implementing.

The interim final rule at issue in this matter serves Congress's intent that the QPA be the driving factor in resolving payment disputes: the rule clarifies that arbitrators should use the QPA as a starting point in evaluating the parties' competing payment offers.[6] The rule's approach is consistent with the language and structure of the statute—both with respect to the specific provisions governing the resolution of payment disputes and taken as a broader whole. And contrary to the plaintiffs' arguments, the rule also reflects the bipartisan compromise that the QPA take a prominent but not solely determinative role: the rule allows for arbitrators to consider other factors.

The plaintiffs are also incorrect regarding the agencies' authority to enact the rule. The agencies, indisputably, have authority to issue rules regarding how arbitrators should determine payment amounts—including via interim final rule. As a result, this Court should uphold the agencies' rulemaking and reject the plaintiffs' challenge.

[6] Additional information submitted by the parties must also be considered so long as it meets basic standards related to credibility and relevance.

II. ARGUMENT

A. By relying on the QPA as the driving factor in resolving out-of-network payment disputes, the rule faithfully effectuates Congress's intent to protect patients from surprise medical bills while lowering health insurance premiums.

Congress sought to address two interconnected issues in passing the NSA: patients often receive unaffordable, unexpected medical bills and the cost of health care in the United States has risen dramatically in the last decade. Addressing the former without consideration of the latter would merely pass the costs of surprise medical bills onto patients, employers, and the government in the form of higher insurance premiums—an unacceptable outcome to amici and the other leaders of the effort. To ensure any legislative fix would not balloon health insurance premiums and instead drive down health care costs, each committee considering the issue reached the same conclusion: regardless of the specific process used, median in-network rates should play a significant role in determining payment amounts in the event of disputes between out-of-network providers and payors. As a result, this solution, in the form of the QPA, became a central component of the final legislation. In implementing the law, the agencies have correctly given the QPA priority in the arbitration (IDR) process.

The devastating effects of surprise billing were first raised before Congress in 2018 during a series of hearings on reducing health care costs held by the U.S. Senate Committee on Health, Education, Labor, and Pensions (HELP).[7] These 2018 cost-containment hearings triggered more

[7] *See* How to Reduce Health Care Costs: Understanding the Cost of Health Care in America: Hearing Before the S. Comm. on Health, Educ., Lab., & Pensions, 115 Cong. 3-4, 54-56, 62 (2018); Reducing Health Care Costs: Eliminating Excess Health Care Spending and Improving Quality and Value for Patients: Hearing Before the S. Comm. on Health, Educ., Lab., & Pensions, 115 Cong. 3-4, 56-57 (2018); Reducing Health Care Costs: Improving Affordability Through Innovation: Hearing Before the S. Comm. on Health, Educ., Lab., & Pensions, 115 Cong. (2018).

targeted hearings on surprise billing and potential legislative fixes the following year, during which there was significant discussion of the importance of preventing a ban on surprise out-of-network bills from causing increased health insurance premiums.[8] As amicus Chairman Pallone stated at the start of one such hearing:

> I strongly believe that any viable solution in this space cannot result in rising health care costs. This debate has shed light on the fact that some provider's charges and hospital fees are inexplicably high, and I worry that if Congress chooses the wrong approach, consumers will simply end up paying those costs through higher premiums. We simply cannot allow this to happen.[9]

This concern was reflected in the bipartisan surprise billing legislation that each of the four committees of jurisdiction—the Senate HELP Committee, the House Energy and Commerce Committee, the House Education and Labor Committee, and the House Ways and Means Committee—subsequently drafted.[10] These lawmakers were attentive to the impact different mechanisms for resolving payment disputes between out-of-network providers and payors would have on health insurance premiums. Although they differed in other respects, *all four bills* included

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[8] *See, e.g.*, Lower Health Care Costs Act: Hearing Before the S. Comm. on Health, Educ., Lab., & Pensions, 116 Cong. (2019); Examining Surprise Billing: Protecting Patients from Financial Pain, Hearing Before the Subcomm. on Health, Empl., Lab., & Pensions of the H. Comm. on Educ. & Lab., 116 Cong. 9, 11, 19, 25, 34, 44–45, 52, 58, 87, 92, 107,109–14, 164–65, 187 (2019); Protecting Patients from Surprise Medical Bills, Hearing Before the Subcomm. on Health of the H. Comm. on Ways & Means, 116 Cong. 33, 49–50, 61, 80 (2019); No More Surprises: Protecting Patients from Surprise Medical Bills: Hearing Before the Subcomm. on Health of the H. Comm. on Energy & Com., 116 Cong. (2019).

[9] No More Surprises: Protecting Patients from Surprise Medical Bills: Hearing Before the Subcomm. on Health of the H. Comm. on Energy & Com., 116 Cong. (2019) (opening statement of Chairman Frank Pallone, Jr.), *available at* https://tinyurl.com/yckez3y5.

[10] These bills were, respectively, the Lower Health Care Costs Act, S. 1895, 116th Cong. (2019); the No Surprises Act, H.R. 3630, 116th Cong. (2019) (subsequently incorporated into the Reauthorizing and Extending America's Community Health Act (REACH Act)), H.R. 2328, 116th Cong. (2019)); the Ban Surprise Billing Act, H.R. 5800, 116th Cong. § 4(a) (2020); and the Consumer Protections Against Surprise Medical Bills Act, H.R. 5826, 116th Cong. (2020).

insurers' median in-network (contracted) rates as a key component in deciding what out-of-network providers should be paid in the event of a dispute.[11]

Why? Because doing so would not only protect patients from surprise bills, but also actually lower insurance premiums overall, leading to billions in savings for Americans and the federal government. In concluding that these bills would affirmatively lower health insurance premiums, the CBO consistently assumed that out-of-network provider rates would move closer to median in-network rates. For example, with respect to the Lower Health Care Costs Act, S. 1895, which pegged out-of-network rates to median-in-network rates, CBO estimated that "premiums would be just over 1 percent lower than they are projected to be under current law. The decline in premiums would occur because the bill would require insurers to reimburse out-of-network providers on the basis of their own median rates for in-network providers . . . ."[12] Even for other bills that relied on an arbitration process in which additional factors could be considered, CBO assumed that the median-in-network rate would be the primary consideration in payment adjudication and therefore result in reduced premiums.[13] In contrast, the CBO found that other

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[11] *See* Lower Health Care Costs Act, S. 1895, 116th Cong. § 103(a) (2019); REACH Act, H.R. 2328, 116th Cong. § 402(a) (2019); Ban Surprise Billing Act, H.R. 5800, 116th Cong. § 4(a) (2020); Consumer Protections Against Surprise Medical Bills Act, H.R. 5826, 116th Cong. § 7(a) (2020).

[12] Cong. Budget Off., At a Glance: S. 1895, Lower Health Care Costs Act 3 (July 16, 2019); *see also* Cong. Budget Off., At a Glance: H.R. 2328, Reauthorizing and Extending America's Community Health Act 6 (Sept. 18, 2019).

[13] *See, e.g.*, Cong. Budget Off., H.R. 5826, the Consumer Protections Against Surprise Medical Bills Act of 2020, as Introduced on February 10, 2020 Estimated Budgetary Effects (Feb. 11, 2020) (assuming that "dispute resolution entities would be instructed to look to the health plan's median payment rate for in-network rate care," and therefore estimating that "average payment rates for both in- and out-of-network care would move toward the median in-network rate, which tends to be lower than average rates," and "that in most affected markets in most years, lower payments to some providers would reduce premiums by between 0.5 percent and 1 percent"); *see also* Cong. Budget Off, H.R. 5800, the Ban Surprise Billing Act, as ordered reported by the House

legislation, drafted outside the committee process, that did not place the same emphasis on median in-network rates would cost billions.[14]

The committees responsible for the bills that eventually became the NSA highlighted the fact that their draft legislation would lower health insurance premiums.[15] And this goal remained paramount as negotiations ensued.[16] Savings were equally important to President Trump, as outlined in the White House principles on surprise billing that helped inform the negotiations.[17]

Like the four committee bills that preceded it, the final bipartisan NSA incorporated median in-network rates, in the form of the QPA, as the central factor for consideration by the

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Committee on Education and Labor on February 11, 2020 Estimated Budgetary Effects (Feb. 13, 2020).

[14] Peter Sullivan, *CBO: Fix Backed by Doctors for Surprise Medical Bills Would Cost Billions*, The Hill (Sept. 24, 2019, 2:48 PM), https://tinyurl.com/2p8899vj.

[15] *See, e.g.*, H.R. Rep. No. 116-615, pt. 1, at 58 (the bill's hybrid approach to resolving payment disputes "is designed to reduce premiums and the deficit"); Opinion, Rep. Frank Pallone, Jr. & Rep. Greg Walden, *It's Time for Congress to Protect Patients from Surprise Medical Bills*, The Hill (Nov. 21, 2019, 6:00 AM), https://tinyurl.com/38edy7h3 ("The No Surprises Act will not only save consumers money by lowering health care premiums, but according to the Congressional Budget Office, it will also save the federal government more than $20 billion over the next 10 years."); House Comm. on Ways and Means, Ways and Means Committee Surprise Medical Billing Plan, https://tinyurl.com/bdchr6ny (the proposed dispute reconciliation process is "[d]esigned to protect against inadvertently raising health care costs").

[16] *See* Press Release, House Educ. & Lab. Comm., Alexander, Murray, Pallone, Walden, Scott, Foxx Joint Statement on White House Surprise Medical Billing Report (July 29, 2020), https://tinyurl.com/7ub85rjw ("Our committees have worked together to develop bipartisan, bicameral compromise legislation that protects patients from surprise medical bills and is fair to providers and insurers. The six of us—progressive Democrats and conservative Republicans—have agreed on a transparent, market-based solution that will lower patients' premiums . . . .").

[17] Fact Sheet, White House, President Donald J. Trump Wants to Protect Patients and Their Families from Surprise Billing (May 9, 2019), https://tinyurl.com/3hv83bnn (including "[f]ederal healthcare expenditures should not increase" as a principle for addressing surprise billing).

arbitrators resolving payment disputes.[18] And the committee leaders who struck the deal—including the Chairs and Ranking Members of the House Energy and Commerce Committee, the House Ways and Means Committee, the House Education and Labor Committee, and the Senate HELP Committee—again highlighted how the bill would resolve "payment disputes between insurers and providers[] without increasing premiums for patients."[19] CBO confirmed this commitment to savings, estimating that the NSA would reduce premiums between 0.5 and 1%.[20] Members of Congress had this CBO score before they voted on the legislation,[21] and relied on the savings from the NSA to authorize federal funding for community health centers through 2023, among other legislative priorities.[22]

The agencies recognized this goal of lowering health care costs in the preamble and effectuated Congress's intent to protect patients from higher out-of-pocket costs and premiums.[23]

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[18] *See* 42 U.S.C. § 300gg-111(c)(5)(C)(i). As discussed below, the QPA is the only *mandatory* component of the arbitration process; other information may be submitted by the parties but is not required. This additional information is also subject to certain qualifications that do not apply to the QPA. *See infra* Part II.B.

[19] Press Release, House Comm. on Energy & Com., Congressional Committee Leaders Announce Surprise Billing Agreement (Dec. 11, 2020), https://tinyurl.com/cyf4zy7n; *see also* House Comm. on Ways & Means, Protecting Patients from Surprise Medical Bills (Dec. 21, 2020), https://tinyurl.com/yafcwrmj.

[20] Cong. Budget Off., Estimate for Divisions O Through FF, H.R. 133, Consolidated Appropriations Act, 2021, Public Law 116-260, Enacted on December 27, 2020 at 3 (Jan. 14, 2021), https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf.

[21] *See* Letter from Representative Frank Pallone, Jr., Chairman of the House Energy & Com. Comm., and Senator Patty Murray, Chair of the Senate Health, Educ., Lab., & Pensions Comm., to Sec'y Xavier Becerra, Secretary of Health and Hum. Servs. at 4 (Jan. 7, 2022), https://tinyurl.com/3e5hzvw3 ("We, along with our colleagues, were fully aware of this score as we enacted this historic legislation in December 2020.").

[22] Consolidated Appropriations Act, Pub. L. No. 116-260, div. BB, tit. III, § 301(a), 134 Stat. 1182, 2922–23 (2020).

[23] *See* Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980, 56061 (Oct. 7, 2020) ("it is anticipated that focusing on the QPA will help mitigate costs and reduce

The rule appropriately gives preeminence to the QPA, while still allowing for departures from it when the parties submit credible information that clearly demonstrates that the QPA is not the appropriate out-of-network rate for a service.[24] Indeed, as amici previously stated in a letter to the agencies, allowing the arbitrators to prioritize other information when it is not credible or does not show the QPA is an inappropriate out-of-network payment rate would serve only to increase health care costs, in direct contradiction to congressional intent.[25]

B. The rule reflects a proper interpretation of the statute.

The statute was written carefully to encompass a bipartisan, bicameral compromise

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government expenditures once the Federal IDR process is fully implemented, as projected by the Congressional Budget Office"); *see also id.* ("the Departments are of the view that this approach will protect participants, beneficiaries, and enrollees from excessive costs, either through reduced costs for items and services or through decreased premiums"); *id.* at 55,996 ("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").

[24] *See* Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980, 55,996 (Oct. 7, 2020) (emphasizing that "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"); *id.* at 56,061 (explaining that "the Departments are of the view that this approach will protect participants, beneficiaries, and enrollees from excessive costs, either through reduced costs for items and services or through decreased premiums" and "it is anticipated that focusing on the QPA will help mitigate costs and reduce government expenditures once the Federal IDR process is fully implemented, as projected by the Congressional Budget Office").

[25] *See supra* note 21. Amici also previously submitted comments to the implementing agencies in support of the rule, as did the Chairman and Ranking Member of the House Education and Labor Committee, Representatives Bobby Scott and Virginia Foxx. *See* Representative Frank Pallone, Jr., Chairman of the House Energy & Com. Comm., and Senator Patty Murray, Chair of the Senate Health, Educ., Lab., & Pensions Comm., to Xavier Becerra, Sec'y of Health & Hum. Serv., et al. (Oct. 20, 2021), https://tinyurl.com/3b7vrawu; Letter from Representative Robert C. "Bobby" Scott, Chairman of House Educ. & Lab. Comm., and Representative Virginia Foxx, Ranking Member of House Educ. & Lab. Comm., to Marty J. Walsh, Sec'y of Dep't of Lab., et al. (Nov. 19, 2021), https://tinyurl.com/mr29rds9.

pursuant to which median in-network rates, in the form of the QPA, would take a prominent but not solely determinative role. Contrary to the plaintiffs' arguments, the rule respects this approach.

The text of the statute alone provides many good reasons to start with the QPA. It is of no small matter that the statute listed the QPA first and separate from the other "[a]dditional circumstances" for consideration in the arbitration process.[26] In the event of a dispute between out-of-network providers and payors, the arbitrators must *always* consider the QPA without qualification.[27] In contrast, consideration of additional information is dependent on the parties' voluntarily submission of that information to the arbitrator or the arbitrator requesting it.[28] Submission of such additional information is not required in every dispute, and it is subject to the prohibition on considering usual and customary charges and public payor rates.[29] In short, such

[26] 42 U.S.C. § 300gg-111(c)(5)(C).

[27] *Id.* § 300gg-111(c)(5)(C)(i)(I).

[28] *Id.* §§ 300gg-111(c)(5)(B)(i)(II), (c)(5)(B)(ii).

[29] *See id.* §§ 300gg-111(c)(5)(B)–(D). The statute provides that the arbitrator shall consider three categories of information in addition to the QPA. The first is "information on any circumstance described in clause (ii)," *Id.* § 300gg-111(c)(5)(C)(i)(II), which includes: the provider's training, experience, and quality and outcomes measurements; the provider or payor's market share; the case acuity or complexity; the provider facility's teaching status, case mix, and scope of services; and demonstrations of good faith efforts (or the lack thereof) by the provider or payor to enter into network agreements and any prior contracted rates, *id.* § 300gg-111(c)(5)(C)(ii). Unlike the QPA, however, submission of this "additional circumstances" information is left to the discretion of the parties. *Id.* § 300gg-111(c)(5)(C)(ii); *see id.* § 300gg-111(c)(5)(B)(ii) (the parties "*may* each submit to the certified IDR entity with respect to such determination any information relating to such offer submitted by either party, including information relating to any circumstance described in subparagraph (C)(ii)" (emphasis added)). The second category is any information requested by the arbitrator, which is left to the arbitrator's discretion to request. *Id.* §§ 300gg-111(c)(5)(B)(i)(II). (c)(5)(C)(i)(II). The third category is "any additional information" provided by either party—again, optional. *Id.* §§ 300gg-111(c)(5)(B)(ii), (c)(5)(C)(i)(II). All three of these optional categories are further qualified by the bar on considering usual and customary charges and public payor rates. *Id.* §§ 300gg-111(c)(5)(C)(i)(II), (c)(5)(D).

information is "supplemental."[30]

The statute also gives significantly more attention to the QPA than these other, "additional" pieces of information. Unlike the "[a]dditional circumstances" listed in Section 300gg-111(c)(5)(C)(ii), the methodology for calculating the QPA is defined in detail at the beginning of the statute[31] and is subject to agency oversight and enforcement: the law requires the agencies to engage in rulemaking regarding the methodology that payors must use to calculate the QPA[32] and institutes auditing processes to ensure payors comply with the requirements governing the QPA.[33] These provisions reinforce the importance of the QPA and provide it an imprimatur the other circumstances lack.

The reasonableness of the QPA as an appropriate out-of-network payment amount is reinforced by the statute's reliance on the QPA in other areas. For example, the statute relies on the QPA as the basis for patients' cost-sharing amounts[34] and requires the agencies to report quarterly on both the number of times arbitrators determine a payment should exceed the QPA

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[30] *See In re Border Infrastructure Env't Litig.*, 915 F.3d 1213, 1223 (9th Cir. 2019) ("In simple terms, 'additional' means 'supplemental.'").

[31] *See* 42 U.S.C. § 300gg-111(a)(3)(E). The statute defines the QPA as a payor's median contracted rate for similar items or services within a specified insurance market and geographic area, subject to certain adjustments. *Id.* § 300gg-111(a)(3)(E)(i). Special rules apply to new plans or coverage, as well as when there is insufficient information to calculate the median contracted rate, including with respect to newly covered items and services. *Id.* §§ 300gg-111(a)(3)(E)(ii)–(iii).

[32] *Id.* § 300gg-111(a)(2)(B). The agencies completed this rulemaking in a timely manner, as directed. *See* Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36,872 (July 13, 2021).

[33] 42 U.S.C. § 300gg-111(a)(2)(A).

[34] With respect to services covered by the law, a patient may not pay more than they would were the service provided by an in-network provider. *Id.* §§ 300gg-111(a)(1)(C)(i), (b)(1)(A). Although the statute uses a different phrase ("recognized amount") for the amount patients must pay, *id.* §§ 300gg-111(a)(1)(C)(iii), (b)(1)(B), the recognized amount is the QPA except where a specified state law or an all-payer model agreement applies, *id.* § 300gg-111(a)(3)(H).

and the amount of each payment as a percentage of the QPA.[35] That these reports specifically address how frequently and to what extent payment amounts depart from the QPA buttresses the conclusion that the QPA is an appropriate starting point for the arbitration process.[36] The statute's explicit bar on the consideration of other rates, such as usual and customary charges and public payor rates,[37] also reflects Congress's determination that the QPA is a reasonable rate and supports the agencies' use of the QPA as a starting place for the arbitration process.

Indeed, plaintiffs acknowledge that contracted rates reflect reasonable payment amounts. As plaintiffs explain in their Complaint,

> When a patient with private insurance coverage receives medical care from an in-network provider, the insurer pays the provider a negotiated, contracted rate for covered items or services. The patient is responsible for only the cost-sharing, such as a co-pay, that is required by her insurance plan. If there is a difference between a provider's billed charges and the contracted rate a provider receives from the insurer, the provider does not bill the patient for the difference. For this reason, *the provider will negotiate her contract with the insurer to ensure that the contracted rate is a reasonable one*.[38]

The QPA reflects the median in-network, contracted rate—that is, the median of a range of "reasonable" rates negotiated by providers in the relevant market. Plaintiffs also acknowledge that both parties to the IDR process are expected to "make only reasonable, well-supported offers" in response to the "'baseball-style' process" Congress adopted, which

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[35] *Id.* §§ 300gg-111(c)(7)(A)(5), (c)(7)(B)(iv).

[36] *See generally Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 321 (2014) ("reasonable statutory interpretation must account for both 'the specific context in which . . . language is used' and 'the broader context of the statute as a whole'"); *Nat'l Ass'n of Home Builders v. Defs. of Wildlife*, 551 U.S. 644, 666 (2007) ("the words of a statute must be read in their context and with a view to their place in the overall statutory scheme").

[37] *Id.* § 300gg-111(c)(5)(D).

[38] Compl. ¶ 29, ECF No. 1 (Dec. 9, 2021) (emphasis added).

"encourages reasonable offers because, if one party's offer is unreasonable, the arbitrator will select the other party's offer even if it is too high or low."[39] This approach, as described here, is consistent with Congress' intent, and the rule adopts common-sense guardrails to help ensure this outcome.

While centering the arbitration process on the QPA, the rule also appropriately does not limit consideration just to the QPA. As part of the bipartisan, bicameral compromise that was struck, the statute included "[a]dditional circumstances" that could be considered if submitted to the arbitrator.[40] The rule provides for the same.[41] The rule's conditions on the consideration of this information merely assure that the arbitration process cannot be derailed by noncredible information or information that does not provide any reason to depart from the QPA starting point.[42] In sum, arbitrators are required to consider the (independently audited) QPA as well as all credible information submitted by the parties and then select an appropriate offer based on their

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[39] Pls.' Br. at 6, ECF No. 3 (Dec. 9, 2021); *id.* at 18 (noting that plaintiffs "have always assumed that parties would submit credible evidence and that arbitrators would take credibility into account when analyzing each of the statutorily mandated factors.").

[40] 42 U.S.C. § 300gg-111(c)(5)(C)(ii).

[41] 45 C.F.R. § 149.510(c)(4). At the same time, in enacting the NSA, Congress plainly rejected an approach that would have authorized an unbridled private arbitration process without clear specifications regarding what should or should not be considered, *see, e.g.*, Protecting Patients from Surprise Medical Bills Act, S. 1266, 116th Cong. (2019) and H.R. 4223, 116th Cong. (2019), which is more akin to the outcome the plaintiffs seek here by vacating the rule.

[42] *See* 45 C.F.R. §§ 149.510(a)(2)(v), (a)(2)(viii), (c)(4). At least some of the additional information that can be submitted should already be reflected in the QPA and thus is unlikely to materially change the arbitrator's analysis. *See* 86 Fed. Reg. at 55,997–98 (explaining why the additional information will often already be reflected in the QPA). For example, information about patient acuity or complexity will already be reflected in the QPA "because the plan or issuer is required to calculate the QPA using median contracted rates for service codes, as well as modifiers, if applicable, and because service codes and modifiers reflect patient acuity and the complexity of the service provided." *Id.* at 55,997.

discretion, consistent with the statute's prescriptions.

C. Congress authorized agencies to issue rules regarding how to resolve payment disputes.

The plaintiffs' suggestion that Congress did not assign the agencies any role in guiding how arbitrators should weigh the various statutory considerations or determine which party's offer is the appropriate reimbursement amount is risible.[43] Congress's intent to delegate implementation of the NSA to the agencies is replete in the statute.[44] Contrary to the plaintiffs' suggestions,[45] an explicit delegation in the specific subsection or clauses regarding considerations for determining payment amounts was not necessary: Congress had already stated that the agencies had rulemaking authority with respect to the arbitration process, inclusive of the arbitrators' determination of the amount of payment.[46] Just so, multiple plaintiffs originally urged the agencies to issue rules on how arbitrators should weigh the QPA against the additional information provided during dispute resolution processes.[47]

Additionally, nothing in the statute bars the agencies from establishing a rubric for how

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[43] *See* Pls.' Br. at 28–30, ECF No. 3 (Dec. 9, 2021).

[44] *See, e.g.*, 42 U.S.C. §§ 300gg-111(a)(2)(A)(i), (a)(2)(B), (c)(2)(A), (c)(3)(A), (c)(4)(A), (c)(4)(F), (c)(5)(e)(iv), (c)(8); *see also* NSA § 118 (authorizing funding for implementation activities, including preparing, drafting and issuing regulations, guidance, and public information, as well as establishing and implementing the processes for independent dispute resolution).

[45] *See* Pls.' Br. 29–30, ECF No. 3 (Dec. 9, 2021).

[46] 42 U.S.C. § 300gg-111(c)(2)(A).

[47] *See, e.g.*, Letter from James L. Madara, CEO, Am. Med. Ass'n, to Chiquita Brooks-LaSure, Admin'r, Centers for Medicare & Medicaid Servs., at 4 (Sept. 7, 2021) ("urg[ing] the Departments" to give arbitrators "[d]irections that the QPA is not to be weighted more than any other submitted information by the IDR entity when picking a party's offer"); Letter from Thomas P. Nickels, Exec. Vice-Pres., Am. Hosp. Ass'n, to Xavier Becerra, Secretary, U.S. Dep't of Health & Human Servs., et al., at 2–3 (Mar. 29, 2021) ("urg[ing]" the Departments to "implement the law" by "[e]nsuring arbiters are considering all relevant evidence").

arbitrators should consider the different types of information before them. Where a statute does not specify how much weight different statutory factors should be given, agencies administering the law can fill in the gaps.[48]

D. Congress anticipated that interim final regulations may be necessary to implement the law on time.

Congress intended this law, including the arbitration process, to be implemented swiftly.[49] And Congress anticipated that interim final rules might be necessary to meet the NSA's effective date of January 1, 2022: it explicitly authorized use of the funds provided to implement the law for the "[p]reparing, drafting, and issuing proposed and final regulations or *interim* regulations."[50] Additionally, the agencies had pre-existing authority to issue interim final rules as they "determine[] are appropriate."[51] Accordingly, the agencies' use of interim final rules—including with respect to providing guidance and expectations for the arbitration process—was appropriate

[48] *See New York v. Reilly*, 969 F.2d 1147, 1150 (D.C. Cir. 1992) ("Because Congress did not assign the specific weight the Administrator should accord each of these factors, the Administrator is free to exercise his discretion in this area."); *see also Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, 140 S. Ct. 2367, 2381 (2020) ("It is a fundamental principle of statutory interpretation that 'absent provision[s] cannot be supplied by the courts.' This principle applies not only to adding terms not found in the statute, but also to imposing limits on an agency's discretion that are not supported by the text. By introducing a limitation not found in the statute, respondents ask us to alter, rather than to interpret, the [law]." (Internal citations omitted)).

[49] *See, e.g.*, 42 U.S.C. §§ 300gg-111(a)(2)(A)(i), 300gg-111(a)(2)(B); 300gg-111(c)(2)(A); 300gg-111(f)(1).

[50] NSA § 118(b)(1) (emphasis added).

[51] *See* 42 U.S.C. § 300gg-92; 26 U.S.C. § 9833; 29 U.S.C. § 1191c.

given Congress's twin goals of protecting patients from surprise medical bills and reducing premiums beginning January 1, 2022.

III. CONCLUSION

The Court should uphold the agencies' actions by denying the plaintiffs' motion for stay pending judicial review, or in the alternative, for summary judgment and granting the defendants' cross-motion for summary judgment.

Dated: January 31, 2022

Respectfully submitted,

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CERTIFICATE OF SERVICE

I, Christopher T. Nace, certify that, on this date, the foregoing document was served by filing it on the Court's CM/ECF system.

Dated: January 31, 2022

/s/ Christopher T. Nace
Christopher T. Nace