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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Association of Air Medical Services, et al.,)	
)	Civil Action
)	No. 21-cv-3031
Plaintiffs,)	
)	ORAL ARGUMENT
vs.)	
)	Washington, DC
U.S. Department of Health and Human Services, et al.,)	March 21, 2022
)	Time: 3:00 p.m.
)	
Defendants.)	

TRANSCRIPT OF ORAL ARGUMENT
HELD BEFORE
THE HONORABLE JUDGE RICHARD J. LEON
UNITED STATES DISTRICT JUDGE

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1 THE COURTROOM DEPUTY: Good afternoon, Your Honor.
2 This afternoon we have civil action No. 21-3031, 21-3231,
3 *Association of Air Medical Services v. the United States*
4 *Department of Health and Human Services, et al.*

5 Will counsel for the plaintiffs please approach the
6 lectern, identify yourself for the record and name the party or
7 parties that you represent, and then defense counsel.

8 MR. STIMSON: Brian Stimson and my law partner
9 Sarah Hogarth.

10 THE COURT: Speak up, please. The mask is not
11 helpful. If you've been vaccinated, take the mask off.

12 MR. STIMSON: Great. I'm Brian Stimson, Your Honor.
13 And my colleague, Sarah Hogarth, and I represent the
14 Association of Air Medical Services.

15 THE COURT: Welcome.

16 MR. STIMSON: Thank you.

17 MR. TYSSE: Good afternoon, Your Honor. James Tysse.
18 I'm with my colleague, Kristen Loveland. We represent the
19 American Medical Association. And also appearing at counsel
20 table today are my co-counsel, representing the American
21 Hospital Association, Stephanie Webster and Douglas
22 Hallward-Driemeier.

23 THE COURT: Welcome.

24 MR. TYSSE: Thank you.

25 MR. McELVAIN: Good afternoon, Your Honor. Joel

1 McElvain for the defendants.

2 THE COURT: Welcome.

3 MR. McELVAIN: Thank you.

4 THE COURT: All right. Counsel, I sent out a -- as
5 I'm sure you're well aware, sent out a minute order earlier
6 today breaking down the speaking rules and times -- not as to
7 who would speak from the specific counsel members, but what
8 party. And so we'll start with the AMS challenges, the
9 methodology of the calculation of the QPA. And that should be
10 McDermott Will, someone from McDermott Will.

11 MR. STIMSON: It will be me, Your Honor.

12 THE COURT: You have 20 minutes.

13 MR. STIMSON: Your Honor, my client, AMS, represents
14 93 percent of the air ambulance industry.

15 THE COURT: You got to speak up, sir. It's hard to
16 hear you. With all this plastic and everything, you got to
17 speak up.

18 MR. STIMSON: My client, AMS, represents 93 percent
19 of the air ambulance industry. They have more than 300 members
20 operating more than 1,000 rotor-wing air ambulances and more
21 than 200 fixed-wing air ambulances. And they include
22 nonprofit, for-profit providers, local, regional and national
23 providers, and hospital and nonhospital providers. They've
24 supported the enactment of the No Surprises Act because they
25 share Congress's goal of ending surprise air ambulance billing.

1 And today they're challenging only discrete parts of both
2 Interim Final Rule Part 1 and Interim Final Rule Part 2 that
3 bear on the payment for the services that they rendered to the
4 public.

5 As you directed, I'll begin by addressing the Part 1
6 challenge. And Part 1 implements § 2799A-1 of the Public
7 Health Service Act. Section 2799A-1 sets forth the direction
8 to the departments to establish a qualified payment
9 methodology, and it also defines the QPA as the median of the
10 contracted rates recognized by the issuer as the total maximum
11 payment under such coverage for the same or similar item or
12 service in the same or similar specialty in the geographic
13 region in which the item or service is furnished.

14 So you've got to have a contracted rate, recognized
15 by a planner issuer in the same or similar specialty for the
16 same or similar service in the same geographic area.

17 The problems with Part 1 on the QPA methodology are
18 threefold. First, it excludes contracted rates and single case
19 agreements from the median. Second, it carves air ambulance,
20 and air ambulance alone, out of the definition of provider in
21 the same or similar specialty, which turns on the usual
22 business practices of the issuer, meaning the contracting
23 practices of the issuer.

24 And then, thirdly, it uses geographic regions that
25 are unduly broad to the point of being arbitrary.

1 So, on the first point, single case agreements, the
2 departments define them as contracts used to supplement the
3 network of the coverage for a specific beneficiary under unique
4 circumstances. The departments acknowledge, in their own
5 regulation defining contracted rate, that single case
6 agreements are network agreements and, in the very same
7 regulation, they say that rates in those network agreements
8 cannot count towards the median, which is internally
9 inconsistent. And they rationalize that inconsistency by
10 saying the term "contracted rate" really means rates negotiated
11 with providers that are contracted to participate with the
12 issuer under the generally applicable terms of coverage.

13 The words "generally applicable terms of coverage"
14 don't appear in the statute. And the departments' efforts to
15 add them to the statute by regulation is contrary to law. What
16 the statute says is that the median is determined using
17 contracted rates recognized by the issuer as the total maximum
18 payment under such coverage. So, if an issuer contracts with a
19 provider for a rate in a single case and then pays that rate,
20 it's recognized that rate as the total maximum payment under
21 the coverage. And it's that simple.

22 The departments try to overcome that simple statutory
23 language by doing a couple of things. The first is that they
24 cite to some journal articles that they assert support their
25 interpretation and addition of the phrase "under generally

1 applicable terms of the regulation." But when you look at
2 those journal articles at JA-739 and JA-346, neither one of
3 them says that single case agreements are outside of coverage
4 or generally applicable terms of coverage.

5 The departments also make a congressional intent
6 argument. They say that Congress intended for the QPA to be
7 reflective of market rates reached under typical contract
8 negotiations, and their interpretation supposedly advances that
9 more so than the plain text.

10 And the problem with that is that when you look at
11 the record, it shows that single case agreements are
12 negotiated. Typically, in the air ambulance industry, they're
13 the product of typical contract negotiations. And I point you
14 to a study at JA-337 through JA-346 that looked at data from
15 three commercial payers from 2014 to 2017. And what that data
16 shows in that study is that 22 percent of air ambulance
17 transports are in network and 72 (sic) percent are out of
18 network. And of the 78 percent that are out of network, 48
19 percent are out-of-network paid-in-full. Which means that
20 approximately 37 percent of transports are out-of-network
21 paid-in-full, in comparison to 22 percent that are reached --
22 in which payment is reached on a network basis.

23 What that means is that providers and issuers reach
24 agreement on the rate of payment more often in single case
25 situations than they do on a network basis, and that alone

1 shows that the departments' reasoning is arbitrary.

2 That arbitrariness is underscored by how the
3 departments approach single-case agreements in the context of
4 balanced billing protections. They say that a single-case
5 agreement is a contract that triggers the application of the
6 balanced billing protections for patients, but it's not a
7 contract when it comes to the determination of the QPA. A
8 contract is either a contract or it's not. It either contains
9 rates or it doesn't. And we submit that single case agreements
10 are contracts that do contain contracted rates that should
11 count towards the median and for that reason the definition
12 should be vacated.

13 Moving on to the --

14 THE COURT: Would the approach that they're taking
15 for this rule, the agencies, would have that have
16 disproportional impact on certain states and certain hospital
17 centers?

18 MR. STIMSON: In terms of the payment that the
19 hospital centers get for providing air ambulance services or --

20 THE COURT: Well, the air ambulance services. I'm
21 thinking states that have larger distances between hospital
22 centers where air ambulance services may be necessary or states
23 where there's a higher percentage of use of some kind of
24 emergency transportation necessary. Would those states be more
25 seriously impacted by the way the agencies define this?

1 MR. STIMSON: Generally, yes. Because rule states,
2 where you have to fly people long distances to get to
3 hospitals, are more dependent on air ambulance services. And
4 if you narrow the band of contracted rates that are used to
5 determine the median, that has the potential effect of reducing
6 the payments that are ultimately made to the providers,
7 regardless of how the -- the component of the rule addressed in
8 the IDR process shakes out. So it is a bigger issue for rural
9 areas.

10 On the second issue that I mentioned, the
11 determination of provider specialty, the departments carved air
12 ambulance, and air ambulance alone, out of their definition of
13 provider in the same or similar specialty, which is the
14 practice specialty defined by the issuer consistent with the
15 issuer's usual business practice. So, the department said for
16 all providers, except air ambulance, the specialty of the
17 provider is going to be determined by the issuer's approach and
18 contract.

19 Now, how the issuer views the provider when they sit
20 across the table from them and contract with them, but for air
21 ambulance, they're all a single specialty. The problem is the
22 rationale that the departments used for that carve-out, and it
23 is they want cost-sharing for air ambulance transports to be
24 the same across-the-board, with no variation. That rationale
25 applies equally to all provider types and it's irrational to

1 single out air ambulance providers on that basis and treat them
2 differently from everyone else.

3 THE COURT: Does it give a reason for that approach?

4 MR. STIMSON: They say that enrollees should not be
5 required to pay higher cost-sharing amounts solely because the
6 air ambulance provider assigned to them has negotiated higher
7 contracted rates or because it has a different revenue model.
8 But that's an issue that arises with every other provider
9 specialty. There's natural variations amongst all providers,
10 some of which is clinical and some of which is economic, and
11 it's not a basis on which to differentiate air ambulance from
12 other providers.

13 The arbitrariness of that is underscored by how the
14 departments approach independent, freestanding emergency
15 departments, or IFEDS. IFEDS are nonhospital emergency
16 departments. They have historically low levels of network
17 contracting, and in that respect they're similar to many air
18 ambulance providers.

19 The departments applied their general definition of
20 provider in the same or similar specialties to IFEDS, but not
21 air ambulance. And the ultimate result is you have two
22 similarly situated providers, one of which is subject to the
23 general rule and one of which is being singled out, which we
24 submit is arbitrary and a basis for vacating that definition.

25 Third issue, Your Honor, is geographic regions. And

1 the departments have told issuers that they, in calculating the
2 QPA, need to first look at all of the metropolitan statistical
3 areas in the state or all of the other areas within the state.
4 And if they can't find three contracted rates in the area of
5 the state where the patient was picked up, they bump up to a
6 census division. And when they bum up to a census division,
7 with a constellation of multiple states, they look at all the
8 metropolitan statistical areas in the census division, or all
9 the other areas in the census division depending on the point
10 of pick up.

11 The rationale they provide for bumping up to census
12 divisions is that Congress intended for the QPA to represent
13 market dynamics. Market dynamics are the basis for using
14 census divisions. The problem is census divisions were
15 designed to aid in the presentation of census data, they
16 weren't designed to approximate the geographic markets for air
17 ambulance services.

18 THE COURT: Isn't the market dynamics reflected in
19 the contractual dispute -- contractual negotiations?

20 MR. STIMSON: Well, there are certainly some
21 commonalities across geographic markets, but the problem is
22 that when you have a census division like the Pacific division,
23 which spans Alaska, Hawaii, California, Oregon, and Washington,
24 there is vastly different conditions on the ground across the
25 division and there aren't shared market dynamics from one end

1 of the division to the other.

2 I'll take, as an example, in that division, San
3 Diego, California and Seattle, Washington. They're both within
4 the metropolitan statistical areas of the Pacific census
5 division. A rotor-wing in San Diego is not going to fly to
6 Seattle because it's 1,000 miles to get there and it's beyond
7 its range and it wouldn't make clinical sense to fly the
8 patient there anyway. That rotor-wing is in the California
9 insurance market, not the Washington insurance market, which is
10 separated by the state of Oregon. And there's a host of unique
11 things that the San Diego provider has to take into account
12 operating in San Diego. It's got unique costs, unique
13 workforce, unique demographics, unique taxes and regulations.
14 It's got unique weather conditions, unique traffic patterns,
15 and a unique health care structure, none of which are shared
16 with Seattle.

17 And the departments' position is that they can
18 somehow divine market dynamics within a census division by
19 lumping Seattle and San Diego together. It just doesn't work.
20 And the arbitrariness of that becomes more apparent if you go a
21 level out and compare someplace like Anchorage, Alaska to
22 San Diego. Those are two totally different markets.

23 This is, unfortunately, a problem of the departments'
24 own making. When they removed single-case agreements from
25 median, they reduced the number of contracted rates that you

1 would count when looking at the MSAs in other portions of
2 individual states. So they had no choice but to move to a
3 larger geographic region.

4 At the same time, Congress provided a solution in
5 this situation, and that is the use of a third-party database
6 to determine the QPA. And the departments have defined the
7 allowed amounts that can be used to populate those databases in
8 a limited way. They've limited them to in-network allowables,
9 as opposed to allowed amounts more generally. And so they've
10 limited the inputs into the QPA and they've limited the use of
11 the alternative that Congress provided.

12 The solution here is not to use arbitrary geographic
13 regions, it's to vacate those geographic region definitions and
14 to implement the statute that Congress enacted by allowing
15 single-case agreements to count towards the median and allowing
16 the use of third-party databases when there's insufficient
17 contracted rates.

18 I think I'm close to my time, Your Honor, so I'm
19 happy to answer any questions that you have. And if you have
20 none, I'll reserve.

21 THE COURT: You can save it. You've still got two
22 minutes -- about two or three minutes left. You can save it
23 for your rebuttal, if you would like.

24 MR. STIMSON: That would be great. Thank you.

25 THE COURT: Mr. McElvain.

1 MR. McELVAIN: Thank you, Your Honor, and may it
2 please the Court. Congress enacted the No Surprises Act to
3 address a market failure. In a free market parties negotiating
4 at arms-length arrive at a fair price for a product. In many
5 instances, however, the health market has not worked in this
6 way. In an emergency, a patient may have no way to shop for a
7 facility or for an air ambulance that is in his health plan.
8 Or, a patient might schedule a procedure at her in-network
9 facility only to later find that part of her care was performed
10 by an out-of-network physician.

11 In cases like these, the market has broken down,
12 providers could drive their prices up, knowing that their
13 services could not be rejected no matter what they charged.
14 The result has been devastating medical debt for individual
15 patients and an explosion in health care costs that has driven
16 up both insurance premiums and federal deficits. Congress
17 addressed this crisis through several interlocking reforms.

18 First, the Act bans providers from balance billing
19 their patients in the circumstances I've just described.
20 Providers are referred, instead, to an arbitration process with
21 the patient's health plan.

22 Congress also directed departments, who are the
23 defendants here, to establish the process under which an
24 arbitrator will determine the payment amount. And Congress set
25 forth a sequence for the arbitrator's decision-making. That

1 sequence begins with what is known as the "qualifying payment
2 amount." This is a term of art in the statute. It is the
3 median of in-network contract rates for a given service in a
4 given region. The statute treats this amount as the proxy for
5 what the price for the service would have been if the provider
6 and the plan had negotiated a fair price in advance.

7 The Air Ambulance plaintiffs take issue with the July
8 rule, the first interim final rule, which sets the methodology
9 for the qualifying payment amount. None of their challenges
10 has merit.

11 First, the rule properly bases the calculation of the
12 QPA off of the generally applicable rates set under the plan
13 documents themselves, rather than ad hoc agreements for
14 out-of-network services that are entered into outside of the
15 plan documents.

16 Second, the rule properly treats all ambulance
17 providers as performing the same medical specialty.

18 Third, the rule appropriately defines the geographic
19 regions for air ambulances in a way that promotes the use of
20 actual market data to set the QPA.

21 And, finally, rule properly bases patients' cost
22 sharing on the in-network rates that are set in plan documents.
23 Therefore, summary judgment should be awarded to the defendants
24 on the Air Ambulance challenge.

25 Turning to the first argument that the plaintiffs

1 have presented regarding single case agreements. I would like
2 to begin just by taking a step back and reminding the Court
3 what we're talking about with regard to single-case agreements.
4 Typically you would expect a provider in a plan or a health
5 policy issuer to enter into negotiations and reach an
6 in-network agreement in advance that would cover this service
7 for this facility at this price with a -- you know, set of -- a
8 table of setting those rates, you know, down the line of what
9 all those prices are, which may or may not include a particular
10 air ambulance provider. If the air ambulance provider remains
11 out of network, the insurer or the plan issue -- I'm sorry, the
12 issuer or the plan would not have a legal obligation to pay
13 for that out-of-network service. That would fall on the
14 patient.

15 However, often the payers, the insurers, the plans
16 make a business judgment that it's better to pay that charge in
17 whole or in part, rather than dumping the entire cost onto the
18 patient, as a matter of business judgement, as a matter of
19 public relations, what have you. So what will happen is even
20 in the absence of a legal compulsion to do so, the payers will
21 enter into a one-off, a single-case agreement where they will
22 pay the air ambulance operator or the other provider for that
23 particular service for that particular patient.

24 THE COURT: Is there a distinction between emergency
25 services versus nonemergency services?

1 MR. McELVAIN: Not for this purpose, no. Well, we do
2 get to the freestanding emergency departments issue, which is
3 actually a separate issue resting on different authority. I'm
4 sorry. I may be confusing issues. There is an issue involving
5 freestanding emergency departments. With regard to the
6 question of single-case agreements, there's no distinction.
7 The rule, across-the-board, is that the relevant rates are the
8 rates that are set under the plan documents themselves in
9 advance, not ad hoc agreements that are entered into outside of
10 the plan, whether it's emergency services or air ambulance
11 services or for any other service otherwise subject to the act.

12 So the statute defines the qualifying payment --
13 excuse me, the qualifying payment amount generally is the
14 median of the contract rates recognized by the planner-issuer
15 under such plans or coverage -- I skipped a little bit of the
16 statutory language, but that's the statutory language -- under
17 such plans or coverage, respectively, as of January 31st, 2019
18 and then adjusted for inflation.

19 So the departments have interpreted that language to
20 mean that the contracted rates that the statute refers to for
21 setting the qualifying payment amount are the rates under the
22 plan documents themselves. So they've included those rates.
23 But, again, as I've said, they've excluded the rates that are
24 separately set under one-off agreements, single-case
25 agreements. And as the departments explained in the rule-

1 making, this definition most closely aligns with the statutory
2 intent of ensuring that the qualifying payment amount reflects
3 the market rates under typical contract negotiations -- meaning
4 typical negotiations for in-network services -- a central
5 purpose of the act, after all, is to ensure that patients do
6 not owe more for out-of-network services than what they would
7 have paid for in-network services. And you can find that in
8 the text of the statute itself under 300gg-111(a)(1) for most
9 providers and 300gg-112(a)(1) with respect specifically to air
10 ambulances.

11 So the statute does not refer to any contract,
12 instead, rates under the plan or coverage. And what does
13 "under the plan" mean? A payment arises under a plan or
14 coverage if it is governed by or is owed by reason of the
15 authority of the terms of the plan or policy documents
16 themselves. We've cited to the *Ardestani* case in our brief.
17 That's not, obviously, a health insurance case, but interpreted
18 the word "under" and applied that dictionary definition of the
19 word "under."

20 So it has to be the plan documents themselves that
21 tell you what the rate is for that service, what the in-network
22 rate for that service is. If there's some separate agreement
23 entered into after the fact, that just simply does not count
24 under the statute.

25 As I mentioned previously, the distinction between

1 single-case agreements and the generally applicable rates under
2 the plan documents themselves turns on the fact that insurers
3 sometimes will essentially voluntarily agree to pay charges, in
4 whole or in part, even if they're not under a legal compulsion
5 to do so.

6 And I would refer the Court, if the Court is
7 interested in further reading on this topic, to the Zack Cooper
8 article, which is page 1073 of the administrative record, page
9 739 of the joint appendix. Also, the Erin C. Fuse Brown
10 article, page 2860 of the administrative record, page 340 of
11 the joint appendix, which both discuss this phenomenon, where
12 insurers will enter into agreements even though they're not
13 legally compelled to do so, even though the plan documents
14 themselves do not compel the payment.

15 One additional point on this argument is, just to
16 remind the Court, as I'm sure you're aware, that the statute
17 does not set the QPA on the basis of any contracts whatsoever,
18 it's on the basis of contract rates under the plans or policies
19 that are in effect as of January 31st, 2019, and then subject
20 to an inflation adjustment.

21 So this makes sense when you think of what Congress
22 was trying to accomplish. They wanted to get the universe of
23 contracted rates under plans that were out there as of a
24 snapshot in time. Plaintiffs are not always on the same plan
25 year; some are on calendar years, some are on other fiscal

1 years. But any plan in force as of January 31st, 2019, whether
2 that was the end of that particular plan's year or the
3 beginning of the plan's year, would count for that particular
4 snapshot in time for purposes of this calculation. And that
5 makes sense when you're talking about plans in general.

6 Under the plaintiffs' theory this qualifier doesn't
7 make any sense whatsoever because there's no reason to think
8 that Congress would have thought that a single-case agreement
9 that just happened to be entered into on the day of January
10 31st, 2019 had any particular relevance to it. It just simply
11 does not make sense under the statutory language.

12 Finally, on this point, the plaintiffs have argued
13 that the defendants have acted inconsistently with regard to
14 the definition of a participating facility. And, again, to
15 take a step back as to why this phrasing is relevant under the
16 statute. Under some circumstances the No Surprises Act will
17 apply for a patient only if they have scheduled an in-network
18 appointment at a, quote, participating facility. And that if
19 it turns out that the patient later receives care from an
20 out-of-network physician at that facility, the Act kicks in and
21 protects the patient from balance billing.

22 So the definition of which facilities are
23 participating facilities matters quite a bit for the purposes
24 of that determination, although less so for the purposes of why
25 we're arguing here today.

1 The definition in the statute of a participating
2 facility is different from the definition of a qualifying
3 payment amount. Statute defines a participating facility as a
4 facility with a direct or indirect contractual relationship
5 with the plan or issuer with respect to the furnishing of such
6 an item or service at the facility. So there's not the same
7 language, there's not the "under the plan" language that we see
8 in the qualifying payment amount. It's simply a different
9 statute. So the disparate treatment makes sense, given the
10 different statutory requirements.

11 Turning to the second argument with regard to
12 treating all air ambulance providers as within the same medical
13 specialty. The statute provides that a qualifying payment
14 amount is the median contracted rate for the service that is
15 provided by a provider in the same or similar specialty. So
16 the departments, of course, needed to define who is within a
17 same or similar specialty, who were in different specialties.

18 The departments considered the matter and decided
19 that all providers of air ambulance services are considered to
20 be a single provider specialty, whether they are owned by
21 hospitals, whether they are owned by independent entities.
22 Now, this is important to the plaintiffs, as I understand their
23 theory, because hospital-based services may have lower rates
24 but independent air ambulance operators, who in recent years
25 have been acquired -- in frequent cases have been acquired by

1 private equity, have adopted a business model of driving up
2 their rates and charging more for the same service.

3 So the departments reason that from the perspective
4 of a patient, if you're picked up by an air ambulance and taken
5 to a hospital or what have you, you are receiving the same
6 service, the same medical specialty is being performed from the
7 perspective of the patient, no matter who is the operator of
8 that airplane or that helicopter or who have you. The patient
9 would have no reason to care whether it's the hospital's air
10 ambulance or whether it's an independent operator's air
11 ambulance; they're receiving the same service either way.

12 THE COURT: There's a difference between that
13 happening if it's an emergency situation versus a nonemergency
14 situation. In a nonemergency situation there's an opportunity
15 to think through in advance the financial consequences of being
16 air ambulated somewhere. In an emergency situation the person
17 frequently isn't even conscious or is under such adverse
18 circumstances that he or she can't possibly be processing
19 anything of that kind.

20 MR. McELVAIN: Correct. And I think in the typical
21 case it would be an emergency that a patient is using an air
22 ambulance. I don't have precise statistics, but I think it's
23 relatively rare that it would be a nonemergency situation where
24 air ambulance services came into play. But regardless,
25 Congress made the judgment that air ambulance services

1 categorically, across the board, are the types of service where
2 the No Surprises Act applies and the law should apply to all
3 such services.

4 And the question here, of course, is simply what does
5 it mean to be in the same or similar specialty from the
6 perspective of hospital-based ambulances versus independent
7 ambulances? The departments reasonably treated that phrase in
8 the statute as referring to the practice specialty of a
9 provider, which as a, you know, cardiology or urology. The
10 type of medicine that a provider provides, or the type of
11 service that is provided, rather than the ownership structure
12 of the entity.

13 The plaintiffs have made an issue of a separate
14 treatment of freestanding emergency departments and hospital-
15 owned emergency departments. The rule does permit insurers to
16 treat those types of facilities separately if they have a
17 standard practice of allowing separate billing from those types
18 of entities. And the plaintiffs' theory is that this same
19 disparate treatment should, therefore, have been allowed for
20 air ambulances.

21 But this treatment arose under a separate statutory
22 provision. There's language in the statute 300gg-111(a)(2)
23 that directs the departments to take into account payment
24 adjustments that -- payment adjustments that take into account
25 the quality or the facility type, including higher acuity

1 settings. The departments found that there was some evidence
2 to believe that there was a difference in the acuity of
3 patients that go to one type of emergency department or the
4 other and so, therefore, permit a disparate treatment to
5 account for the fact that there was that relevant distinction.

6 There's no evidence in the record that there's a
7 similar distinction to be drawn among these types of air
8 ambulance providers. And in any event, air ambulance providers
9 are not facilities within the meaning of this language.

10 "Facility" is a term of art in the statute that refers to
11 hospitals, freestanding clinics, I believe ambulatory surgical
12 centers, an actual facility that has a building, say, not an
13 air ambulance provider. So this separate statutory authority
14 just simply did not come into play for air ambulance providers
15 at all.

16 Turning to the third argument that the plaintiffs
17 have raised, going to the scope of the geographic regions. So,
18 again, to remain the Court, the qualifying payment amount is
19 the median of the contracted rates for service provided in the
20 geographic region in which the item or service is furnished.
21 And the Act also directs the departments to issue regulations
22 that would establish the methodology to determine the
23 qualifying payment amount and, specifically, to define these
24 geographic regions.

25 So, the departments exercises authority to say, in

1 the first instance, the relevant geographic regions for air
2 ambulances would be all of the metropolitan statistical areas
3 in one state and all of the areas within that state outside of
4 those MSAs, if that does not provide sufficient data. And by
5 sufficient data, that means at least three in-network rates
6 that you could find to set a median, because you need at least
7 three -- one, two, three -- to set the median of number two in
8 the middle.

9 If you cannot get at least those three contract rates
10 from the geographic region so defined, then the fallback --
11 which is what the plaintiffs challenge -- the fallback is to go
12 to all the MSAs within the larger census region or all the
13 non-MSA areas within the census region.

14 So the question is, if you don't get enough data from
15 within that one particular state, is it permissible to draw
16 this larger geographic region? Or were the departments
17 required to accept the plaintiffs' proffered alternative, which
18 was to draw price figures, pricing data from a database.

19 I think the first response to that is simply that no
20 such database exists. The departments could not have
21 committed -- could not have acted arbitrarily or capriciously
22 if they declined to rely on a database that simply does not
23 exist. And I'll refer the Court to the letter from Cameron
24 Curtis, who is, himself, the president of the Association of
25 Air Medical Services, the plaintiff here. There's one such

1 letter, which is ECF 5-8. It's with the plaintiffs' summary
2 judgment papers. And there's a second letter from Mr. Curtis
3 at pages 291 and 292 of the joint appendix that makes the same
4 point, that no such database exists. The air ambulance
5 providers were volunteering to create this database for the
6 departments. The departments -- that was a very kind offer,
7 but the departments reasonably declined that kind offer and
8 chose to go with actual market data from actual contracts that
9 exist outside and, you know, among actual providers and actual
10 payers instead.

11 Turning to the final point, the plaintiffs have also
12 taken issue with the departments' use of the qualifying payment
13 amount to set patients' cost-sharing payments. So, to remind
14 the Court, the qualifying payment amount plays two roles under
15 the statute.

16 First, it is used to base what cost-sharing a patient
17 will owe for a particular service and then, separately, it
18 forms the basis -- as I believe we'll be talking about later
19 this afternoon, will be it forms the basis of setting payments
20 between providers and insurers.

21 This argument goes to the first purpose; it goes to
22 how do you go about setting the patients' cost sharing? Under
23 300gg-112, which is the air ambulance statute, the statute
24 specifies that a patient's cost sharing should be based on the
25 amount that would apply if such services are provided by a

1 participating provider. But the statute does not itself
2 directly specify how do you go about determining what that
3 amount would have been if there were a participating provider.
4 So the departments reasonably chose to fill that gap by looking
5 to the parallel structure in 300gg-111, which applies to other
6 providers. And under that statute cost sharing ultimately
7 turns, absent a statutory exception, on the qualifying payment
8 amount.

9 And so, the departments look at gg-111, applied the
10 same framework to gg-112 and said if we use the qualifying
11 payment amount, that would be a fair approximation of what the
12 in-network price would have been for the service.

13 Now, the plaintiffs take issue with this treatment.
14 They read the statute -- their argument, as I understand it, is
15 300gg-111 explicitly bases this calculation on the qualifying
16 payment amount. There is no such explicit language in
17 300gg-112. Therefore, the plaintiffs argue, under the
18 *expressio unius canon* Congress must have meant to foreclose the
19 departments from using the qualifying payment amount for this
20 calculation.

21 But there is a host of authority in D.C. Circuit that
22 states that the *expressio unius canon* has little force in the
23 administrative setting. *Van Hollen versus FEC*, from 2016, is
24 one such case from the Circuit. *Catwaba County versus EPA*, a
25 2009 case from the D.C. Circuit, makes the same point. A

1 congressional mandate in one section and silence in another
2 often suggests not a prohibition, but simply a decision not to
3 mandate any solution in the second context, i.e., to leave the
4 questioning to agency discretion. And that exactly describes
5 300gg-111 and 300gg-112 and the circumstances here.

6 The alternative under which, as I understand the
7 plaintiffs' argument, the patients' cost-sharing would
8 ultimately turn on whatever agreement is ultimately arrived at
9 between the provider and the payor, would essentially return
10 patients back to the middle of these payment disputes. And
11 that would put -- the central purpose of the No Surprises Act
12 was to take patients out of those disputes, after all, and make
13 sure that patients had fiscal certainty, rather than facing
14 uncertain medical debt from the types of medical services to
15 which the No Surprises Act applies.

16 So for these reasons we believe that the AMS's
17 challenges to the rule should be rejected and summary judgment
18 should be awarded to the defendants. And I would invite any
19 questions from the Court.

20 THE COURT: We'll get to the rebuttal, then we'll
21 take a break.

22 MR. McELVAIN: Thank you.

23 THE COURT: You'll have seven minutes.

24 MR. STIMSON: Thank you, Your Honor. I want to talk,
25 first, about the contracted rate issue and then talk about the

1 database point. So, I think there's a perhaps a
2 misunderstanding of the relationship between plan documents and
3 network contracts that is animating the discussion.

4 The plan documents are between the plan and the
5 enrollee. The coverage would be between the issuer and the
6 beneficiary. A network contract is between the planner issuer
7 and the provider that delivers the services, and it sets forth
8 the rate that the planner issuer pays to the provider.

9 The plan documents will typically say something along
10 the lines of we will pay our in-network or out-of-network
11 allowable for the services on your behalf, enrollee or
12 beneficiary. What they don't do is unilaterally impose
13 contracted rates on providers. They can't, because the
14 providers are not party to the plan documents. It's a
15 tripartite arrangement.

16 So what the government is arguing in the real world
17 doesn't make logical sense. They're saying that you would only
18 look to contracted rates in plan documents when the contracted
19 rates, whether it's on a network basis or a single case basis,
20 set forth in the agreement between the planner issuer and the
21 provider. The plan documents simply obligate the planner
22 issuer to pay the provider on the enrollee or beneficiary's
23 behalf.

24 The government seems to be positing that plans and
25 issuers pay out-of-network charges out of the goodness of their

1 hearts. And that can't possibly be true. Because you or I or
2 anyone else goes to plans and issuers and buys out-of-network
3 benefits so that those charges are paid in whole or in part.
4 They're not paid out of the goodness of the plan's or issuer's
5 hearts. They're paid because there's an obligation to do so.

6 And the Cooper and Brown articles say just that,
7 actually. If you go to the Cooper and Brown articles, they're
8 at JA-739 and JA-346, they acknowledge the reality that plans
9 and issuers under the plan documents are obligated to pay
10 amounts on behalf of their beneficiaries. Sometimes they pay
11 the full bill charges, sometimes they pay a portion of the bill
12 charges, and sometimes they pay nothing, if they don't believe
13 that the service is covered. That's all the -- all those
14 articles stand for and they don't support the government's
15 interpretation.

16 On the database issue, it is true that AMS has -- has
17 acknowledged in comments that there is not presently a database
18 of allowed amounts. But, two points are worth noting. One,
19 that's the answer that the government -- that Congress
20 prescribed to the issue of the lack of contracted rates.
21 Congress didn't prescribe the use of census divisions so that
22 you could compare rates -- you could use rates in Seattle as a
23 comparator for rates in San Diego. The government prescribed
24 the use of a database.

25 AMS, in its comments, offered to assist the

1 government in developing a database of allowed amounts. And
2 that's at JA-292. And the government did not take AMS up on
3 that offer. Instead, the government narrowed its reading of
4 the plain language of allowed amounts to exclude out-of-network
5 allowed amounts, which would have enabled the building of
6 robust database that would have solved the geographic region
7 problem. So, again, that issue is a problem of the
8 government's own making.

9 Thank you, Your Honor.

10 THE COURT: All right. We're going to take a
11 ten-minute break. My court reporter has been working awfully
12 hard, deserves a rest. And we'll be back in ten minutes and
13 then we'll hear from the parties on the status of the Texas
14 order, where the government sees it going, what the
15 government's position is going to be with regard to that, and
16 get whatever response the American Medical Association -- I
17 think Akin Gump's counsel is prepared to address that issue.

18 See you in ten minutes.

19 (Recess.)

20 THE COURT: All right, Counsel. Let's start with the
21 government.

22 What's the government doing on the appeal of that
23 decision in Texas? Are they appealing it or not appealing it?

24 MR. McELVAIN: I don't have a definite answer for
25 that, Your Honor, just yet. I recognize that's not an entirely

1 satisfactory answer, but we --

2 THE COURT: It's been about a month.

3 MR. McELVAIN: We have not appealed yet. And
4 we've -- as we've previously stated --

5 THE COURT: In fact, it's almost exactly a month.

6 MR. McELVAIN: That sounds about right, yes, Your
7 Honor. I can tell you that we haven't appealed yet. I can
8 say, as we previously said in our papers, that we are working
9 on a final rule and our anticipation, our intent is to issue a
10 final rule no later than May.

11 THE COURT: You have, under the rules in that
12 circuit, right, 60 days or 90 days?

13 MR. McELVAIN: 60 days. So the appeal time hasn't
14 run yet. And I'm sorry, I just cannot make a definitive
15 representation to you as to whether we will appeal or not. All
16 I can tell you, as you're already aware, that we have not yet
17 appealed, And we're working on a file rule.

18 THE COURT: Is that -- the opinion of the judge in
19 Texas, it's a national -- ruling of national proportions,
20 right?

21 MR. McELVAIN: We urged the Court not to enter a
22 ruling with nationwide implications, with nationwide effect.
23 He reject that suggestion and vacated the particular portions
24 of the rule across the board. So, yes, we do understand his
25 ruling to have nationwide effect.

1 THE COURT: So as to the portion of this case that
2 the American Medical Association is involved in, dicta is in
3 place?

4 MR. McELVAIN: The dicta is in place. We just spoke
5 to the AMA, which is also challenging 149.510. I guess there
6 are some asterisks to offer there. First, with respect to the
7 Air Ambulance challenge, they are challenging --

8 THE COURT: Those issues weren't raised in the Texas
9 case, right?

10 MR. McELVAIN: Correct, 149.520 is a separate
11 regulation which was not addressed by the Texas court. I
12 should note, it's a little bit more complicated than that
13 because 149 --

14 THE COURT: Is that possible?

15 MR. McELVAIN: Could it possibly be more complicated?

16 THE COURT: This is like something out of a fake
17 courts exam.

18 MR. McELVAIN: That's a fair point.

19 149.520, in part, incorporates 149.510, so that
20 complicates the issue to a certain extent. The agencies are
21 working on guidance that would address what standards are under
22 the remaining portions of the regulations for both air
23 ambulances and other providers. That guidance isn't out yet.
24 We're working as fast as we can to get that out for the
25 arbitrators. So, you know, that guidance is forthcoming.

1 But, I think the bottom line is that, yes, there is a
2 live dispute that remains with the air ambulance providers.
3 149.520 was not addressed by the Texas court and so we would
4 urge that summary judgment be awarded for the defendants in the
5 air ambulance challenge for the reasons we've expressed in our
6 briefs. And I would be happy to go into them, if the Court was
7 inclined to hear argument.

8 THE COURT: Of course the other alternative is to
9 wait and see what happens with the appeal and the new rule you
10 said that they're working on.

11 MR. McELVAIN: Right. We're working on a final rule.
12 Our intent is to issue a final rule no later than May. That is
13 our intent. I cannot make that 100 percent guarantee. There
14 are no 100 percent guarantees in life, but that is what we're
15 hoping to achieve.

16 THE COURT: The DOJ's thinking is it's preferable for
17 the Court to go ahead and issue a ruling, rather than wait
18 until May?

19 MR. McELVAIN: I think if the Court is inclined to
20 wait, then we would be perfectly amenable to that. There's --
21 this case has diminishing relevance as each day goes by and
22 there will be a final rule in the near future, which I imagine
23 we may very well be back in this courtroom on, depending on if
24 the providers --

25 THE COURT: Well, I think that's probably a fair

1 assumption, that there might be reason to challenge that, too.

2 MR. McELVAIN: I can't make any representations as to
3 what the content of the rule may be. Maybe the providers will
4 be unhappy, maybe insurers will be unhappy and we would get a
5 lawsuit in a different direction. I just simply can't make any
6 representations one way or the other.

7 THE COURT: All right. Let me hear from AMA's
8 counsel.

9 MR. TYSSE: Good afternoon, Your Honor. James Tysse
10 on behalf of plaintiffs in the American Medical Association,
11 American Hospital Association matter.

12 This Court, Your Honor, can and should go ahead and
13 enter summary judgment in favor of plaintiffs on their claims
14 challenging the September rule in both the AMS matter and in
15 our matter. It has the power to do so. As the government just
16 said, it acknowledged that it can and could do so with respect
17 to the AMS claims. It should do so on the claim in our matter
18 as well. And I'm happy to explain why in some detail.

19 THE COURT: Yeah, because, look, we don't just whip
20 off opinions around here.

21 MR. TYSSE: Of course not.

22 THE COURT: You want me to pump out a 60-, 70-page
23 opinion, or longer, when there's a new rule coming out in May,
24 which you may want to amend your complaint and challenge that
25 for whatever reasons -- at least I'm talking hypothetically. I

1 don't know what's going to happen, obviously.

2 MR. TYSSE: Of course.

3 THE COURT: You know, we do more than enough writing
4 around here as it is.

5 MR. TYSSE: I understand, Your Honor.

6 THE COURT: More than enough.

7 MR. TYSSE: I understand, Your Honor. I think it
8 could be a quite short opinion, though, in our view.

9 THE COURT: I'm sure if you were writing it.

10 MR. TYSSE: I think the Eastern District of Texas got
11 it right. It's -- the statute is clear. Congress sets the
12 policy, not the departments. And that's essentially what the
13 opinion can say; that's about as simple as it is.

14 But let me give you --

15 THE COURT: I don't think the D.C. Circuit would like
16 an opinion like that. The D.C. Circuit likes things with
17 ribbons and bows on it. This is my 20th anniversary, this
18 week. So I'm used to how the D.C. Circuit operates and they
19 like things, you know, jot and tittle, ribbons and bows, laid
20 out. So we're talking probably, in a case of this complexity
21 and magnitude, somewhere between 40 and 60 pages or 40 and 75
22 pages. That's a lot of work, especially if it's going to all
23 be thrown up in the air and changed in May.

24 MR. TYSSE: Well, I appreciate that point, Your
25 Honor. I understand it is a lot of work. At the same time, if

1 you would indulge me, let me provide a few reasons why I think,
2 notwithstanding that fact, we would still urge you to rule and
3 not wait until May.

4 And the first is that, I think as the government just
5 acknowledged, the Court, unquestionably, has a live controversy
6 with respect to the AMS claims. The reason is, AMS is
7 challenging, as we just discussed, a separate provision, it's
8 45 CFR 149.520(b)(2), in particular. And what that language
9 says in that particular provision, it actually borrows some of
10 the offending language that the Eastern District of Texas stuck
11 out. In particular, that information provided by a party to
12 the arbitration must also, quote, clearly demonstrate that the
13 qualifying payment amount is materially different from the
14 appropriate out-of-network rate. That is an existing
15 regulation right now that is extent and binding parties to
16 arbitrations. And while this regulation is in place, there is
17 a live controversy on that issue.

18 Now, because the Court is going to -- needs to
19 adjudicate that issue, we submit there's no reason why it
20 should not also adjudicate the exact same issue in the
21 companion case that this Court consolidated at the government's
22 urging on judicial economy grounds. And I think the reason is,
23 of course, any opinion in that case is likely to be appealed.
24 It would make no sense for only a portion of -- the AMS portion
25 of the claim to go up on appeal and not have the rest of the

1 consolidated case go up. So we think that, again, this is an
2 operative provision right now that is offensive for the exact
3 same reason --

4 THE COURT: And, of course, if there was a circuit
5 conflict at some point, it could go to the Supreme Court.

6 MR. TYSSE: Sure enough, Your Honor. But either way,
7 I think my plaintiffs -- my clients, excuse me, and the
8 American Hospital Association clients would like to be part of
9 that appeal process. We feel strongly about -- that this rule
10 is injuring our clients daily, threatens to impose serious
11 injuries, and we want to be part of explaining to both this
12 Court, as well as the D.C. Circuit and any Court that will have
13 jurisdiction why this rule is plainly contrary to the statute.
14 So it just doesn't make sense, we think, to kind of
15 double-track the cases.

16 We also seek broad relief, Your Honor. We seek to
17 invalidate a couple of provisions that were not invalidated in
18 the Texas case. They're set forth in our notice of
19 supplemental authority. Both of them are, sort of, part and
20 parcel of the broader rule. And I think another, kind of,
21 important consideration is that unlike in the Texas action, the
22 American Medical Association and American Hospital Association
23 plaintiffs have nationwide membership and indisputable
24 standing.

25 One of the arguments that the government has raised

1 in the Texas action is that the plaintiffs in that suit lack
2 standing. And if they appeal, which we -- so far they've
3 vigorously defended this case, we have assumed they will
4 appeal. But if they do, they could also seek a stay of that
5 judgment pending appeal, they could seek to overturn the
6 judgment based on the lack of standing of those members.
7 Obviously, that would immediately -- the harms that my clients
8 face would spring into effect immediately, as soon as that were
9 to happen.

10 THE COURT: I don't know in the Fifth Circuit loves
11 standing issues the way the D.C. Circuit does. The D.C.
12 Circuit loves those issues.

13 MR. TYSSE: That is possible true, Your Honor, but I
14 do think it is a threshold issue that would have to be
15 adjudicated in that case. That does not have to be adjudicated
16 here, where the parties clearly have standing.

17 And I think the final reason, that this probably
18 really gets to your point, is why issue a ruling in this at
19 all. Like I said, I think because the AMS regulation is
20 outstanding, there is a live dispute there. You know, the
21 Court should go ahead and rule on both. But, I think, you
22 know, part of the issue is that even now the departments are
23 working on a final rule, as they've said. It's presumably
24 going to try to, you know, tweak this in some respect or
25 another. But I think a ruling from this Court that was in

1 accordance with the ruling of the Eastern District of Texas or
2 even, perhaps, built on that ruling would help the situation
3 that my clients are facing by giving -- you know, sending a
4 clear message, essentially, to the agency about why they have
5 gone so far astray in their statutory construction.

6 I think, given it's a live controversy, there's no
7 reason why this Court, which has, you know, virtually
8 unflagging jurisdiction to adjudicate controversies within its
9 jurisdiction could not go ahead and adjudicate the controversy
10 and then, you know, the agency would have to take that into
11 account when it promulgated its rule.

12 I think, beyond that, there's two other, kind of,
13 harms that are kind of ongoing. One is that, as we've set
14 forth in our papers, particularly our initial stay papers,
15 there are negotiations right now going on between health care
16 providers on the one hand and commercial insurers on the other
17 hand over the appropriate payment rates. Part of those
18 negotiations, you know, for contracts, for in-network
19 contracts, have to do with, well, how are out-of-network
20 payments going to be decided upon under the No Surprises Act.

21 So it's actually important to get clarity on that
22 issue sooner or later. And just kind of kicking the can down
23 the road for a few months, to May, prejudices those
24 negotiations.

25 I think there is a third point, which is under the

1 statutory scheme, there's a 30-day open negotiation period
2 before we get to the arbitration process. So our briefs are
3 really focused on the arbitration process and what happens
4 there. But, before that happens, there's a 30-day period where
5 insurers and health care providers can try to negotiate a fair
6 price.

7 Well, obviously, when there's this much uncertainty
8 over the status of this rule, what the government is going to
9 do, those negotiations are going to come to a halt. The
10 parties can't know what is going to be a fair price to offer if
11 this elephant in the room is out there where, you know, all
12 these cases are stayed, the appeal process is not going
13 forward. So I think that's yet another reason why it's
14 important to rule on this issue now, rather than kicking the
15 can down the road.

16 And I think I'll make one more point on that, too,
17 which is that I think the government said something to the
18 effect of, you know, there's a fair assumption that we'll just
19 be back here again in a few months. And I think it's -- from
20 our perspective, we don't want to be back here in a few months.
21 We think Congress already made its choice. We think the choice
22 it made was very clear. It, in pretty unusually detailed
23 language, I think, set forth the specific factors and standards
24 that it wants the independent arbitrators to consider. It did
25 not, unlike in several other provisions throughout 300-111, you

1 know, provide the department shall issue regulations that, you
2 know, will go to the balancing of these factors or the weighing
3 of the factors.

4 And Congress used language -- in fact, it borrowed
5 language: Shall consider or shall take into consideration
6 direct language from D.C. Circuit case law, particularly the
7 *American Corn Growers* case and the *Public Service Commission of*
8 *Indiana* case, where courts have said, oh, when Congress used
9 that language, we assumed that the decision-maker is going to
10 get discretion to make the ultimate decision and that an agency
11 can't come over the top until, for example, in the *American*
12 *Corn Growers* case, they state how to exercise its discretion.

13 So we assume, in other words, that Congress
14 legislates against a backdrop of existing case law. And in
15 this circumstance they borrowed language that says Congress is
16 not imposing a particular structure, go ahead and adjudicate
17 the claim based on your own expertise. And these are all
18 certified independent expert arbitrators.

19 So, again, that's -- that's all to say that, again,
20 the government said that there's a fair assumption that we'll
21 be back in a few months. And we don't want to be back in a few
22 months and have to litigate this all over again. We think a
23 decision in this Court that makes clear that they can't do what
24 they've done, they can't impose a presumption, create a
25 presumption out of thin air -- that's obvious, that's nowhere

1 in the statute -- and they can't say that the arbitrator must
2 select one offer over another based, you know, again, where
3 it's nowhere to be found.

4 But even just the fact that the agencies have, sort
5 of, extracted one factor -- to borrow the language from
6 *American Corn Growers* extracted one factor out of a list and
7 treated it completely differently, I think, again, goes to show
8 that they've gone far astray in their rulemaking power and
9 there's no reason to delay relief.

10 So, again, we don't want to be back here litigating,
11 in six months, a revamped but still a legal rule. So, to the
12 extent that this Court is willing, we think that the
13 appropriate course is to go ahead and adjudicate the live
14 controversy involving AMS and the live controversy involving
15 the American Medical Association and the American Hospital
16 Association.

17 If the Court has further questions, I'm happy to
18 address any of them. I'm also happy to address the merits, to
19 the extent the Court is interested. But I defer to the Court's
20 judgment on what, if any, questions it has.

21 THE COURT: Let me give AMS a chance to speak a few
22 words on this matter.

23 MR. TYSSE: Thank you, Your Honor.

24 THE COURT: Thank you, sir.

25 How does it strike you, sir?

1 MR. STIMSON: I'm sorry, Your Honor?

2 THE COURT: How does it all strike you?

3 MR. STIMSON: We generally concur with the points
4 made by the AMA, and I would just double down on two of those.

5 The first is that the defects in the rules are
6 primarily legal in nature and they're not things that can be
7 fixed through tweaking in the margins. There's a core
8 statutory construction issue on Part 2 that the government got
9 wrong and then there's a core statutory construction issue on
10 Part 1 that the government got wrong and we think that it would
11 be a waste to come back and litigate the same issues in six
12 months.

13 There's also some urgency on the part of my clients
14 for clarity, both in the litigation and in the rulemaking and
15 in their business operations generally. This is affecting
16 their negotiations with payers, plans and issuers, it's
17 affecting the resources and the time and the personnel that
18 they're deploying to prepare for independent dispute
19 resolution. And the absence of a ruling that speaks to
20 § 149.520 in advance of April has the potential to prejudice
21 them in IDR proceedings that occur between now and the issuance
22 of a new rule. And for that reason it's very important to
23 them, if Your Honor chooses to address 149.520 before the first
24 IDR decisions start to roll in.

25 With that, I'm happy to answer any questions.

1 THE COURT: No, that's fine.

2 MR. STIMSON: Thank you, Your Honor.

3 MR. McELVAIN: Your Honor, may I have 30 seconds?

4 THE COURT: You may. You can actually have a couple
5 minutes. How is that? Seems only fair.

6 MR. McELVAIN: I negotiated against myself. I should
7 never do that.

8 Just a couple of quick points with regard to
9 Mr. Tysse's comments on behalf of the AMA plaintiffs. If I
10 understood his position correctly, I believe he was urging this
11 Court to issue an opinion which would be helpful on the
12 rulemaking process because it would serve in an advisory
13 capacity for the agencies to take into account for the next
14 rule.

15 If there's one issue that is absolutely core to the
16 notion of Article III jurisdiction, it's that Courts do not
17 issue advisory opinions. They decide live controversies. And
18 I think it's quite doubtful, with respect to the AMA
19 plaintiffs, that there is still a live controversy.

20 To be fair, the AMA plaintiffs do say that they are
21 challenging two additional sentences of the regulation that
22 were not vacated by the Texas court. But if you look at those
23 particular provisions, one is 149.510(a)(2)(v), which is the
24 definition of credible information. It tells the arbitrator
25 only consider credible information.

1 I'm having trouble understanding what the plaintiffs'
2 objection is to that argument. If the question is: Are
3 arbitrators prohibited from considering information that is
4 incredible, that is not credible, that is a merits argument
5 that I am very comfortable having. But even before we get to
6 the merits, I have genuine doubt that there is a live
7 controversy and that they suffer any harm from that particular
8 provision.

9 Similarly, they also seek the vacatur of the third
10 sentence of 149.510(c)(4)(ii)(A), which reads as follows: In
11 these cases, the certified IDR entity -- the arbitrator -- must
12 select the offer as the out-of-network rate that the certified
13 IDR entity determines best represents the value of the
14 qualified IDR items or services, which could be either offer.

15 Again, I'm having trouble understanding what the
16 plaintiff's objection is to that particular sentence, when it's
17 a stand-alone sentence. I had understood up to this point the
18 plaintiffs' claim that they were prejudiced by the rule because
19 the rule did not allow the arbitrators to determine fair value
20 if they're -- after the conclusion of merits briefing, if they
21 seek to recast their theory, to claim that they're harmed
22 because they are not permitted to gain unfair value from the
23 arbitrator, I guess I would like to know what that claim is and
24 have the opportunity to respond to it, that's all.

25 THE COURT: Well, I have a practice, which you may or

1 may not be aware of, in cases that are complex and have
2 substantial issues, and especially novel issues, I give the
3 parties a chance -- based on my own experience years ago as a
4 litigator, where invariably would go out for a beer afterwards
5 and said, I wish I'd said this, I wish I'd said this, I wish
6 I'd said this.

7 So, well, you'll get a transcript in this case,
8 obviously, and when you've reviewed the transcript, invariably
9 you'll said, I wish I'd said this, I wish I'd said this, I wish
10 I'd said this. So I'll give you a chance to supplement your
11 pleadings. I'll give you ten days from the date you get your
12 copy of the transcript. And it won't be cross -- you know,
13 back and forth.

14 Each side can do one supplemental, limited to what
15 was asked or said here in the courtroom, and not new issues,
16 not raising new issues. And we'll put a 12-page limit. That's
17 it. It's got to be 12 pages or less. And it's got to be
18 limited to what was discussed here in the courtroom. And all
19 three parties, the government and the two plaintiffs can submit
20 something, and just to supplement or clarify something you've
21 said or wish you'd said during the course of the hearing today.

22 It's very heavily briefed and very well argued. I
23 commend all of you on your pleadings and for the briefing and
24 the arguments today. I wish we had more of those quality
25 briefs and arguments more frequently. But, obviously, it's an

1 important matter, it has tremendous ramifications and
2 consequences to the parties involved, and the government. And,
3 so, it's something that's going to take some serious, careful
4 thought, and hard work at some point. So the only question is
5 when and under what circumstances. And if you need to flesh
6 that out a little more, both sides are welcome to do that, too.

7 Thank you, Counsel.

8 MR. McELVAIN: Thank you, Your Honor.

9 THE COURT: Have a good day.

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CERTIFICATE OF OFFICIAL COURT REPORTER

I, JANICE DICKMAN, do hereby certify that the above and foregoing constitutes a true and accurate transcript of my stenographic notes and is a full, true and complete transcript of the proceedings to the best of my ability.

Dated this 22nd day of March, 2022

Janice E. Dickman, CRR, CMR, CCR
Official Court Reporter
Room 6523
333 Constitution Avenue, N.W.
Washington, D.C. 20001