UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

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

BRIEF OF *AMICUS CURIAE* BLUE CROSS BLUE SHIELD ASSOCIATION IN SUPPORT OF DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT AND OPPOSITION TO PLAINTIFFS' MOTION FOR STAY PENDING JUDICIAL REVIEW, OR IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT

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CORPORATE DISCLOSURE STATEMENT

The Blue Cross Blue Shield Association ("BCBSA") is a trade association whose members have no ownership interests. BCBSA is unincorporated. It has no parent corporation. And because it has no stock, there is no publicly held corporation that owns 10% or more of its stock.

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INTERESTS OF *AMICUS CURIAE*[1]

The Blue Cross Blue Shield Association ("BCBSA") is the non-profit association that promotes the national interests of thirty-five independent, community-based, and locally operated Blue Cross Blue Shield health insurance companies ("Blue Plans"). Together, the Blue Plans provide health insurance for over 111 million people—one third of all Americans—in every zip code in all fifty states, the District of Columbia, and Puerto Rico. Blue Plans offer a variety of insurance products to all segments of the population, including federal employees, large employer groups, small businesses, and individuals. As leaders in the healthcare community for more than eighty years, Blue Plans seek to expand access to quality healthcare for all Americans and have extensive knowledge of and experience with the health insurance marketplace. BCBSA has an interest in advising the Court regarding the manner in which the interim final rule ("IFR"), which is the subject of this suit, will help remedy distortions in the market for healthcare services and restrain costs for patients, including those enrolled in Blue Plans.

INTRODUCTION

The IFR specifies the process by which arbitrators should select the appropriate payment under the No Surprises Act ("Act") for services rendered to patients by certain physicians and healthcare facilities ("providers") who do not participate in the provider networks offered by the patients' health insurers or health plans ("out-of-network providers"). The IFR reflects the Departments'[2] diligent efforts to faithfully implement the intent of Congress when it sought to end

[1] Pursuant to LCvR 7(o) of the Rules of the U.S. District Court for the District of Columbia and Federal Rule of Appellate Procedure 29(a)(4), BCBSA states that no counsel for a party authored this brief in whole or in part; and that no person—other than BCBSA, its members, or its counsel—contributed money that was intended to fund preparation of this brief.

[2] The "Departments" collectively refers to the institutional defendants in this action: the U.S. Department of Health and Human Services ("HHS"), the U.S. Department of Labor, the U.S. Department of the Treasury, and the Office of Personnel Management.

so-called "surprise billing," which occurs "when a consumer covered by a health plan is unexpectedly treated by an out-of-network provider and is required to pay the difference between what the plan pays and the provider's charge," often amounting "to thousands of dollars of unforeseen medical costs." H.R. Rep. No. 116-615, pt. I, at 47 (Dec. 2, 2020). The Act applies 1) when patients receive emergency care from out-of-network providers; and 2) when patients receive ancillary medical care from out-of-network physicians but at a facility, such as a hospital, that participates in the provider network of the patients' health plan. *See* 42 U.S.C. §§ 300gg-131, 300gg-132.

Congress recognized that surprise billing was becoming an increasingly common practice in the healthcare market and that *all* patients were paying the price. *See* H.R. Rep. No. 116-615, pt. I, at 53-55. A minority of emergency providers and hospital-based physicians ("Surprise Billers") have unfairly leveraged their patients' inability to choose which providers render care in these settings to charge exorbitant rates. Indeed, data shows that many Surprise Billers charge grossly inflated rates, in some instances demanding more than 1,000% of the payments made by the Medicare program for the exact same services. In the Act, Congress carefully considered the interests of healthcare providers, payors, and, above all, patients. It balanced those interests in designing an independent dispute resolution ("IDR") process pegged to the qualifying payment amount ("QPA"), which reflects the median rate allowed by the payor for the same service to its network of contracted providers. The IFR implements Congress's considered judgment that the QPA represents the presumptively reasonable value for healthcare services covered by the Act.

The plaintiffs here complain that the primary role of the QPA in the IDR process will affect the market landscape for healthcare services. But this argument misses the point. Congress fully understood that the status quo is a market highly susceptible to distortion by the inability of patients

to choose their providers based on cost, and that Surprise Billers have exploited that opportunity in a manner that has inflated healthcare costs for patients. Congress rejected that status quo, and the IFR ensures that patients will enjoy the benefits that Congress intended.

Plaintiffs also contend that the IFR will prompt payors to sharply narrow their provider networks, which will harm patients' access to needed care. But market-based incentives and network adequacy requirements codified in state and federal laws ensure that provider networks will remain sufficiently broad to meet patients' needs—and the empirical evidence from states that have implemented similar measures confirms that plaintiffs' conjecture is baseless. The adverse effects predicted by plaintiffs and their *amici* have no factual basis.

Plaintiffs' procedural challenges to the IFR fare no better. Even if Congress had not expressly authorized the Departments to promulgate interim final rules, the Departments had good cause to do so, because regulated parties require advance guidance about the arbitration process required by the Act before the law takes effect on the deadline set by Congress. Health insurers, for instance, must design and implement policies and procedures for arbitrating payment disputes before those arbitrations can begin. Thus, the Court should reject plaintiffs' motion for a stay or summary judgment and grant the Departments' cross-motion for summary judgment.

ARGUMENT

I. The IFR Prioritizes a Payment Metric That Reflects the Reasonable Value of Healthcare Services.

The Departments promulgated the IFR in September 2021 pursuant to Congress's directive to establish regulations that govern the "baseball-style" arbitrations between payors and healthcare providers to resolve payment disputes under the Act. *See* Defs.' Mem., Dkt. 51-1, at 7-13. Plaintiffs challenge provisions of the IFR that direct an arbitrator to "select the [party] offer closest to the [QPA] unless [the arbitrator] determines that credible information submitted by either

party … clearly demonstrates that the [QPA] is materially different from the appropriate out-of-network rate."[3] 45 C.F.R. § 149.510(c)(4)(ii)(A). Under the Act, the QPA reflects "the median of the contracted rates recognized by the plan or issuer … 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 geographic region in which the item or service is furnished"—in other words, the median contracted rate. 42 U.S.C. § 300gg-111(a)(3)(E). The QPA must be calculated as of January 31, 2019, using a methodology that Congress directed the Departments to establish, and then adjusted over time for inflation. *Id.* As the Departments have explained, the IFR requires arbitrators to "look first to the QPA" because the QPA, in Congress's judgment, "represents a reasonable market-based payment for relevant items and services" rendered to patients. *Requirements Related to Surprise Billing: Part II*, 86 Fed. Reg. 55,980, 55,996 (Oct. 7, 2021). Indeed, the median contracted rates reflected in the QPA represent the best evidence of true "market" prices for healthcare services, and thus, as "the statute contemplates," "typically the QPA will be a reasonable out-of-network rate." *Id.*

The reasonable market value of a good or service "is 'the price that [it] would bring by bona fide bargaining between well-informed buyers and sellers,'"—that is, "the price [it] would sell for in an arm's length, open-market transaction." *New Eng. Deaconess Hosp. v. Sebelius*, 942 F. Supp. 2d 56, 59 (D.D.C. 2013) (quoting 42 C.F.R. § 413.134(b)(2)). Median contracted rates typically represent reasonable market values because they "are established through arms-length negotiations between providers and facilities and plans and issuers (or their service providers)."

[3] The IFR provides that "[c]redible information means information that upon critical analysis is worthy of belief and is trustworthy," while "[m]aterial difference means a substantial likelihood that a reasonable person with the training and qualifications of a certified IDR entity making a payment determination would consider the submitted information significant in determining the out-of-network rate and would view the information as showing that the [QPA] is not the appropriate out-of-network rate." 45 C.F.R. § 149.510(a)(2).

86 Fed. Reg. at 55,996. Contracted rates account for the vast majority of transactions in the private healthcare market: most patients receive care from providers who participate in a payor's network rather than on an out-of-network basis, even among healthcare specialties in which patients are most likely to receive care from out-of-network providers.[4] Congress understood that median contracted rates reflect reasonable market values. *Each* of the congressional committees that reported bills that ultimately resulted in the passage of the Act "determined the QPA to be a reasonable, market-based rate" and "included the QPA as the primary rate that IDR entities should consider when making decisions."[5] The Departments applied this congressional judgment, declaring that "the QPA should reflect standard market rates arrived at through typical contract negotiations and should therefore be a reasonable out-of-network rate under most circumstances." 86 Fed. Reg. at 55,996.

While the Act permits IDR entities to consider certain information other than the QPA, it prohibits consideration of a few specified criteria, and comparing these prohibited considerations with the QPA illustrates nicely why Congress concluded that the QPA represents a reasonable market rate. On the one hand, the Act directs that an IDR entity "shall not consider usual and customary charges" or "the amount that would have been billed" by the provider if not limited by the Act. 42 U.S.C. § 300gg-111(c)(5)(D). Billed charges do not represent reasonable market values because they reflect rates unilaterally demanded by a healthcare provider rather than rates that a payor and provider have negotiated. "Usual and customary" charges suffer from the same

[4] *See* Jean Fuglesten Biniek et al., *How Often Do Providers Bill Out of Network?*, Health Care Cost Inst. (May 28, 2020), https://perma.cc/3X75-CMN7; Kevin Kennedy et al., *Surprise Out-of-Network Medical Bills During In-Network Hospital Admissions Varied by State and Medical Specialty, 2016*, Health Care Cost Inst. (Mar. 28, 2019), https://perma.cc/K4L8-4VGC.

[5] Letter from Sen. Patty Murray & Rep. Frank Pallone, Jr. to Sec'y Xavier Becerra (Jan. 7, 2022), at 4; *see* H.R. 2328, 116th Cong. (2019); S. 1895, 116th Cong. (2019); H.R. 5800, 116th Cong. (2020); H.R. 5826, 116th Cong. (2020).

flaw: a "usual and customary" charge under the Act "refers to the amount providers in a geographic area usually charge for the same or similar medical service." 86 Fed. Reg. at 55,999.[6] Usual and customary charges, then, may reflect unilaterally set charges that are typically billed by providers in a given area in the aggregate, but this metric similarly fails to reflect market values because there is often "a big difference between usual and customary charges and the usual and customary amount that providers actually get paid"—that is, the true market rate.[7] On the other hand, the Act prohibits IDR entities from selecting traditional Medicare or other government payment rates. 42 U.S.C. § 300gg-111(c)(5)(D). Traditional Medicare, like other public health plans, "sets prices administratively in an attempt to reflect efficient costs."[8] Thus, Congress prohibited IDR entities from considering payment amounts set by one party alone—both billed charges unilaterally set by healthcare providers, and payment rates set by traditional Medicare and other government programs—and instead required them to consider a metric set through bilateral negotiations: the median contracted rates embodied in the QPA.[9]

Contracted rates are *not* unilaterally dictated by payors, as plaintiffs suggest. *See, e.g.*, Pls.' Mot., Dkt. 3, at 34. Robust empirical evidence shows that contracted rates for both facilities and physicians vary significantly across and within geographic markets and medical specialties, both absolutely and relative to the rates paid by Medicare. The mean contracted rate for a hip

[6] *See* Loren Adler et al., *Understanding the No Surprises Act*, USC-Brookings Schaeffer Initiative for Health Pol'y (Feb. 4, 2021), https://perma.cc/ZUM8-8PDS (noting that usual and customary charges are typically based on "unilaterally set" billed charges).
[7] George A. Nation III, *Taking Advantage of Patients in an Emergency: Addressing Exorbitant and Unexpected Ambulance Bills*, 62 Vill. L. Rev. 747, 750 (2017).
[8] Erin Duffy et al., *Surprise Medical Bills Increase Costs for Everyone, Not Just for the People Who Get Them*, USC-Brookings Schaeffer Initiative for Health Pol'y (Oct. 2, 2020), https://perma.cc/87TX-KT9K.
[9] *See* Julie Appleby, *Here's What the New Ban on Surprise Medical Billing Means for You*, NPR (Dec. 30, 2021), https://perma.cc/GTA4-GQM9.

replacement in the New York metropolitan area, for example, is more than twice as much as the mean contracted rate for the same procedure in the Baltimore area, and contracted rates for office-based lower back MRIs vary drastically *within* the Miami area, with rates of under $200 at the 25th percentile and more than $1,400 at the 75th percentile.[10] The ratio of average private contracted rates to Medicare rates likewise varies significantly between and within geographic areas and medical specialties.[11] This substantial variance in average contracted rates dispels any argument that health insurers set those rates by fiat, as the plaintiffs and their *amici* suggest, because such variations occur when prices are determined through individual negotiations rather than unilateral price setting.[12] Payors *and providers* negotiate contracted rates, and ample evidence shows that median contracted rates are the best available measure of the reasonable value of healthcare services for patients.

II. The IFR Curbs Further Distortions in the Market for Healthcare Services and Will Help Restrain Healthcare Costs for Patients.

Because the QPA is tied to the median contracted rates from 2019 and then adjusted for inflation, the market distortions caused by surprise billing—and the inflated payment rates that have resulted—are already baked into the IDR process established by the Act. The IFR merely furthers Congress's goal of preventing future market distortions and restraining costs for patients.

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[10] Nisha Kurani, et al., *Price Transparency and Variation in U.S. Health Services*, Peterson-KFF Health Sys. Tracker (Jan. 13, 2021), https://perma.cc/869A-2GNG.

[11] *See generally* Paul B. Ginsburg, *Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power*, Ctr. for Studying Health Sys. Change, Research Br. No. 16 (Nov. 2010), https://perma.cc/2EPQ-WUPS.

[12] *See, e.g.*, Sarah L. Barber et al., *Price Setting and Price Regulation in Health Care*, World Health Org. (2019), at 29-30, https://perma.cc/N9JG-8K8N.

A. Surprise Billers have commanded above-market rates by exploiting the inability of their patients to choose alternative providers, and this minority of providers in specialties covered by the Act has had an outsized impact on the payment rates for those services.

Congress passed the No Surprises Act to correct an increasingly worrying "failure in the health care market." H.R. Rep. No. 116-615, pt. I, at 53. Most providers negotiate contracted rates with health plans and offer their services to members of those plans at the negotiated rates.[13] But market distortions have caused some "providers—particularly in certain specialties—to have little or no incentive to contract to join a health plan's network." *Id.* Some providers "face highly inelastic demands for their services because patients lack the ability to meaningfully choose or refuse care"[14]: patients rarely ask if a physician or facility has contracted with their health plans before receiving urgent care in the emergency room, or when treated by ancillary hospital-based physicians, like radiologists and anesthesiologists, that patients seldom choose themselves. *Id.* In the years before Congress passed the Act, growing numbers of Surprise Billers began exploiting their patients' lack of choice to increase their own charges and payment rates. *See* Defs.' Mem., Dkt. 51-1, at 3-6 (surveying developments). While Surprise Billers represent a minority of providers, their outsized impact on the market has led to "highly inflated payment rates" in these specialties; Congress found that "the median billed charge for emergency medicine is 465 percent of the Medicare rate," for example, while the median billed charges for diagnostic radiology and anesthesiology are 402% and 551% of Medicare rates, respectively. H.R. Rep. No. 116-615, pt. I, at 53.[15] Average billed charges in these specialties exceed Medicare rates by a far greater margin

[13] *See, e.g.*, Loren Adler et al., *State Approaches to Mitigating Surprise Out-of-Network Billing*, USC-Brookings Schaeffer Initiative for Health Pol'y (Feb. 2019), at 4, https://perma.cc/DMS6-8K6V.

[14] Inelastic demand is present when higher prices for a good or service do not deter buyers from purchasing the good or service, such as when buyers lack meaningful options between sellers. *See, e.g.*, *Kleen Prods. LLC v. Georgia-Pacific LLC*, 910 F.3d 927, 931 (7th Cir. 2018).

[15] Studies have similarly shown that hospitals' billed charges for emergency services have grown

than average billed charges in other specialties.[16] Even the *average* billed charges for certain procedures have run as much as *1,000%* of Medicare rates.[17]

The inelastic demand for emergency and hospital-based services, in short, allows Surprise Billers "to bill out-of-network patients at basically whatever rate they choose, which in turn allows them to negotiate very high rates when they do come in-network," leading to higher average contracted rates across the specialties most associated with surprise billing.[18] While average contracted rates for all physicians represented 128% of original Medicare rates in 2018, the average contracted rates of the specialties most associated with surprise billing represented significantly higher multiples of the Medicare rate: 200% for radiologists, 306% for emergency physicians, and 344% for anesthesiologists.[19] The comparatively higher contracted rates in these specialties are rooted in the ability of Surprise Billers to balance bill their patients in the out-of-network setting[20]—and some Surprise Billers have openly embraced that they rely on the threat of "balance billing" as a "source of contract negotiating leverage" with health insurers.[21] Congress passed the

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at a faster rate than hospitals' billed charges for non-emergent services. *See* Robert Murray, *Hospital Charges and the Need for a Maximum Price Obligation Rule for Emergency Department & Out-of-Network Care*, Health Affairs Forefront (May 16, 2013), https://perma.cc/66NE-HAUP.

[16] *See* Adler et al., *supra* n.13, at 7, https://perma.cc/DMS6-8K6V; *see also* Tim Xu et al., *Variation in Emergency Department vs. Internal Medicine Excess Charges in the United States*, 177(8) JAMA Internal Medicine 1139 (Aug. 1, 2017), https://perma.cc/2NAC-5CVR (finding that some emergency medicine providers charge as high as 12.6 times Medicare rates).

[17] *See* AHIP Ctr. for Pol'y & Rsch., *Charges Billed by Out-of-Network Providers: Implications for Affordability* (Sept. 2015), at 4, https://perma.cc/XMZ7-BVM4.

[18] Loren Adler et al., *Breaking Down the Bipartisan Senate Group's New Proposal to Address Surprise Billing*, USC-Brookings Schaeffer Initiative for Health Pol'y (May 21, 2019), https://perma.cc/383W-58A9; *see also* Glenn Melnick & Katya Fonkych, *Regulating Out-of-Network Hospital Emergency Prices: Problem and Potential Benchmarks*, Health Affairs Forefront (Mar. 23, 2020), https://perma.cc/67XJ-K7L3.

[19] Adler et al., *supra* n.18, https://perma.cc/383W-58A9.

[20] Duffy et al., *supra* n.8, https://perma.cc/87TX-KT9K.

[21] Letter from TeamHealth Holdings, Chief Executive Officer, to U.S. Senate Bi-Partisan Workgroup on Surprise Medical Billing (Mar. 13, 2019), at 1, https://perma.cc/D468-YCQ3; *see also* Caitlin Owens, *TeamHealth Sent Thousands of Surprise Medical Bills in 2017*, Axios (Dec.

Act fully aware of evidence that Surprise Billers use the threat of balance billing to charge "highly inflated payment rates," which "are, in turn, reflected in the cost of in-network care."[22] H.R. Rep. No. 116-615, pt. I, at 53.

B. Private equity groups have fueled the growth of surprise billing and the associated rising costs for healthcare services.

Private equity groups in particular have been a driving force in the growth of surprise billing and the resulting inflation of payment rates for healthcare services.[23] "The private equity business model often centers on risky investments with short-term horizons." 86 Fed. Reg. at 56,046. Private equity "firms often take on large amounts of debt to acquire an asset, then introduce structural and operational changes to extract value or increase revenue growth potential in the aim of selling the asset for a higher valuation." *Id.* Some private equity groups have met the challenge of quickly generating revenue and limiting costs by "identifying and exploiting existing market dysfunctions."[24]

As Congress recognized, such a market distortion—namely, the "financial opportunity

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5, 2019), https://perma.cc/PJ8D-PUSN.

[22] Plaintiffs ignore this market reality when they point to a letter from BlueCross BlueShield of North Carolina ("BCBS-NC") as an example of abusive market conduct by health insurers resulting from the IFR. *See* Compl., Dkt. 1, ¶ 9; Pls.' Mot., Dkt. 3, at 34-35. BCBS-NC, a single-state, not-for-profit insurer, sent the letter to less than 0.001% of healthcare providers in its network—54 in total, out of well over 15,000 providers in the network. This small minority of providers maintained legacy contracted rates that BCBS-NC sought to renegotiate based on reasonable market rates.

[23] *See* Richard M. Scheffler et al., *Soaring Private Equity Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk*, Am. Antitrust Inst. (May 18, 2021), at 39 & n.143, https://perma.cc/9XJU-7PK6 ("Surprise billing is a tactic that was pioneered by private equity firms that bought up physician practices that contracted with hospitals to provide coverage for their emergency rooms.").

[24] Erin Fuse Brown et al., *Private Equity as a Divining Rod for Market Failure: Policy Responses to Harmful Physician Practice Acquisitions*, USC-Brookings Schaeffer Initiative for Health Pol'y (Oct. 2021), at 27, https://perma.cc/9Q45-XPYY; *see also* Eileen Appelbaum & Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses?* 5 (Inst. for New Econ. Thinking, Working Paper No. 118, 2020), https://perma.cc/ULD9-PZV5 (discussing challenge of "extracting value in a short time frame").

from inflated out-of-network prices"—"has made health care an attractive market for private equity firms," which have invested heavily in both hospitals and physician groups. H.R. Rep. No. 116-615, pt. I, at 53-54. Overall private equity investments in healthcare have steadily increased since the 1990s, with total investments ballooning from $5 billion annually in 2000 to $100 billion in 2018, and the trend has "accelerat[ed] in recent years."[25] Private equity firms have acquired physician practices at increasing rates, with one study finding year-over-year increases in practice acquisitions across the study period of 2013 (59 acquisitions) through 2016 (136 acquisitions).[26] Private equity groups have also acquired 282 unique hospitals between 2003 and 2017, resulting in private equity ownership of 7.5% of all nongovernmental hospitals in the country by the end of this time period.[27] At the same time, hospitals increasingly relied on physician staffing companies to supply medical professionals for their emergency departments and other needs, and private equity groups now own the two largest staffing firms that together account for 30% of that market: KKR owns Envision Healthcare and Blackstone owns Team Health Holdings.[28]

Surprise billing has been "key" to private equity groups' "highly profitable business strategy."[29] Private equity firms acquiring physician practices have focused "heavily in emergency medicine staffing companies and the ancillary hospital-based specialties that have been able to

[25] Brown et al., supra n.24, at 3, https://perma.cc/9Q45-XPYY.
[26] Jane M. Zhu et al., *Private Equity Acquisitions of Physician Medical Groups Across Specialties, 2013–2016*, 323(7) JAMA 663 (Feb. 18, 2020), https://perma.cc/S5GK-PVM3. The authors cautioned that their study likely "underestimate[s] total acquisitions," as the underlying data is "based on publicly announced transactions"—a fraction of all transactions—and "available data lag[s] behind the rapid pace of private equity acquisitions." *Id.*
[27] Anaeze C. Offodile II et al., *Private Equity Investments in Health Care: An Overview of Hospital and Health System Leveraged Buyouts, 2003–17*, 40(5) Health Affairs 719, 722 (May 2021), https://perma.cc/VJ92-GGAS.
[28] Appelbaum & Batt, *supra* n.24, at 3, 55, https://perma.cc/ULD9-PZV5.
[29] Rachel Bluth & Emmarie Huetteman, *Investors' Deep-Pocket Push to Defend Surprise Medical Bills*, KHN (Sept. 11, 2019), https://perma.cc/L9LC-N3QL.

leverage out-of-network balance billing as a profit strategy."[30] In one study, for example, anesthesiologists represented the highest proportion of physician practice acquisitions (33.1%) from 2013 through 2016, followed by emergency physicians (15.8%).[31] The focus of private equity firms on these practices is a direct result of how "surprise medical bills allow them to extract high payments for medical care from patients and/or insurance companies"[32]—and how their ability to surprise bill gives them "greater leverage in price negotiations with insurers when they are in-network," so they can demand above-market contracted rates.[33]

These tactics have driven rising healthcare costs for patients. One study found, for example, that private equity–owned hospitals "had higher charge-to-cost ratios" than other hospitals, and that "this gap widened" over the study period from 2003 to 2017.[34] Another study found that the charge-to-cost ratios of 204 hospitals rose significantly after they were acquired by private equity groups, as compared to other hospitals, and that the greatest increases were observed in emergency departments, which are strongly associated with surprise billing.[35] These studies reflect how the "private equity–driven practice" of surprise billing generates revenue at patients' expense,[36] as "hospitals with higher charge-to-cost ratios can induce higher payments from patients and insurers."[37] "The design of the private equity business model" in acquiring physician practices is equally "geared to driving up the costs of patient care" through surprise billing.[38] And,

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[30] Brown et al., *supra* n.24, at 11, https://perma.cc/9Q45-XPYY.
[31] Zhu et al., *supra* n.26, https://perma.cc/S5GK-PVM3.
[32] Appelbaum & Batt, *supra* n.24, at 68-69, https://perma.cc/ULD9-PZV5.
[33] Brown et al., *supra* n.24, at 12, https://perma.cc/9Q45-XPYY; *see also supra* at 9.
[34] Offodile et al., *supra* n.27, at 719, https://perma.cc/VJ92-GGAS.
[35] Joseph D. Bruch et al., *Changes in Hospital Income, Use, and Quality Associated with Private Equity Acquisition*, 180(11) JAMA Internal Medicine 1428 (Aug. 24, 2020), https://perma.cc/TF2K-RGDF.
[36] Scheffler et al., *supra* n.23, at 39 n.143, https://perma.cc/9XJU-7PK6.
[37] Offodile et al., *supra* n.27, at 724-25, https://perma.cc/VJ92-GGAS.
[38] Appelbaum & Batt, *supra* n.24, at 64, https://perma.cc/ULD9-PZV5.

again, surprise billing results in not only excessive billed charges for individual services provided on an out-of-network basis, but also inflated contracted rates that increase costs for all insured patients.[39] Congress understood in passing the Act that private equity has fueled the growth of surprise billing, *see* H.R. Rep. No. 116-615, pt. I, at 53-54, and the Departments incorporated that understanding in promulgating the IFR, *see* 86 Fed. Reg. at 56,046-47.

C. The QPA's function in the IDR process will help restrain rising healthcare costs for patients while fairly compensating out-of-network providers.

By challenging the IFR, plaintiffs seek to protect the inflated charges and the market distortions that surprise billing perpetuates at the expense of patients. Patients ultimately bear the burden of higher healthcare costs in the form of higher premiums and patient responsibility, such as co-insurance.[40] Accordingly, while surprise billing takes a particularly grave toll on patients facing unexpected liabilities to certain out-of-network providers, they are not the only consumers harmed by surprise billing; the market distortions caused by surprise billing have increased the overall cost of healthcare services, and "those costs are passed on to enrollees through higher premiums."[41]

Relying on the QPA as a primary consideration in the IDR process helps to curb future market distortions by limiting inflated costs and thus restraining the growth of premiums, benefitting all patients.[42] The Congressional Budget Office's analysis of the Act confirms that use of the QPA as the primary payment measure for covered out-of-network services will prompt

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[39] *See supra* at 9.
[40] Katherine Baicker & Amitabh Chandra, *The Labor Market Effects of Rising Health Insurance Premiums*, 24 J. Labor Econ. 609, 631 (2006) (finding that "the cost of increasing health insurance premiums is borne primarily by workers in the form of decreased wages for workers with [employer health insurance]—so that they bear the full cost of the premium increase").
[41] Duffy et al., *supra* n.8, https://perma.cc/87TX-KT9K.
[42] *See id.*; Erin L. Duffy et al., *Policies to Address Surprise Billing Can Affect Health Insurance Premiums*, 26(9) Am. J. Managed Care 401 (Sept. 11, 2020), https://perma.cc/AJ2G-WFLC.

healthcare providers whose rates are outliers—well surpassing the median—to adjust their rates toward the median, which "would reduce premiums by between 0.5 percent and 1 percent."[43] Studies reflect that prioritizing the QPA in the IDR process is necessary to realize these lower costs for patients. Data from New York, which enacted a statute similar to the No Surprises Act but tied its IDR process to the 80th percentile of a billed charges database, suggests that an IDR process based on providers' "rack rates" results in increased costs that are ultimately passed on to patients.[44] Data from New Jersey, which enacted a comparable statute, suggests the same.[45] Empirical evidence thus confirms the reasoning behind the Act, which the Departments affirmed in the IFR: giving the QPA a primary role in the IDR process "will generally slow the rapid growth of health care costs, both by lowering costs in the near term relative to the status quo and by slowing the rate of health care cost inflation in future years." H.R. Rep. No. 116-615, pt. I, at 57-58.

The IFR also implements a fair process that will not "force[] [providers] to accept unfairly low reimbursement rates," as plaintiffs allege. Pls.' Mot., Dkt. 3, at 33. First, by tying the QPA to median contracted rates from 2019, the Act defines the QPA to reflect healthcare market dynamics as they stood before the Act was passed. *See* 42 U.S.C. § 300gg-111(a)(3)(E). The QPA

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[43] Cong. Budget Office, *Estimate for Divisions O Through FF H.R. 133, Consolidated Appropriations Act, 2021, Public Law 116-260 Enacted on December 27, 2020* (Jan. 14, 2021), https://perma.cc/XYR2-9ZUB. In fact, as discussed, *all* of the bills considered by relevant congressional committees designated the QPA as the primary factor for IDR entities to consider, *see supra* at 5 & n.5, and the analyses of *each* of these bills conducted by the Congressional Budget Office specifically found that prioritizing the role of the QPA would reduce health insurance premiums. *See* Letter from Sen. Murray & Rep. Pallone, *supra* n.5, at 4 (collecting and quoting analyses).

[44] Loren Adler, *Experience with New York's Arbitration Process for Surprise Out-of-Network Bills*, USC-Brookings Schaeffer Initiative for Health Pol'y (Oct. 24, 2019), https://perma.cc/ZVP8-HX7R.

[45] Benjamin L. Chartock et al., *Arbitration Over Out-of-Network Medical Bills: Evidence from New Jersey Payment Disputes*, 40(1) Health Affairs 130 (Jan. 2021), https://perma.cc/6569-N2Y5.

thus locks in contracted rates that payors and providers negotiated in the market environment distorted by surprise billing—in fact, some critics of the Act have argued that its definition of the QPA codifies payment rates "inflated by the threat of surprise billing" and does not do enough to remedy the market distortions caused by surprise billing.[46] Second, though plaintiffs seem to treat the QPA as dispositive, the IFR plainly does not. The IFR instructs arbitrators to use the QPA as a starting point, but it also requires them to "tak[e] into account" the other statutory criteria enumerated in the Act. 45 C.F.R. § 149.510(c)(4)(ii)(A). The IFR allows healthcare providers and payors to submit other information to the arbitrators for consideration and the IFR gives arbitrators flexibility to depart from the QPA as circumstances require.

III. The Use of the QPA as the Primary Reference Point in the IDR Process Will Not Lead to Unduly Narrow Provider Networks or Impede Patient Access to Care.

There is no evidentiary basis to find that the IFR will cause payors to shrink their provider networks to inadequate levels that impact patients' access to care. This is true, in part, because payors have other market and regulatory incentives to maintain robust provider networks.

A. The IFR incentivizes healthcare providers to participate in payor networks.

Some healthcare providers, particularly emergency providers and hospital-based providers of ancillary services, have historically had little to no incentive to enter health plan networks. *See supra* at 8. While "for most physicians in most geographic areas, it is not possible to maintain a practice without entering some insurer networks because few patients are willing to bear the higher costs associated with seeing an out-of-network physician," "that basic dynamic does not apply" for these providers.[47] Because "patients generally are not able to choose these emergency and

[46] Matthew Fiedler et al., *Recommendations for Implementing the No Surprises Act*, USC-Brookings Schaeffer Inst. on Health Pol'y (Mar. 16, 2021), https://perma.cc/YUY8-C7ZV. Tying the QPA to 2019 median contracted rates, as the Act does, also rebuts any notion that payors will be able to artificially depress the QPA through future contracting practices.
[47] Adler et al., *supra* n.13, at 4, https://perma.cc/DMS6-8K6V.

ancillary providers," they "can often remain out of network without significantly reducing their patient volume."[48] This market dysfunction has proven lucrative for Surprise Billers and incentivizes them to remain out-of-network and saddle patients with the associated expense of balance billing. The IFR will likely incent broader networks, as Surprise Billers who previously refused to join a network because they could exact excessive out-of-network charges directly from their patients will now have more incentives to contract at reasonable network rates.

B. Payors continue to have market incentives to maintain broad provider networks, which benefit both health plans and patients.

Plaintiffs argue that the IFR will encourage payers to severely restrict their networks to the cheapest available healthcare providers. *See, e.g.*, Pls.' Mot., Dkt. 3, at 41. But they fail to acknowledge the market forces that encourage broad provider networks. Many health insurers sell broader networks as a benefit of their health plans, "because their customers value flexibility when making decisions regarding healthcare." *Methodist Health Servs. Corp. v. OSF Healthcare Sys.*, 2016 WL 5817176, at *2 (C.D. Ill. Sept. 30, 2016). "Large employers," in particular, "tend to require broad networks to satisfy the preferences of diverse work forces with a single or small number of insurance plans," leading insurers to "contract with the majority of hospitals and physicians in a market, in order to best compete for the large employer groups that compose the bulk of the market."[49] Market forces, in other words, discourage health insurers from unduly narrowing their provider networks, because "plans that do not have sufficient geographic coverage in a market will have difficulty marketing their insurance products to employers and their employees." *FTC v. ProMedica Health Sys., Inc.*, 2011 WL 1219281, at *7 (N.D. Ohio Mar. 29,

[48] Duffy et al., *supra* n.42, https://perma.cc/AJ2G-WFLC.
[49] Mark A. Hall & Paul B. Ginsburg, *A Better Approach to Regulating Provider Network Adequacy*, USC-Brookings Schaeffer Initiative for Health Pol'y (Sept. 2017), at 1, https://perma.cc/B3RG-J9T6.

2011).

While some health insurers offer more narrow provider networks, many consumers prefer plans with broader networks, and this preference is especially pronounced among those enrolled in employer-sponsored health plans,[50] which can be a competitive advantage for employers in the labor market. Thus, there remain strong competitive and market forces that incentivize health insurers to maintain sufficiently broad networks, and there is no reason to believe that the IFR will alter these longstanding market incentives.

C. Because of the many benefits associated with provider networks, payors remain incentivized to contract with even high-cost healthcare providers.

Aside from the market forces that incentivize payors to maintain broad provider networks, there are other administrative and operational reasons why payors prefer to contract with healthcare providers. Contracting with hospitals and hospital-based providers allows payors to better facilitate disease management and care coordination for patients, including those with chronic conditions. For example, network providers are often included in a payor's utilization and quality management programs.[51] In addition, network contracts allow payors to facilitate the referral of their members to other network providers where possible, thus improving continuity of care.[52] These efforts help to prevent readmissions and offer more integrated and higher quality care to patients, which in turn reduces costs to payors.

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[50] *See* Liz Hamel et al., *Kaiser Health Tracking Poll: February 2014*, KFF (Feb. 26, 2014), https://perma.cc/TF35-YW2B; *see also* Coleman Drake, *What Are Consumers Willing to Pay for a Broad Network Health Plan? Evidence from Covered California*, 65 J. Health Econ. 63 (2019), https://perma.cc/S75C-47WA; McKinsey Ctr. for U.S. Health Sys. Reform, *Hospital Networks: Evolution of the Configurations on the 2015 Exchanges* (Apr. 2015), https://perma.cc/XQR5-P2ER.

[51] *See* Peter R. Kongstvedt, *Essentials of Managed Care* (6th ed. 2013), ch. 4 (explaining that a health plan can require a healthcare provider to agree to cooperate with the plan's utilization management program and quality management program, and to agree to the plan's right to audit clinical and billing data for care provided to plan members).

[52] *See id.*

Moreover, because network contracts typically set forth the payment rates that a payor will remit to the healthcare provider for specific services, they afford the payor certainty on reimbursement rates, which in turn reduces administrative costs attendant to provider appeals, litigation, and arbitrations.[53] Thus, quite apart from market forces that encourage broader networks, there are many economic incentives for payors to maintain adequate provider networks that will not be impacted at all by the Act or the IFR.

D. State and federal network adequacy requirements ensure that payors will not offer unduly narrow provider networks for patients.

State and federal laws offer an additional backstop to the market-based incentives for health insurers to maintain sufficiently broad provider networks. Since the mid-1990s, most states have adopted "network adequacy standards that require[] each network plan to demonstrate that it ha[s] contracted with sufficient providers throughout its service area."[54] "Today, network adequacy standards are in place in all states for most insured products."[55] Federal law has also imposed network adequacy standards on qualified health plans since 2012.[56] Health plans take network adequacy laws seriously, as do state regulators.[57] State insurance regulators conduct market conduct examinations that scrutinize whether health plans offer provider networks sufficient to serve their patients' needs.[58] Statutory and regulatory network adequacy requirements are thus

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[53] *See id.*

[54] Christen Linke Young et al., *The Relationship Between Network Adequacy and Surprise Billing*, USC-Brookings Schaeffer Initiative for Health Pol'y (May 10, 2019), https://perma.cc/6EV8-5M8P.

[55] *Id.*

[56] *See* 42 U.S.C. § 18031(c)(1) (Affordable Care Act provision requiring HHS to "establish criteria for the certification of health plans as qualified health plans"); 45 C.F.R. § 156.230.

[57] *See, e.g.*, Jane B. Wishner & Jeremy Marks, *Ensuring Compliance with Network Adequacy Standards: Lessons from Four States*, Urban Inst. (Mar. 2017), at 8, https://perma.cc/6ZT6-WANB ("Regulator respondents in all four study states reported that upon receipt of initial network filings, they had instructed an insurer to alter a proposed network or offer 'alternative access accommodations' to ensure the adequacy of a proposed provider network.").

[58] *See, e.g.*, Fla. Off. of Ins. Reg., Target Market Conduct Final Examination Report of Humana

designed to ensure that health plans maintain sufficiently robust provider networks.

E. Empirical evidence suggests that the IFR will not lead to unreasonably narrow provider networks or impede patient access to care, as plaintiffs claim.

Empirical evidence suggests that the IFR will not prompt health insurers to narrow their provider networks to levels that impede patients' access to care. State surprise billing laws that were enacted before the No Surprises Act offer valuable evidence on this question.

In 2017, for instance, California enacted a surprise billing law that "requires fully-insured plans to pay out-of-network physicians at in-network hospitals the greater of the insurer's local average contracted rate or 125% of the Medicare reimbursement rate."[59] On average, contracted rates for *all* physicians' services in California equated to 128% of Medicare rates.[60] If plaintiffs' hypothesis were correct, California would have experienced a substantial narrowing of provider networks after passage of this law; indeed, more substantial than they imagine under the IFR, which allows IDR entities to consider provider-submitted information that the California law excludes. The data does not bear out that theory, however. One study concluded that "on average, in-network specialty doctors either remained flat, or increased by as much as 26%."[61] Another study found "a modest shift toward claims from in-network service providers across all the affected specialties timed to the law's implementation," but did not find "similar changes for emergency medicine, which was unaffected by the law," a finding that flatly "contradicts … claim[s] of

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Medical Plan, 2014 FL Market Conduct LEXIS 17, at *15-16 (Oct. 30, 2015) (reporting on plan's addition of oncologists to satisfy network adequacy standards); Conn. Ins. Dep't, Market Conduct Report on Aetna Health Inc., 2014 CT Market Conduct LEXIS 25, at *35-38 (June 6, 2017) (examining compliance with network adequacy requirements).

[59] Loren Adler et al., *California Saw Reduction in Out-of-Network Care from Affected Specialties After 2017 Surprise Billing Law*, USC-Brookings Schaeffer Initiative for Health Pol'y (Sept. 26, 2019), https://perma.cc/8BSS-AH9S.

[60] Bill Johnson et al., *Comparing Commercial and Medicare Professional Services Prices*, Health Care Cost Inst. (Aug. 13, 2020), https://perma.cc/483G-7YY7.

[61] Jeanette Thornton, AHIP, *Can We Stop Surprise Medical Bills AND Strengthen Provider Networks? California Did*, Am. J. Managed Care (Aug. 22, 2019), https://perma.cc/64C5-8GQ7.

widespread diminishing network breadth."[62] The available evidence simply offers no support for plaintiffs' allegations of disastrous consequences for patient access to network providers.

IV. Even Absent the Departments' Express Authority to Promulgate Interim Final Rules, Good Cause Would Support Doing So Here, as Health Insurers Require Guidance Regrading the Act's Arbitration Process Before the Law Becomes Effective.

Even if Congress had not expressly authorized the Departments to promulgate interim final rules, the need of regulated parties for advance guidance about arbitrations under the Act amounts to good cause for forgoing notice-and-comment rulemaking under the Administrative Procedure Act, *see* 5 U.S.C. § 553(b)(B). Health insurers in particular must know how arbitrations will be structured so they can prepare adequately. As the Departments recognized, health insurers must set premium or contribution rates and otherwise adjust benefit designs, and in some instances seek approval for these adjustments, to account for the changes the IFR implements. 86 Fed. Reg. at 56,044. Insurers also must design internal policies and procedures, such as for initiating IDR processes and for using the IDR portal to prepare and submit the offers and materials arbitrators will consider, in order to ensure that the IDR process operates as Congress envisioned. The Departments needed to give all regulated parties the advance guidance necessary "to meet the tight deadlines set by Congress to protect patients from surprise medical bills."[63]

CONCLUSION

For the foregoing reasons, the Court should deny plaintiffs' motion for summary judgment and grant defendants' cross-motion for summary judgment.

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[62] Adler et al., *supra* n.59, https://perma.cc/8BSS-AH9S.

[63] Letter from Sen. Patty Murray & Rep. Frank Pallone, Jr. to Sec'y Xavier Becerra (Jan. 7, 2022), *supra* n.5.

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