UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA

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

BRIEF OF 12 PATIENT AND CONSUMER ADVOCACY ORGANIZATIONS AS *AMICI CURIAE* IN SUPPORT OF DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT

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INTEREST OF *AMICI CURIAE*[1]

Amici curiae The Leukemia & Lymphoma Society ("LLS"), Arthritis Foundation, Cancer Support Community, Epilepsy Foundation, Every Texan, Families USA Action, Family Voices, Hemophilia Federation of America, The Mended Hearts, Inc., National Multiple Sclerosis Society, National Patient Advocate Foundation, and the United States Public Interest Research Group, Inc. ("U.S. PIRG") (collectively, "*Amici*") are patient and consumer advocacy organizations that represent or work on behalf of millions of patients and consumers across the country, including those facing serious, acute, and chronic health conditions.[2] *Amici* are committed to ensuring that all Americans have a high-quality health care system and access to comprehensive, affordable health insurance to prevent disease, manage health, cure illness, and ensure financial stability.

Many patients served by *Amici* are among the one in six Americans who have received a surprise medical bill.[3] Given the impact of surprise bills on those served by *Amici*, many *Amici* joined community principles for surprise billing reforms[4] and worked with Congress to develop the bipartisan, bicameral No Surprises Act of the 2021 Consolidated Appropriations Act (the "No Surprises Act" or the "Act"), Pub. L. No. 116-260, 134 Stat. 1182 (2020) (codified at 42 U.S.C. § 300gg-111). With these community principles as our guide, many *Amici* were heavily

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[1] All parties have consented to the filing of this brief. No counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of the brief. No person other than *amici curiae* made a monetary contribution to the preparation or submission of this brief.

[2] Descriptions of *Amici* are included in the accompanying motion for leave to file brief as *amici curiae*.

[3] *See* Lunna Lopes *et al*., Kaiser Family Found., *Data Note: Public Worries About And Experience With Surprise Medical Bills* (Feb. 28, 2020), https://bit.ly/3r9Qiz2.

[4] *See* ALS Ass'n *et al.*, *Surprise Medical Billing Principles* (Feb. 2020), https://bit.ly/356VtHe.

engaged throughout the legislative process leading to the Act's passage and Defendants' rulemaking to implement the Act.

Because the patients and consumers we serve have a strong interest in the outcome of this litigation, *Amici* respectfully submit this brief in support of Defendants' Cross-Motion for Summary Judgment, ECF No. 51 ("Defendants' Cross-Motion").

SUMMARY OF ARGUMENT

Effective implementation of the No Surprises Act is necessary to reduce the financial burden of illness on patients and help contribute to longer, healthier lives. Through the Interim Final Rule, *Requirements Related to Surprise Billing; Part II*, 86 Fed. Reg. 55,980 (Oct. 7, 2021) (the "Rule"), Defendants have promulgated reasonable, uniform standards that will help prevent abuse of the No Surprise Act's independent dispute resolution ("IDR") process for resolving payment disputes between out-of-network providers and payers. The Rule is consistent with the statute and will protect patients and consumers from surprise medical bills and high health costs.

Amici submit this brief to assist the court in understanding the nature and extent of these harms to patients and consumers from surprise billing that the No Surprises Act was designed to address, and to explain why the Rule is faithful to the statutory text and Congressional intent. Based on their experience advocating for patients and consumers during the legislative and rulemaking processes, *Amici* are uniquely positioned to explain to the Court why the Rule is consistent with the text of the No Surprises Act and furthers Congress' two primary goals in enacting the Act: (1) protecting patients from the most pervasive types of surprise out-of-network bills; and (2) lowering health care costs overall. Plaintiffs' faulty interpretation of the Act's IDR requirement will frustrate the central purposes of the Act: encouraging more in-

network participation by providers and reducing out-of-pocket costs and premiums for patients and consumers.

Because Plaintiffs' requested *vacatur* or stay of the Rule would harm patients and consumers across the country, including those served by *Amici*, this Court should reject Plaintiffs' claims and grant Defendants' Cross-Motion.

ARGUMENT

I. SURPRISE MEDICAL BILLS RESULT IN HIGHER OUT-OF-POCKET COSTS FOR PATIENTS AND INFLATED HEALTH COSTS THAT CONTRIBUTE TO INCREASED HEALTH INSURANCE PREMIUMS.

As Congress recognized in passing the No Surprises Act, surprise medical bills can impose "staggering" financial burdens on patients and their families.[5] Patients receive out-of-network bills through no fault of their own when they unknowingly receive care from a provider that is not in their insurance network. Patients usually have no way to choose their physician or hospital in an emergency. Nor can they know whether certain specialists who may treat them during a visit to an in-network hospital—such as anesthesiologists or radiologists—are outside of their plan's network until after receiving a surprise bill. Patients with chronic or serious conditions, such as those at risk of a heart attack or with cancer, face an elevated risk of receiving out-of-network bills.[6]

[5] *See* H.R. Rep. No. 116-615, pt. 1, at 52 (2020) [Admin. Rec. 278-428] (describing stories of patients harmed by surprise medical bills and noting that "[t]he financial liability imposed on patients by surprise medical bills can be staggering").

[6] *See* Karen Pollitz *et al.*, *Surprise bills vary by diagnosis and type of admission*, Peterson-KFF Health Sys. Tracker (Dec. 9, 2019), https://bit.ly/3o5ZouG.

A. Surprise Medical Bills Have Harmed Millions of Patients and their Families Across the United States.

Surprise bills are common and have resulted in significant out-of-pocket costs for directly affected patients and higher premiums for privately insured consumers.[7] A patient might receive a surprise bill in an emergency if the closest hospital is outside the patient's network or if the patient is seen by an out-of-network emergency room physician at an in-network hospital. According to one study, 18 percent of all emergency visits by patients in large employer plans in 2017 had at least one out-of-network charge that could result in a surprise bill.[8] Another study estimated that one in five inpatient emergency room visits could lead to a surprise bill.[9]

Surprise bills also affect patients when they seek non-emergency care (such as surgery or maternity care) at in-network facilities. Among patients in large employer plans, 16 percent of in-network hospital stays in 2017 included at least one out-of-network charge that could lead to a surprise bill.[10] Another study found that 20 percent of all patients who had an elective procedure—such as a hysterectomy, knee replacement, or heart surgery—with an in-network primary surgeon at an in-network facility were still at risk of a surprise bill from an out-of-

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[7] *See* H.R. Rep. No. 116-615, pt. I, *supra* note 5, at 53 (summarizing the data on surprise billing and noting that the cost of inflated payment rates from certain provider specialties "are directly felt through higher out-of-pocket expenses and exorbitant surprise bills for out-of-network care, as well as by all consumers who share in rising overall health care costs through higher premiums").

[8] Karen Pollitz *et al.*, *An examination of surprise medical bills and proposals to protect consumers from them*, Peterson-KFF Health System Tracker (Feb. 10, 2020), https://bit.ly/3KLJ1gF.

[9] Christopher Garmon & Benjamin Chartock, *One In Five Inpatient Emergency Department Cases May Lead To Surprise Bills*, 36 Health Affairs 177, 177-81 (2017), https://doi.org/10.1377/hlthaff.2016.0970.

[10] Karen Pollitz *et al.*, *supra* note 8.

network specialist.[11] Of these, potential surprise bills averaged more than $1,200 for anesthesiologists and more than $3,600 for surgical assistants.[12] And over 18 percent of families with in-network childbirths in 2019 potentially received a surprise bill for maternal or newborn care, with one-third of these families facing potential surprise bills exceeding $2,000.[13]

These surprise bills add up. A recent study found that Americans owed more than $140 billion dollars in medical debt and that unpaid medical bills are the largest driver of that debt.[14] Surprise bills can hit low-income consumers the hardest: more than one-fourth of adults are unable to pay their monthly bills or are one $400 financial setback away from being unable to pay them in full.[15] The added burden of an unexpected medical expense—which could total hundreds or thousands of dollars—can spell financial ruin for many families.

B. Surprise Billing Increases Health Insurance Premiums and Overall Health Care Costs for Privately Insured Individuals.

In addition to higher out-of-pocket costs, surprise medical bills increase health care costs, which, in turn, increases premiums for those with private health insurance.[16] One study found that health care spending for people with employer-sponsored insurance would be reduced by 3.4 percent (about $40 billion annually) if certain hospital-based specialists—anesthesiologists,

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[11] Karan R. Chhabra *et al.*, *Out-of-Network Bills for Privately Insured Patients Undergoing Elective Surgery with In-Network Primary Surgeons and Facilities*, 323 J. Am. Med. Ass'n 538, 538-47 (2020) [Admin. Rec. 1416-45].

[12] *Id.*

[13] Kao-Ping Chua *et al.*, *Prevalence and Magnitude of Potential Surprise Bills for Childbirth*, JAMA Health F. 1 (July 2, 2021), https://bit.ly/3o7GTpL.

[14] Raymond Kluender *et al.*, *Medical Debt in the US, 2009-2020*, 326 J. Am. Med. Ass'n 250, 255 (2021), https://bit.ly/3KFqh23.

[15] Bd. of Governors of Fed. Reserve Sys., *Economic Well-Being of U.S. Households in 2020* 4, 33 (May 2021), https://bit.ly/3FZzXkl.

[16] *See* Erin Duffy *et al.*, Brookings Inst., *Surprise medical bills increase costs for everyone, not just for the people who get them* (Oct. 2, 2020), https://brook.gs/3FWoXnQ.

pathologists, radiologists, and assistant surgeons—were unable to send surprise bills to patients.[17] Another study found that about 12 percent of health plan spending is attributable to ancillary and emergency services where providers commonly send surprise bills to patients, leading researchers to conclude that policies to address surprise bills could reduce premiums by 1 to 5 percent.[18] These studies make clear that, even if not all patients receive a surprise bill, everyone pays the price for this practice through higher health costs and premiums.

II. CONGRESS INTENDED FOR THE NO SURPRISES ACT TO PROTECT PATIENTS FROM SURPRISE BILLS AND LOWER HEALTH CARE COSTS.

Protecting patients from surprise medical bills is at the heart of the No Surprises Act. But the law did more than just protect patients from these potentially catastrophic out-of-pocket expenses. The law was also designed to lower health care costs and prevent abuse of the IDR process. The legislative debate over the No Surprises Act and several precursor proposals highlights Congress' consistent and bipartisan objectives of protecting patients from surprise medical bills, reducing health care costs, and, in turn, lowering health insurance premiums. For more than two years, Congress considered four major precursor proposals before ultimately enacting the Act in its current form.[19] While the details of these proposals varied, each bill considered by the committees of jurisdiction would have directly protected patients from surprise medical bills and reduced premiums for consumers. Lowering health care costs was a unifying

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[17] Zack Cooper *et al.*, *Out-Of-Network Billing And Negotiated Payments For Hospital-Based Physicians*, 39 Health Affairs 24, 24 (2020) [Admin. Rec. 1397-1405].

[18] Erin L. Duffy *et al.*, *Policies to address surprise billing can affect health insurance premiums*, 26 Am. J. Managed Care 401, 401-04 (2020) [Admin. Rec. 1383-88].

[19] Other bipartisan legislative proposals, including the STOP Surprise Medical Bills Act of 2019 and the Protecting People from Surprise Medical Bills Act of 2020, included an IDR mechanism and would have allowed consideration of commercially reasonable rates or usual and customary charges (instead of the median in-network rate or qualifying payment amount). As those bills were not advanced in committee or scored by the CBO, they are not discussed here.

feature of these proposals, underscoring Congress' intent that any protections should also reduce, or at least not increase, insurance premiums.[20]

A. Bipartisan Precursor Proposals to the No Surprises Act Shared the Goal of Reducing Out-of-Pocket Costs for Patients and Overall Health Expenses.

1. Lower Health Care Costs Act

Congressional focus on surprise billing began in earnest in 2018 during hearings held by the U.S. Senate Committee on Health, Education, Labor & Pensions ("Senate HELP Committee") on how to reduce health care costs.[21] These hearings led Senate HELP Committee Chair Lamar Alexander (R-Tenn.) and Ranking Member Patty Murray (D-Wash.) to introduce the Lower Health Care Costs Act,[22] which the Congressional Budget Office ("CBO") estimated would reduce premiums by just over one percent relative to current law.[23]

2. No Surprises Act of 2019

At the same time the Senate HELP Committee debated the Lower Health Care Costs Act, the U.S. House of Representatives Committee on Energy and Commerce debated its own proposal, the No Surprises Act of 2019, which was introduced by Committee Chair Frank Pallone, Jr. (D-N.J.) and Ranking Member Greg Walden (R-Ore.) in July 2019.[24] Here too, the

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[20] *See* Letter from Sen. Murray & Rep. Pallone to Hon. Xavier Becerra, Sec'y of Health & Human Servs. (Jan. 7, 2022), https://bit.ly/3qTHv45.

[21] *See, e.g.*, *How to Reduce Health Care Costs: Understanding the Cost of Health Care in America: Hearing of the S. Comm. on Health, Educ., Labor & Pensions*, 115th Cong. 832 (June 27, 2018), https://bit.ly/33VO9xD.

[22] S. Comm. on Health, Educ., Labor & Pensions, *Senate Health Committee Leaders Introduce Bipartisan Legislation to Reduce Health Care Costs* (June 19, 2019), https://bit.ly/33Zg3sA.

[23] Cong. Budget Off., *S.1895, Lower Health Care Costs Act* 3 (July 16, 2019) ("CBO S.1895 Cost Est."), https://www.cbo.gov/system/files/2019-07/s1895_0.pdf.

[24] *See* H. Energy & Commerce Comm., *Pallone & Walden on Committee Passage of No Surprises Act* (July 17, 2019), https://bit.ly/3AoucvE.

CBO estimated that premiums would be about one percent lower than projected to be under current law.[25] The bill's sponsors touted the legislation's protections against surprise bills and premium savings, citing the CBO's estimate of $20 billion in savings to the federal government in the first decade after its enactment.[26]

3. Consumer Protections Against Surprise Medical Bills Act

In December 2019, bipartisan leaders of the House Ways and Means Committee—Chair Richard E. Neal (D-Mass.) and Ranking Member Kevin Brady (R-Tex.)—agreed on a strategy to address surprise bills that included an IDR process "[d]esigned to protect against inadvertently raising health care costs."[27] The agreement led to introduction of the Consumer Protections Against Surprise Medical Bills Act in February 2020. The CBO estimated that this legislation would result in insurance premium reductions of between 0.5 and one percent.[28]

4. Ban Surprise Billing Act

In February 2020, the House Education and Labor Committee advanced its own bipartisan legislative proposal, the Ban Surprise Billing Act, introduced by Chair Robert C. Scott (D-Va.) and Ranking Member Virginia Foxx (R-N.C.).[29] In a summary of that proposal, the Committee noted that the IDR process "[p]uts in place several commonsense guardrails to

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[25] Cong. Budget Off., *H.R. 2328, Reauthorizing and Extending America's Community Health Act* 6 (Sept. 18, 2019) ("CBO H.R. 2328 Cost Est."), https://www.cbo.gov/publication/55640.

[26] Reps. Frank Pallone Jr. & Greg Walden, *It's time for Congress to protect patients from surprise medical bills*, The Hill (Nov. 21, 2019), https://bit.ly/33E85FF.

[27] H. Ways & Means Comm., *Ways and Means Committee Surprise Medical Billing Plan* (Dec. 11, 2019), https://bit.ly/3tZAroC.

[28] 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) ("CBO H.R. 5826 Cost Est."), https://www.cbo.gov/publication/56122.

[29] H. Educ. & Labor Comm., *Committee Advances Bipartisan Solution to Ban Surprise Billing* (Feb. 11, 2020), https://bit.ly/32pifZW.

prevent the IDR process from leading to higher health care costs and premiums for consumers and from excessive utilization of the process."[30] The CBO agreed with this effect, estimating that the Ban Surprise Billing Act would reduce premiums by roughly one percent.[31]

B. The No Surprises Act Shared the Earlier Bills' Goal of Reducing Health Costs.

Congress' commitment to protecting patients from surprise medical bills and reducing health care costs culminated in a bipartisan, bicameral compromise that became the version of the No Surprises Act ultimately enacted as part of the 2021 Consolidated Appropriations Act. On December 11, 2020, the chairs and ranking members of the Senate HELP Committee and the House Committees on Energy and Commerce, Ways and Means, and Education and Labor announced this bipartisan agreement.[32] As with the earlier committee bills, lowering health care costs remained a high priority. The joint statement noted that, "We have reached a bipartisan, bicameral deal in principle to protect patients from surprise medical bills and promote fairness in payment disputes between insurers and providers, *without increasing premiums for patients*."[33] The CBO confirmed this intent and estimated that the No Surprises Act would reduce premiums by between 0.5 and one percent.[34]

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[30] H. Educ. & Labor Comm., *Section-by-Section: The Ban Surprise Billing Act (H.R. 5800)* 1-2 (Feb. 11, 2020), https://bit.ly/3Iylvlo.

[31] Cong. Budget Off., *H.R. 5800, the Ban Surprise Billing Act, as ordered reported by the House Committee on Education and Labor on February 11, 2020, Estimated Budgetary Effects* (Feb. 13, 2020) ("CBO H.R. 5800 Cost Est."), https://www.cbo.gov/publication/56134.

[32] S. Comm. on Health, Educ., Labor & Pensions, *Congressional Committee Leaders Announce Surprise Billing Agreement* (Dec. 11, 2020), https://bit.ly/3rSj1Ht.

[33] *Id.* (emphasis added).

[34] 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* 3 (Jan. 14, 2021) ("CBO H.R. 133 Estimate") [Admin. Rec. 779-86].

It was no mystery why these bills would reduce premiums. For each bill, the CBO consistently assumed that premiums would decline because payments to some providers would be lower than current average rates.[35] The same was true of bills with an IDR mechanism, such as the Consumer Protections Against Surprise Medical Bills Act and the Ban Surprise Billing Act.[36] The CBO analyses of these bills reflected the same conclusion: average payment rates for both in- and out-of-network care would move toward the median in-network rate under the proposed laws.[37] Since the median in-network rate tends to be lower than average rates, premiums would be reduced by up to one percent in most affected markets in most years.[38]

Many *Amici* were highly engaged with lawmakers throughout this legislative process. One of the core principles adopted by coalitions of patient and consumer advocates was that new surprise billing protections should "ensure costs are not simply passed along to patients through higher premiums or out-of-pocket costs"[39] and "hold costs down."[40] This dual focus on out-of-pocket costs and premiums is also reflected in the comments that many *Amici* and others made to Congress.[41] Based on this history, there is no question that Congress' intent in passing the No Surprises Act was both to protect patients from surprise medical bills and lower health care costs.

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[35] *See* CBO S.1895 Cost Est., *supra* note 23, at 3; CBO H.R. 2328 Cost Est., *supra* note 25, at 6.

[36] *See* CBO H.R. 5826 Cost Est., *supra* note 28; CBO H.R. 5800 Cost Est., *supra* note 31.

[37] *See* CBO H.R. 5826 Cost Est., *supra* note 28; CBO H.R. 5800 Cost Est., *supra* note 31.

[38] *See* CBO H.R. 5826 Cost Est., *supra* note 28; CBO H.R. 5800 Cost Est., *supra* note 31.

[39] ALS Ass'n *et al.*, *supra* note 4, at 2.

[40] Letter from Families USA *et al.* to House Speaker Pelosi and House Minority Leader McCarthy, at 2 (July 10, 2019), https://bit.ly/3tQAra6.

[41] *See, e.g.*, *id.*; Letter from Families USA *et al.* to House Speaker Pelosi and Leaders McConnell, McCarthy, and Schumer (Nov. 12, 2019), https://bit.ly/3tWPCP9.

Although Plaintiffs may not like that a primary goal of Congress in passing the Act was to lower health care costs,[42] it indisputably was.

III. THE RULE PROTECTS PATIENTS AND CONSUMERS BY HOLDING DOWN PREMIUMS AND ENCOURAGING IN-NETWORK NEGOTIATIONS.

The Rule dutifully follows the No Surprise Act's mandate and Congress' intent to rein in health care costs—and, in turn, help limit premiums for patients and consumers. Following Congress' lead, Defendants explicitly crafted the rule to "protect participants, beneficiaries, and enrollees from excessive costs, either through reduced costs for items and services or through decreased premiums,"[43] and "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."[44]

In challenging the Rule, Plaintiffs present an inconsistent and unsound interpretation of the No Surprises Act that would undermine these goals by leading to an unpredictable, administratively burdensome IDR system that could award out-of-network providers with payments far above market rates when doing so is not warranted based on the circumstances.

A. Plaintiffs' Preferred IDR Process Would Burden Patients and Families with Higher Premiums, Frustrating a Central Purpose of the No Surprises Act.

As Defendants explain in their brief, Plaintiffs specifically object to the "instructions that the arbitrator, when choosing between the competing amounts proposed by the provider and by

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[42] *See* Pls.' Mem. in Support of Mot. for Stay Pending Judicial Review, or in the Alternative, for Summ. J. ("Pls.' Mem.") 10, 27, ECF No. 3.

[43] 86 Fed. Reg. at 56,061; *see also id.* at 55,996 ("[A]nchoring 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[.]")

[44] *Id.* at 56,061 (citing CBO H.R. 133 Estimate, *supra* note 34).

the group health plan or health insurance issuer, should look first to a figure known in the Act as the 'qualifying payment amount,' or QPA."[45] But the Rule—by instructing arbitrators to select the offer that is closest to the QPA unless there is credible information that this amount is incorrect—is consistent with the statute for the reasons identified in the Rule's preamble.[46]

Even as Plaintiffs object to the IDR process, they advance several arguments that underscore the reasonableness of the Rule and Defendants' fidelity to the No Surprises Act's requirements. For instance, Plaintiffs acknowledge that providers already negotiate with payers to "ensure that the contracted rate is a *reasonable* one."[47] In turn, the QPA—which is based on the median of a payer's contracted rates[48]—is "reasonable" by Plaintiffs' own standard and thus provides a sensible starting point for IDR entities. If a provider believes the QPA is an unreasonable payment amount in a specific case, that provider can submit information to the IDR entity to support that view.[49] Under the Rule, the IDR entity must consider all credible information, thereby ensuring that the ultimate payment amount is "reasonable" as the Act requires.[50]

Plaintiffs also cast the Rule's requirement that IDR entities may only consider *credible* information as "one-sided."[51] But Plaintiffs simultaneously concede that parties to an IDR proceeding are expected to give "only reasonable, well-supported offers" and that they have

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[45] Defs.' Mem. in Support of Cross-Mot. Summ. J. ("Defs.' Mem.") 2, ECF No. 51-1.

[46] 86 Fed. Reg. at 55,984-85, 55,996-98.

[47] Compl. ¶ 29, ECF No. 1 (emphasis added).

[48] *See* 42 U.S.C. § 300gg-111(a)(3)(E)(i)(I); *see also generally* 45 C.F.R. § 149.140(c) (setting forth the methodology for calculating the QPA).

[49] *See* 86 Fed. Reg. at 56,128 (45 C.F.R. § 149.510(c)(4)(i)).

[50] *See* 86 Fed. Reg. at 56,128 (45 C.F.R. § 149.510(c)(4)(iii)).

[51] Pls.' Mem. at 18.

"always assumed that parties would submit credible evidence and that arbitrators would take credibility into account when analyzing each of the statutorily mandated factors."[52] Consistent with Plaintiffs' own understanding of the Act's requirements, the Rule merely formalizes this assumption to ensure that IDR entities do not consider non-credible information submitted by either party while leaving the determination of whether information is credible to each IDR entity.[53] Defendants fully explained why these IDR guardrails were reasonable in the Rule's preamble.[54]

A stay or *vacatur* of the challenged provisions of the Rule, as Plaintiffs seek, would result in an unpredictable and administratively burdensome IDR process, the costs of which will be borne directly by patients and their families in the form of higher premiums. Without the Rule's presumption that the QPA is the appropriate payment amount in most cases, arbitrators would be left without a clear, consistent way to balance the statutory factors. Both providers and payers would lose the uniform expectations that the Rule's IDR process establishes, leading to less predictable outcomes and increasing the likelihood of above-market payments to out-of-network providers. Providers would then be incentivized to remain out of network and use the IDR process to obtain a higher payment instead of negotiating for a reasonable, market-based payment. These higher payments, combined with the administrative costs associated with the IDR process, would be passed along to patients in the form of higher premiums. The relief Plaintiffs seek would thus perpetuate the cost crisis that the No Surprises Act was expressly designed to remedy.

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[52] *Id.* at 6, 18.

[53] *See* 86 Fed. Reg. at 56,125 (45 C.F.R. § 149.510(a)(2)(v)) (defining "credible information" as "information that upon critical analysis is worthy of belief and is trustworthy").

[54] *See* 86 Fed. Reg. at 55,984-85, 55,996-98.

B. The Rule's Emphasis on the QPA is Appropriate and Consistent with Congress' Intent to Lower Health Care Costs.

Nothing in the Rule prevents IDR arbitrators from considering the statutorily mandated factors and any other information that the parties submit during the IDR process.[55] Rather, the Rule *requires* that arbitrators consider all these factors so long as that information is credible and clearly demonstrates that the QPA is not the appropriate out-of-network payment for a service given the specific circumstances of an individual case.[56]

Prior to promulgation of the Rule, it was assumed that Defendants would issue guidance to arbitrators on how to balance the IDR factors consistent with the No Surprise Act's requirements. In its February 11, 2020, analysis of the Consumer Protections Against Surprise Medical Bills Act, the CBO noted that "[i]n determining the most reasonable rates, dispute resolution entities would be instructed to look to the health plan's median payment rate for in-network rate care."[57] Notably, in letters to Defendants this year regarding No Surprises Act implementation, Plaintiffs themselves understood that Defendants would issue such guidance in implementing regulations and urged federal officials to issue rules on how IDR entities should weigh the QPA against the additional information.[58]

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[55] *See* Defs.' Mem. at 19-20.

[56] *See id.* at 12-13; 86 Fed. Reg. at 56,128 (45 C.F.R. § 149.510(c)(4)(iii)).

[57] CBO H.R. 5826 Cost Est., *supra* note 28.

[58] *See, e.g.*, Letter from James L. Madara, CEO, Am. Med. Ass'n, to Chiquita Brooks-LaSure, Adm'r, Ctrs. for Medicare & Medicaid Servs. 4 (Sept. 7, 2021), https://www.regulations.gov/comment/CMS-2021-0117-7371 ("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. V.P., Am. Hosp. Ass'n, to Hon. Xavier Becerra, Sec'y of Health & Human Servs., *et al.* 2-3 (Mar. 29, 2021), https://bit.ly/3r58jyh ("urg[ing]" the Departments to "implement the law" by "[e]nsur[ing] arbiters are considering all relevant evidence").

Plaintiffs' mere disagreement with how the agencies weighed the factors is an insufficient basis for challenging the Rule.[59] And, as Defendants explain in their brief, Plaintiffs' preferred interpretation is at odds with the text and purpose of the No Surprises Act, so Plaintiffs' claim that the Rule is contrary to law should fail.[60] Unlike Plaintiffs' unsound interpretation of the Act's IDR provisions, the Rule follows the statute by requiring arbitrators to consider the QPA and other factors, and heeds Congress' intent by encouraging health care payers and providers to negotiate, resulting in increased in-network care at more affordable rates for patients and their families.[61]

C. The Rule's Arbitration Standards Will Likely Promote More In-Network Care and Reduce Out-of-Pocket Costs and Premiums for Consumers.

Plaintiffs and their supporting *amici* argue that the Rule will jeopardize access to care and harm patients by forcing providers to accept lower rates or reducing access to in-network care. But these so-called harms are nonexistent or significantly overblown and cannot justify a stay or *vacatur* of the challenged provisions of the Rule.

First, evidence from states with existing protections against surprise billing suggests that a well-designed IDR process that does not incentivize the overuse of arbitration can lead to higher rates of participation of in-network providers. In California, for example, in-network service provision rose and remained high after implementation of the state's law in 2017.[62]

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[59] *Cf. Hearth, Patio & Barbecue Ass'n v. EPA*, 11 F.4th 791, 805 (D.C. Cir. 2021).

[60] *See* Defs.' Mem. at 30-34.

[61] *See* Letter from Reps. Bobby Scott & Virginia Foxx to Hon. Martin J. Walsh, Sec'y of Labor, *et al.* (Nov. 19, 2021), https://bit.ly/3rRkVYV; Letter from Rep. Frank Pallone, Jr. & Sen. Patty Murray to Hon. Xavier Becerra, Sec'y of Health & Human Servs., *et al.* (Oct. 20, 2021), https://bit.ly/3tTM54k.

[62] *See* Loren Adler *et al.*, Brookings Inst., *California saw reduction in out-of-network care from affected specialties after 2017 surprise billing law* (Sept. 26, 2019), https://brook.gs/3KQ8cyz.

Evidence from other laws adopted in states, including Connecticut and New York, also shows out-of-network providers choosing to join payer networks after implementation of surprise billing reforms.[63]

Second, payers have legal and economic incentives to maintain robust provider networks. While the No Surprises Act does not include new standards that require payers to have adequate provider networks, many payers are subject to network adequacy requirements under existing federal and state laws.[64] Where legal requirements might not exist, insurers and plans have market-based incentives to compete for business by offering products with provider networks that ensure access to a broad range of in-network care.[65] Strong network adequacy protections are key to ensuring access to care and help mitigate concerns raised by Plaintiffs and their *amici*.

Third, most providers and facilities do *not* balance bill patients for care. Fewer than half of the providers across medical specialties send out-of-network bills; of those that do, most do so less than 10 percent of the time.[66] As such, the challenged provisions of the Rule will have very little impact on most providers.[67] Even if the Rule were to impact some types of specialty

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[63] *See* Loren Adler *et al.*, Brookings Inst., *Changes in emergency physician service prices after Connecticut's 2016 surprise billing law* (Sept. 23, 2021), https://brook.gs/3G1dSlG; N.Y. Dep't of Fin. Servs., *New York's Surprise Out-Of-Network Protection Law Report on the Independent Dispute Resolution Process* 8 (Sept. 2019) [Admin. Rec. 1342-71].

[64] *See* Justin Giovannelli *et al.*, *Regulation of Health Plan Provider Networks*, Health Affairs Health Policy Brief (July 28, 2016), https://bit.ly/32E9H1B.

[65] *See* Gary Claxton *et al.*, *Employer strategies to reduce health costs and improve quality through network configuration*, Peterson-KFF Health Sys. Tracker (Sept. 25, 2019), https://bit.ly/3G8MaUf.

[66] Jean Fuglesten Biniek *et al.*, Health Care Cost Inst., *How often do providers bill out of network?* (May 28, 2020), https://bit.ly/3KRS8MA.

[67] *See* Kevin Kennedy *et al.*, Health Cost Inst., *Surprise out-of-network medical bills during in-network hospital admissions varied by state and medical specialty, 2016* (Mar. 28, 2019), https://bit.ly/3GcNVzr.

providers, hospitals and other facilities have strong financial incentives to ensure that they have sufficient staff for well-functioning emergency departments and operating rooms.[68] Experience suggests that facilities and hospital-based clinicians will ensure access to care by taking necessary actions like making higher payments to out-of-network clinicians.[69] Hospitals and other facilities will then negotiate with payers to secure higher in-network rates to account for these marginal costs.

Fourth, Plaintiffs cite inapposite examples to illustrate their concerns about the QPA and IDR process. For example, in trying to rebut Defendants' common-sense position that an out-of-network payment amount for the simple repair of a superficial wound would not be higher in most cases "just because a provider has 30 years of experience versus 10 years of experience,"[70] Plaintiffs point to the complexity of providing care to patients who have "extenuating circumstances" such as substance use, psychiatric disorders, or homelessness that may complicate otherwise routine care.[71] In addition to painting the medical needs of individuals with disabilities and unhoused individuals with a broad brush, Plaintiffs ignore that many such patients are less likely than average to be enrolled in private health insurance (and thus more

[68] *See* Chloe O'Connell *et al.*, *Trends in Direct Hospital Payments to Anesthesia Groups: A Retrospective Cohort Study of Nonacademic Hospitals in California 2019*, 131 Anesthesiology 534, 534-42 (2019), https://doi.org/10.1097/ALN.0000000000002819.

[69] *See id*.

[70] 86 Fed. Reg. at 55,997.

[71] Pls.' Mem. at 17.

likely to be receive health coverage, if any, through Medicare or Medicaid),[72] such that the No Surprises Act and the Rule would be less likely to apply to their care. But even where the Act's requirements would apply to the care of individuals for whom treatment might be more complicated, higher costs associated with any such complexity would be fully accounted for in the IDR process: as the Rule itself contemplates, the provider simply needs to submit credible information to the IDR entity warranting a departure from the QPA in each such case.[73]

Finally, in contrast to assertions that the Rule will harm safety-net and other providers, lower-cost providers may stand to gain under the Rule's IDR provisions. This is because the QPA is the *median* of existing rates, meaning half of facilities or providers were previously paid prices at or below the QPA. As such, many safety-net and other lower-cost providers and facilities could secure rates closer to the QPA, thus improving the financial stability of providers.

CONCLUSION

The Rule is consistent with the text and purpose of the No Surprises Act and will benefit patients by implementing an IDR process that helps ensure lower health care costs for privately insured Americans. The Court should deny Plaintiffs' Motion for Stay Pending Judicial Review, or in the Alternative, for Summary Judgment, grant Defendants' Cross-Motion for Summary Judgment, and uphold the Rule.

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[72] *See generally* Nat'l Health Care for the Homeless Council, *Health Insurance at HCH Programs, 2020* 1-3 (Oct. 2021), https://bit.ly/340GtdR (discussing health insurance barriers for individuals experiencing homelessness); Jae Kennedy *et al.*, *Disparities in Insurance Coverage, Health Services Use, and Access Following Implementation of the Affordable Care Act: A Comparison of Disabled and Nondisabled Working-Age Adults*, 54 Inquiry 1, 1 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5798675/.

[73] *See* 86 Fed. Reg. at 55,997 (noting that the out-of-network payment amount for the simple repair of a superficial wound would not necessitate a rate higher than the QPA in most cases; *see also* Defs.' Mem. at 17 (explaining how the IDR process can account for outliers).

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Respectfully submitted,

/s/ Joseph J. Wardenski

Joseph J. Wardenski (admitted *pro hac vice*)
WARDENSKI P.C.
195 Plymouth Street, Suite 519
Brooklyn, NY 11201
(347) 913-3311
joe@wardenskilaw.com

Counsel for The Leukemia & Lymphoma Society, Arthritis Foundation, Cancer Support Community, Epilepsy Foundation, Every Texan, Families USA Action, Family Voices, Hemophilia Federation of America, The Mended Hearts, Inc., National Multiple Sclerosis Society, National Patient Advocate Foundation, and the United States Public Interest Research Group, Inc.